UNIVERSIDADE FEDERAL DO RIO DE JANEIRO – UFRJ

CENTRO DE CIÊNCIAS DA SAÚDE – CCS

INSTITUTO DE PSIQUIATRIA – IPUB

GUSTAVO CARVALHO DE OLIVEIRA

A VIOLÊNCIA, O DIREITO E A PSIQUIATRIA: DA INSTITUCIONALIZAÇÃO À DESINSTITUCIONALIZAÇÃO, DA CESSAÇÃO DE PERICULOSIDADE AOS HOMICÍDIOS SEXUAIS

RIO DE JANEIRO

2021

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Tese apresentada ao Programa de Pós-graduação em Psiquiatria e Saúde Mental do Instituto de Psiquiatria da UFRJ

Tese apresentada ao Programa de Pós-graduação em Psiquiatria e Saúde Mental do Instituto de Psiquiatria da Universidade Federal do Rio de Janeiro, como requisito parcial à obtenção do título de Doutor em Psiquiatria e Saúde Mental

Orientador: Alexandre Martins Valença

RIO DE JANEIRO

2021

“A VIOLÊNCIA, O DIREITO E A PSIQUIATRIA: DA INSTITUCIONALIZAÇÃO À DESINSTITUCIONALIZAÇÃO, DA CESSAÇÃO DE PERICULOSIDADE AOS HOMICÍDIOS SEXUAIS”

Gustavo Carvalho de Oliveira

Tese de doutorado submetida ao Programa de Pós-graduação em Psiquiatria e Saúde Mental (PROPSAM), do Instituto de Psiquiatria da Universidade Federal do Rio de Janeiro – UFRJ, como parte dos requisitos necessários à obtenção do título de Doutor em Psiquiatria e Saúde Mental.

Aprovada em 30.06.2021 por:

Prof. Dr. Alexandre Martins Valença - Presidente

(participação por vídeo conferência)_____
Prof. Dr. Antônio Egídio Nardi – Membro titular interno

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Prof. Dr. William Berger - Membro titular interno

(participação por vídeo conferência)_____
Profa. Dra. Kátia Mecler – Membro titular externo

(participação por vídeo conferência)_____
Prof. Dr. Elias Abdalla-Filho – Membro titular externo

DEDICATÓRIA

I*n memoriam*: **Professor Miguel Chalub**

(29.03.1938-30.05.2021),

Ele me acolheu e me recebeu no meu primeiro contato com a Psiquiatria Forense no Instituto Heitor Carrilho há 6 anos. Obrigado, és inspiração a todos nós da Psiquiatria Forense. Descanse em paz, Mestre dos mestres.

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EPÍGRAFE

“Como dois e dois são quatro

Sei que a vida vale a pena

Embora o pão seja caro

E a liberdade pequena”

Ferreira-Gullar

RESUMO

Esta pesquisa teve por objetivo estudar relações diversas entre a Violência, o Direito e a Psiquiatria, por meio da realização de uma coletânea de seis artigos científicos separados em três capítulos.

Uma revisão de literatura revelou que a presença de doença mental, de modo isolado, não é fator diretamente associado ao maior risco de violência e que fatores relacionados à própria institucionalização e privação de liberdade se relacionam à predição de violência. O sofrimento de violência por parte dos doentes mentais institucionalizados, devido à negligência tanto com a sua saúde física como a psíquica, são fatores que causam muita preocupação. Um segundo estudo realizado em uma instituição de longa permanência, em Brasília, revelou um perfil de indivíduos institucionalziados homens, com idade média de 47,6 anos, solteiros, com baixa escolaridade, pouca qualificação profissional e em polimedicação com histórico de comportamento agressivo e diagnóstico de Esquizofrenia. Dois itens mostraram-se altamente relacionados a um maior tempo de institucionalização, com significância estatística: polimedicação e antecedente de internação por comportamento violento. Um terceiro estudo, de uma série de casos sobre parricídio, matricídio e filicídio, ilustrou que esses crimes foram praticados por indivíduos com transtornos mentais e sem adequado acompanhamento terapêutico, sendo que decisões judiciais optaram por inimputabilidade e semi-imputabilidade, daí a medida de segurança para todos, com finalidade protetiva e terapêutica. Um quarto estudo realizado no Instituto Médico-Legal do Distrito Federal, com a finalidade de verificar fatores considerados relevantes pelos peritos oficiais para a cessação de periculosidade em indivíduos que cumpriam medida de segurança, mostrou que os principais itens considerados pelos peritos nas avaliações foram os referentes aos instrumentos PCL-R, START e a parte não estática da HCR-20 e da TTV, que são passíveis de alteração com o passar do tempo. A padronização e sistematização dessas perícias é fundamental para que as decisões se tornem coesas e respaldadas pelos estudos científicos mais atualizados.

Um quinto estudo sobre a literatura científica atualizada mostrou um crescimento de vários tipos de violência contra a mulher no período de isolamento social: violência sexual, mortalidade por violência doméstica, redução dos direitos reprodutivos, exploração sexual e maior impacto econômico-financeiro, inclusive

com maior perda de empregos e aumento da exploração sexual de mulheres, de modo ainda mais grave nos países pobres. As medidas de isolamento social, indiscutivelmente necessárias para o controle da disseminação do vírus num contexto pandêmico, devem ser adotadas, porém cabe aprimorar a maneira de realizá-las, de modo a minimizar danos na saúde mental dos indivíduos, visto que há risco de grave adoecimentos, especialmente às populações mais vulneráveis, como mulheres e pessoas com transtornos mentais.

Em um sexto estudo, realizamos comparações entre homicídios sexuais e não sexuais em Austrália e Nova Zelândia, por meio de duas amostras controladas, encontrando resultados bastante relevantes, com presença de 101 itens significativamente diferentes, conforme estudo estatístico detalhado. Destacam-se as diferenças entre o estilo de vida do agressor e da vítima em cada tipo de homicídio, diferenças em relação à abordagem do agressor à vítima e a atividade da vítima antes do crime. A morte provocada por estrangulamento ou asfixia, o assassinato brutal com excesso de violência ("*overkilling*"), a presença de comportamento sádico, o uso de múltiplas armas e o histórico de alguma ofensa sexual prévia foram significativamente mais frequentes nos homicídios sexuais. Isso reforça a hipótese de que o homicídio sexual é um crime específico e muito distinto de outros homicídios, e mesmo de outros crimes sexuais. Após os resultados do estudo comparativo, foram realizadas cinco regressões logísticas, visando à criação de modelos com o intuito de predizer a possibilidade de um homicídio ser sexual, sendo os itens estudados separados em quatro dimensões: perfil do agressor; características da vítima e suas atividades no momento do crime; cena do crime; local de recuperação do corpo da vítima. A 5ª regressão logística unificou as quatro referentes às dimensões analisadas, criando-se um modelo preditivo geral. Todas as regressões foram significativas e a última delas mostrou que, no caso de um homicídio em que, concomitantemente, estão presentes as seguintes características: vítima e agressor não se conheciam previamente; a duração do crime foi superior a uma hora; a vítima estava trabalhando momentos antes do crime; a cena do crime foi um quarto ou alojamento (ambiente/cômodo utilizado para dormir); e a vítima foi encontrada nua, em um local onde não seria possível ouvir a vítima, sugerem que se trata de um homicídio sexual, segundo o modelo preditivo obtido.

Esta tese concluiu que a relação entre a psiquiatria, o direito e a violência pode ser explorada e interpretada sob diferentes vertentes, desde os processos de institucionalização e o estudo dos fatores associados ao risco de violência nos indivíduos com doença mental, às repercussões na saúde psíquica e na violência contra a mulher, seja no contexto de isolamento social, seja no estudo dos homicídios sexuais. Não foi objetivo nosso encerrar essa ampla temática ou chegar a alguma conclusão definitiva sobre a mesma, mas sim fomentar conhecimento técnico-científico e promover reflexões em áreas intimamente relacionadas, mas muitas vezes, analisadas e estudas de modo independente.

Palavras-Chave: Psiquiatria Legal; Internação compulsória do doente mental; Transtornos mentais; Violência; Pandemia; COVID-19; Violência contra mulheres; Homicídios sexuais; Modelos preditivos.

ABSTRACT

This research aims at studying the various relationships between Violence, Law and Psychiatry, through a collection of six scientific articles divided into three chapters.

A literature review showed that the isolated presence of mental illness is not a factor directly associated with increased risk of violence. Factors related to institutionalization and deprivation of liberty are related to the prediction of violence. Violence suffered by institutionalized mental patients, due to negligence with both their physical and mental health, are factors that cause a lot of concern. A cross-sectional study carried out in a long-term institution in Brasília revealed a profile of institutionalized male individuals, with a mean age of 47.6 years, single, with low education, low professional qualification and on polymedication with a history of aggressive behavior and diagnosis of Schizophrenia. Two items highly related to a longer time of institutionalization, with statistical significance: polymedication and a history of hospitalization for violent behavior. A case series study on the subject of parricide, matricide and filicide showed that they were commited by individuals with mental disorders without adequate therapeutic. The study of the crimes revealed that the court decisions found these invdividuals not responsible or partially responsible by reason of insanity and ordered safety measures in all cases, with protective and therapeutic purposes. A cross-sectional study carried out with the Federal District Coroner's Office, with the purpose of verifying the factors considered relevant by official experts for the cessation of dangerousness in individuals already under safety measures, showed that in the experts' evaluations the items most considered were those related to the PCL- R, START and the non-static part of the HCR-20 and TTV. The standardization and systematization of these reports are essential for expert decisions to be supported by updated scientific studies.

The recent scientific literature has shown an increase in various types of violence against women during social isolation: sexual violence, mortality from domestic violence, reduction of reproductive rights, sexual exploitation, and greater economic and financial impact, including higher job loss and increased sexual exploitation of women, even more severely in poor countries. Social isolation measures, necessary to control the spread of the virus in a pandemic context, must be adopted, but it is important to improve the ways to implement them, in order to

minimize harm to the mental health of individuals, specially those more vulnerable and at higher risk, such as women and people with mental disorders.

The comparative study between sexual and non-sexual homicides in Australia and New Zealand used two controlled samples and found relevant results, with 101 significantly different items, according to statistical tests. The study found some differences between the aggressor's and the victim's lifestyle in each type of homicide, differences in relation to the aggressor's approach to the victim, and the victim's activity before the crime. Death caused by strangulation or suffocation, brutal murder with excessive violence (‘overkilling’), the presence of sadistic behavior, the use of multiple weapons and the history of some previous sexual offense were significantly more frequent in sexual homicides. This supports the hypothesis that sexual homicide is a specific crime, very distinct from other homicides and even from other sexual crimes. After the comparative study, we conducted five logistic regressions to develop models to predict if a homicide is sexual, based on four dimensions: aggressor’s profile; characteristics of the victims and their activities at the time of the crime; crime scene; body recovery scene. The fifth logistic regression unified the previous four, creating a general predictive model. All regressions were significant and the last one indicated that, in a homicide in which, simultaneously: victim and aggressor did not know each other previously, the duration of the crime was greater than one hour, the victim was at work moments before the crime, the crime scene was a room or accommodation (bedroom/room used to sleep) and the victim was found naked in a place where it would not be possible to hear the victim, it is probably a sexual homicide, according to the predictive model obtained.

This thesis concluded that the relationship between psychiatry, law and violence can be explored from different perspectives: from institutionalization processes and the study of factors associated with the risk of violence in persons with mental illness, to the repercussions on mental health and violence against women, whether in the context of social isolation or in the study of sexual homicides. The goal is not to find a definitive conclusion on all these topics, but rather to offer technical-scientific knowledge and promote debate in closely related areas that are often independently analyzed and studied.

Key-Words: Forensic Psychiatry; Commitment of Mentally Ill; Mental disorders; Violence; Pandemic; COVID-19; Violence against women; Sexual Homicide; Predictive models.

LISTA DE SIGLAS

AIDP - Associação Internacional de Direito Penal

AustLII - Australasian Legal Information Institute

Bireme - Centro Latino-Americano e do Caribe de Informação em Ciências da Saúde

CAPES - Coordenação de Aperfeiçoamento de Pessoal de Nível Superior

CNPq - Conselho Nacional de Desenvolvimento Científico e Tecnológico

CID-10 – Classificação Internacional de Doenças 10ª edição

COVID-19 – Coronavírus Disease

CP – Código Penal Brasileiro

DSM IV – Diagnostic and Statistical Manual of Mental Disorders 4° edition

DSM V – Diagnostic and Statistical Manual of Mental Disorders 5° edition

EVCP - Exames de Verificação de Cessação de Periculosidade

FBI - Federal Bureau of Investigation

H1N1 - Influenza A subtipo H1N1

HCR-20 – Historial, Clinical, and Risck Management-20

HSO – Homicide Sexual offender

ICD-10 – International Classification of disorders 10° edition

Lilacs - Latin American and Caribbean Health Sciences Literature

MS – Ministério da Saúde do Brasil

NGRI – Not guilty by reason of insanity

NSH – Non-Sexual Homicide

NHSO – Non Homicide sexual offender

NZLII - New Zealand Legal Information Institute

OMS – Organização Mundial de Saúde

PCL-R – Psychopathic Checklist Revised

PubMed/MEDLINE - United States National Library of Medicine at the National Institutes of Health

SARS - Síndrome Respiratória Aguda Grave

SeSaS - Sexual Sadism Scale

SciELO - Scientific Electronic Library

SH – Sexual Homicide

SHO – Sexual Homicide Offender

START - Short-Term Assessment of Risk and Treatability

SVR-20 Sexual Violence Risk-20

TTV - Two-Tiered Violence Risk Estimates Scale

UIDP - União Internacional de Direito Penal

UN – United Nations

US – United States of America

UK – United Kingdom

VSA – Violent Sexual Assaults

VRAG – Violence Risk Appraisal Guide

WHO: World Health Organization

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1. INTRODUÇÃO

Violência, segundo a Organização Mundial da Saúde (OMS, 2002), é definida pelo "uso intencional da força física ou do poder, real ou em uma forma de ameaça ou efetivamente, contra si próprio, mesmo, contra outra pessoa, ou contra um grupo ou uma comunidade, que resulte ou ocasione, ou tenha grande possibilidade de resultar em probabilidades de acarretar lesão, morte, dano psicológico/psíquico, deficiência ou alterações do desenvolvimento ou privações". Há, ainda, uma clara relação entre ato e ação praticada e a intenção do indivíduo que apresenta ou se envolve em um comportamento violento. MINAYO & SOUZA (1997) definiram a violência como "qualquer ação intencional perpetrada por indivíduo, grupo, instituição, classe ou nação, dirigida a outrem, que cause prejuízos, danos físicos, sociais, psicológicos e/ou espirituais. "

O estudo dos transtornos mentais e sua possível associação com o comportamento violento, além de polêmico, encontra grandes dificuldades metodológicas, como avaliações diagnósticas muitas vezes não padronizadas, indiretas, retrospectivas, além da ocorrência de comorbidades, com destaque para o uso de substâncias psicoativas, e da própria abrangência do conceito de violência. (TEIXEIRA et al, 2007).

Os modelos de assistência psiquiátrica ambulatorial promoveram grandes avanços no tratamento das pessoas com transtornos mentais e, sem dúvida, são as principais diretrizes do tratamento psiquiátrico atualmente. Por outro lado, se as situações de adoecimento mental grave não forem avaliadas com parcimônia, há o risco de surgirem concepções equivocadas, como, por exemplo, uma ideia de se negar completamente a necessidade da internação hospitalar, em situações muito graves (KRAMP & GABRIELSENL, 2009).

Os transtornos mentais podem, em certas situações, alterar as percepções do indivíduo acometido, acarretando mudanças em seu comportamento e julgamento de valores, o que possibilita a ocorrência de infrações legais. Dessa maneira, a interlocução entre o Direito e a Psiquiatria se tornará necessariamente um caminho para lidar de uma maneira mais assertiva e justa em tais situações. CHALUB (2016) descreve detalhadamente as inúmeras alterações psíquicas possíveis, desde obnubilação de consciência, alteração do ritmo do pensamento e surgimento de sentimentos e emoções patológicos, até a ocorrência de fenômenos perceptivos anormais, abolição dos processos lógico-formais e alteração da identidade pessoal. Segundo esse autor, esses fenômenos provocam perda ou grave redução da faculdade de entender a realidade e de agir de acordo com ela.

Dessa maneira, em se considerando um especial interesse nessa interlocução Psiquiatria, Direito e Violência, esta pesquisa buscou explorar diversos aspectos comuns, desde a institucionalização à desintitucionalização de doentes mentais, o estudo da responsabilidade penal com foco na periculosidade e sua cessação e os crimes violentos contra mulheres, com ênfase nos homicídios sexuais.

2. REFERENCIAL TEÓRICO

2.1 Violência e Transtornos Mentais: institucionalização, periculosidade e tratamento compulsório na Psiquiatria

O conceito de violência é amplo, não restrito a ocorrência de lesões físicas, podendo surgir, por exemplo, na forma de ameaças, ocasionando privações e modificações no desenvolvimento do indivíduo. Dessa maneira, as relações entre violência e transtornos mentais envolvem tanto a suposta periculosidade imputada a essa população, que reflete um estigma histórico de que são indivíduos necessariamente violentos; quanto o aspecto relacionado às diversas violências sofridas pelas pessoas com transtornos mentais, considerando-se a definição da OMS.

O uso do termo *Transtornos Mentais* em detrimento do termo *doença mental* é a preferência da OMS, desde o final do século XX, que já apareceu na CID-10, como também em publicações voltadas para práticas envolvendo Saúde Mental (OMS, 1993; OMS, 1998). Trata-se de um termo que traz um aspecto amplo, já que englobaria as diversas alterações, muitas vezes transitórias, capazes de modificar o estado psíquico de uma pessoa, podendo estar associado, ou não, a uma doença mental propriamente dita. Em razão de a literatura internacional preferir o termo *Mental Disorders* (melhor traduzido como transtornos mentais), essa é a opção de termo usado para se referir a doenças ou a transtornos mentais em geral nos artigos desta tese.

Um primeiro aspecto de destaque é que o possível risco que envolve a associação entre violência e transtornos mentais é comumente estudado e avaliado em amostras ou populações específicas, como hospitais, casas de custódia ou prisões (OLIVEIRA et al., 2017; SHORT et al., 2013, MECLER, 2010, MOSCATELO, 2001, ADSHEAD, 1998, FLANNERY, 2000). Entretanto, há pesquisas mostrando que essa relação pode ser analisada também em outros contextos, como em estudos populacionais gerais e em comunidades sem restrição da liberdade. (KRAMP et al., 2009, FAZEL et al., 2011, GHOREISHI et al., 2015).

Um outro ponto fundamental estudado na literatura recente é a possibilidade de prevenção de violência praticada por indivíduos com transtornos mentais, especialmente quando há um correto acompanhamento multidisciplinar e manejo clínico (MENEZES, 2001; ABDALLA-FILHO *et al*, 2002; ALDEN *et al*, 2007; VALENÇA et al, 2011). Por outro lado, a má adesão é descrita em diversas pesquisas como um fator relacionado ao risco de violência em pessoas com transtornos mentais (HARRIS et al, 1993; MILLS et al, 2013; MORANA et al, 2006). Esse aspecto torna relevante a

discussão de se considerar o tratamento involuntário e/ou compulsório desses indivíduos, com o objetivo do cuidado imediato e contínuo de sua saúde, o que poderia ter como consequência positiva, para esse grupo com baixa adesão, a melhora clínica e, consequentemente, a prevenção do risco de violência.

Apesar da carência de estudos sistematizados sobre periculosidade e transtornos mentais até a primeira metade do século XX, a psiquiatria conviveu naquela época com seus momentos mais tristes, em que de forma progressiva e indiscriminada, deu-se um processo de *institucionalização* envolvendo diversos indivíduos com transtornos mentais. Há múltiplos relatos na literatura sobre o tema de "tratamentos" degradantes, punitivos ou carentes de humanização e de duração prolongada ou de prazo indeterminado. (CORREIA, 2017; ARBEX, 2013).

Ao longo da história, a institucionalização foi a medida adotada para lidar com esses indivíduos, especialmente os portadores de *doença mental*, no sentido clássico, como as psicoses, mas também referindo-se a pessoas "fora da norma", como acontece em distúrbios do comportamento, déficits cognitivos e outras dificuldades no campo psíquico. Por esse motivo e pela carência de um tratamento individualizado, multiprofissional e digno, o dispositivo da institucionalização passou a ser usado de forma abusiva e indiscriminada, gerando sérias consequências à saúde e à vida de muitos doentes e às suas famílias. A falta de recursos terapêuticos e de conhecimento científico à época foram importantes reforços para situações por vezes desumanas e ineficazes.

Nesse sentido, o final do século XX e o início do século XXI funcionaram de modo marcante como catalisadores de um processo transformador que envolveu não apenas mudanças físicas nas estruturas institucionais manicomiais, como também questionamentos e mudanças na mentalidade e na cultura sobre as doenças mentais, conhecido como *desinstitucionalização.*

Esse processo só pode se tornar viável por meio da adoção de políticas públicas que visem a um aprimoramento do tratamento em saúde mental para, de fato, desinstitucionalizar, em um sentido amplo e transformador, objetivando rever conceitos, preconceitos, estigmas e demais fatores que envolvem o processo de adoecimento psíquico. Naturalmente, a oferta de novos dispositivos de atendimento em saúde mental, como os Centros de Atenção Psicossocial, equipes muldisciplinares e o acompanhamento ambulatorial não hospitalar das pessoas com transtornos mentais.

2.2. Breve histórico sobre o estudo da periculosidade, a psiquiatria forense e a legislação brasileira: imputabilidade penal e medidas de segurança

O surgimento do conceito de periculosidade criminal se deu no final do século XIX, com a Escola Positiva do Direito Penal, tornando-se uma base para o Direito Penal Moderno. Ao contrário do Direito Clássico, que apenas explorava a gravidade do delito e criava uma punição correspondente, o Direito Positivo compreende o delito como um sintoma de periculosidade, como "índice revelador da personalidade criminal" (MECLER, 2010).

Sob a luz do Direito Positivo, o indivíduo criminoso não é considerado um ser racional agindo livremente, e sim visto como portador de anormalidades somato-psíquicas (BRUNO, 1991), não se enquadrando na "norma". A Ciência deve se ocupar em desvendar fatores que expliquem o crime, não se atendo a questões morais ou discriminatórias, devendo contemplar aspectos diversos: sociais, psicológicos e médicos (MECLER, 2010).

Assim, tais conceitos e processos influenciam diretamente o Direito, revisões legislativas e tudo o que envolve diretamente a Psiquiatria Forense e a figura do médico perito, sobre o qual muitas vezes recairá a responsabilidade/necessidade de se posicionar a respeito das capacidades psíquicas dos indivíduos. A decisão sobre o momento correto para a "liberação" do indivíduo internado também recai a esse médico perito, o que pode inclusive ter ao menos duas consequências distintas e nocivas: uma internação excessivamente prolongada, podendo chegar a uma institucionalização possivelmente evitável, ou, no "outro lado da moeda", uma alta precoce que poderia teoricamente oferecer risco à sociedade.

O primeiro autor a tentar sistematizar juridicamente a concepção de periculosidade foi GARÓFALO, em 1878. Ele defendeu as sanções como um meio de prevenção, não restritas à gravidade do delito ou ao dever violado, mas também à "temibilidade" do agente. A "temibilidade" foi definida por esse autor como "a perversidade constante e ativa do delinqüente e a quantidade de mal previsto que se deve temer por parte do mesmo" (GARÓFALO, 1893).

A partir desse conceito-chave e com a fundação da União Internacional de Direito Penal (UIDP em 1889), atual Associação Internacional de Direito Penal – AIDP, foram sendo debatidos e estudados diversos critérios para classificar o "grau de perigo" de um agente.

Assim, em 1913, no Congresso Internacional da UIDP, foram criadas três categorias de indivíduos perigosos: os reincidentes; os alcoólicos e deficientes de qualquer espécie; os mendigos e vagabundos (MECLER, 2010).

Em 1920, ÁSUA estabeleceu os seguintes fatores para a determinação da periculosidade: "a personalidade do homem, sob seu tríplice aspecto: antropológico, psíquico e moral; a vida anterior ao delito; a conduta do agente após o delito; a qualidade dos motivos; o delito cometido" (ÁSUA, 1920).

LOUDET, 1967, considerou a aplicação do estado de periculosidade equivalente à Medicina Preventiva, pois a tomada de medidas asseguradoras e tutelares antes do surgimento da reação antissocial seriam a real defesa social. Então, criou os seguintes índices de periculosidade:

a) médico-psicológicos: "aqueles que surgem da existência de estados de alienação mental de semi-alienação ou de simples desequilíbrios psíquicos vinculados ou não a perturbações somáticas, que, em determinada ou indeterminada circunstância, permitem prognosticar uma reação antissocial em um dado sujeito. "

b) sociais: "estão condicionados por fatores ambientais. " Neste caso, a periculosidade não está dentro do sujeito, e sim, fora, no ambiente que "o nutre, o estimula, o excita". Suprimindo "este estímulo, este alimento, esta excitação", a periculosidade desaparece. Das causas sociais, as mais importantes, para o autor, seriam as econômicas.

c) legais: Referem-se aos antecedentes criminais e ao delito. LOUDET considerava os índices legais como os de menor importância. Para ele, tais índices, na maioria dos casos, não fariam outra coisa senão trazer elementos complementares aos demais e, freqüentemente, se encontram subordinados aos índices médico-psicológicos e sociais.

(MECLER, 2010)

Os conceitos apresentados tiveram como consequência uma necessidade de se realizar um ajuste da pena à natureza do criminoso e ao uso do princípio de defesa social, justificando o uso de medidas capazes de proteger a sociedade e o indivíduo perigoso. Assim, essa definição de periculosidade foi incorporada à legislação brasileira com o Código Penal de 1940, em que se introduziu o sistema do duplo binário, que criou duas possibilidades de natureza distinta para os imputáveis. A pena, de caráter retribuitivo, imposta de acordo com a culpa do sujeito e a gravidade do delito; e a medida de segurança, de caráter preventivo, que considerava o grau de periculosidade do acusado. A finalidade desta é a proteção da sociedade e o tratamento do indivíduo, objetivando anular sua periculosidade (CARRARA, 1998; MECLER, 2010).

Esse conceito foi ao encontro do que o Psiquiatra Forense Heitor Carrilho defendia, décadas antes: "A Psiquiatria Pericial não deve se restringir a verificar se o indivíduo é mentalmente desenvolvido. O estado perigoso e a consequente temibilidade dos delinqüentes, examinados à luz de um

rigoroso critério antropopsicológico serão a base em que se apoiará toda a legislação repressiva (CARRILHO, 1941) ".

A revisão da parte geral do Código Penal de 1984 retirou o sistema do duplo binário, dispensando a medida de segurança para os imputáveis. MORAES, 2001, destacou que o uso generalizado do conceito de periculosidade presumida e a consequente medida de segurança aplicados exclusivamente aos inimputáveis mantinham a concepção de que o doente mental seria necessariamente perigoso, em um primeiro olhar.

Segundo a legislação brasileira, inimputável é aquele: "inteiramente incapaz de entender o caráter ilícito do fato ou de determinar-se de acordo com esse entendimento" (CP art. 26). Os menores de idade possuem inimputabilidade absoluta. Além desses, aqueles que apresentam Doença mental ou Desenvolvimento mental incompleto ou desenvolvimento mental retardado podem ser considerados inimputáveis, se houver concomitantemente, nexo entre a doença e o delito, além do comprometimento do entendimento e da determinação do indivíduo. Este é o chamado critério biopsicológico.

A semi-imputabilidade é uma outra situação possível, que ocorre quando o indivíduo apresenta prejuízo, mas não abolição, do seu entendimento ou determinação. Essa situação costuma ser mais frequente nos casos de Transtornos de Personalidade ou mesmo quando há Desenvolvimento Mental retardado, especialmente nos níveis leve e moderado do Retardo Mental. (ABDALLA-FILHO, 2016). Nesses casos especiais, há a prerrogativa de o juiz optar pela medida de segurança, ou ainda, pela redução da pena a ser aplicada, de um a dois terços. A existência de especial tratamento curativo é um requisito legal para a aplicação da medida de segurança aos semi-imputáveis (CP art. 26). Conforme o sistema jurídico brasileiro, é o convencimento do juízo, por meio da prova pericial e demais provas processuais, que irá balizar a decisão judicial de cada caso específico. A legislação atual prevê que a medida de segurança pode ser cumprida em regime de internação em hospital de custódia e tratamento psiquiátrico (CP, art. 96, I) ou na forma de tratamento ambulatorial (CP, art. 96, II), sendo também facultado ao juízo decidir qual a modalidade terapêutica a ser adotada.

A cessação da periculosidade deve ser averiguada por meio de perícia médica (Exame de Verificação de Cessação de Periculosidade - EVCP), realizada por Perito Oficial Médico Psiquiatra. Embora as medidas de segurança tenham duração indeterminada, o juiz, quando profere a sentença, estabelece o prazo mínimo (de um a três anos). O EVCP deve ocorrer quando o prazo mínimo fixado terminar e será repetido anualmente enquanto a conclusão pericial for de periculosidade não cessada, ou será realizado quando o juiz, a qualquer momento, solicitá-lo. Nesse contexto, a periculosidade é um

conceito jurídico, e não médico, e implica na capacidade de se prever o comportamento futuro do sujeito submetido à medida de segurança (MECLER, 2010).

2.3. Instrumentos de avaliação de risco de violência

O desenvolvimento de instrumentos de avaliação padronizados nas últimas décadas é uma maneira de sistematizar de forma mais clara e objetiva a previsão do risco de violência. Seu uso mais frequente na prática clínica pode promover maior incorporação dos itens desses instrumentos às avaliações de periculosidade ou, utilizando-se o termo mais coerente, risco de violência. Com isso, pode-se ter uma maior confiabilidade quanto à possibilidade de indivíduos cometerem atos violentos, seguida de intervenções terapêuticas, reduzindo-se o risco de recidiva criminal.

Alguns dos instrumentos mais utilizados são: VRAG (Violence Risk Appraisal Guide), HCR-20 (Historical, Clinical and Risk Management), TTV (Two-Tiered Violence Risk Estimates Scale), START (Short-Term Assessment of Risk and Treatability) e a PCL-R (Psychopathy Checklist – Revised). A seguir, os instrumentos serão apresentados brevemente.

A V-RAG (HARRIS et al, 1993) é um instrumento que possui 12 itens e cujo foco de análise são itens históricos e biográficos dos indivíduos que possuem pontuações específicas, que levam em conta:

1. Pontuação na PCL-R (escala utilizada para o diagnóstico de psicopatia, que será explicada na sequência);
2. Comportamento escolar desajustado durante ensino fundamental;
3. Separação dos pais antes dos 16 anos de idade;
4. Índice de Cornier-Lang (pontuação relacionada a quantidade de outros delitos prévios não violentos);
5. Estado civil sem vínculo conjugal;
6. Idade em que cometeu o delito (inversamente proporcional ao risco);
7. Fracasso em liberdade condicional prévia;
8. Gravidade das lesões provocadas à vítima no delito;
9. Diagnóstico de transtorno de personalidade;
10. Diagnóstico de Esquizofrenia;
11. Sexo da Vítima (a pontuação é menor quando a vítima é do sexo feminino);
12. Histórico de uso abusivo de bebida alcoólica.

A HCR-20 (WEBSTER, 1995) é uma avaliação do risco de comportamento violento futuro em populações psiquiátricas e criminosas. Ela aborda, de maneira mais ampla, vinte itens, divididos em três aspectos: Histórico, Clínico e Manejo de Risco, aproximando-se melhor da finalidade do Exame de Verificação de Cessação de Periculosidade. Seus itens são subdivididos em três subgrupos: “H” (referentes a itens históricos), “C” (referentes a itens clínicos) e “R” (referentes ao Manejo de Risco).

A) Itens históricos:

1.Violência prévia;

2. Idade precoce no primeiro incidente violento;

3. Instabilidade nos relacionamentos;

4. Problemas no emprego;

5. Problemas com uso de substâncias;

6. Doença mental importante;

7. Psicopatia;

8. Desajuste precoce;

9. Transtorno de personalidade;

10. Fracasso em supervisão prévia.

B) Itens clínicos;

11. Falta de insight;

12. Atitudes negativas;

13. Sintomas ativos de doença mental importante;

14. Impulsividade;

15. Sem resposta ao tratamento.

C) Itens de Manejo de Risco:

16. Planos inexequíveis;

17. Exposição a fatores desestabilizadores;

18. Falta de apoio pessoal;

19. Não aderência às tentativas de tratamento;

20. Estresse.

A pontuação máxima da HCR-20 é de 40 pontos, sendo que cada item pode ter pontuação entre 0 e 2, de acordo com ausência, presença parcial ou presença total. Não há um ponto de corte específico que delimite um alto risco de reincidência.

A TTV é um instrumento desenvolvido por MILLS et al, 2005, que é dividida em duas partes, sendo que a primeira (parte "A") é composta por 10 itens e a segunda (parte "M") possui 13 itens. A parte "A" da TTV foca em questões biológicas e da história pessoal do indivíduo, possuindo pontuação máxima de 13 pontos. Tratando-se de uma parte "imutável", cada item é pontuado em 0 ou 1 ponto, no caso de ausente ou presente, respectivamente, à exceção dos itens A3, A4 e A5, em que a pontuação pode oscilar entre 0 e 2 pontos (ausente, fracamente ou fortemente presente). A parte "M" da TTV

procura avaliar o momento atual do indivíduo, variando entre 0 e 26 pontos, visto que cada um dos 13 itens podem receber pontuação entre zero e dois pontos (ausente, presente requerendo monitoramento, presente requerendo intervenção). Não há um ponto de corte específico, porém um estudo feito pelos próprios autores sobre recidiva criminal após três anos da aplicação do instrumento encontrou que, com uma pontuação de até 5 pontos, a recidiva foi de 5%, enquanto em uma pontuação superior a 13 pontos, a recidiva foi de 55% (MILLS et al, 2013). A seguir, os itens que compõem a TTV.

A) Parte A:

A1. Comportamento antissocial na infância;

A2. Comportamento antissocial na adolescência;

A3. Idade precoce da primeira condenação criminal;

A4. Quantidade de prisões prévias;

A5: Quantidade de condenações prévias por comportamento violento;

A6: Falha em período de supervisão comunitária;

A7: História de uso abusivo de bebidas alcoólicas;

A8: Falha em completar o Ensino Médio;

A9: História de associação para cometimento de crime;

A10: Dificuldades interpessoais/inter-relacionais.

B) Parte M:

M1. Emprego;

M2. Situação financeira

M3. Abuso de substâncias;

M4. Situação da saúde mental;

M5. Instabilidade familiar;

M6. Presença de associação para cometimento de crimes;

M7. Atitudes antissociais;

M8. Boa utilização do tempo ocioso;

M9. Participação nas intervenções e condições propostas para o tratamento;

M10. Estabilidade no humor;

M11. Presença de suporte social;

M12. Envolvimento com ambiente com alta criminalidade ou envolvimento com pessoas ligadas a atividade criminosa;

M13: Presença de fatores estressores.

A START é um instrumento desenvolvido também por WEBSTER et al, 2004, o criador da HCR-20. Verificando que a HCR-20 dava um grande peso aos itens "estáticos" (subgrupo "H"), sua equipe decidiu focar-se nos itens passíveis de modificação, com o intuito de monitorar e gerenciar uma redução ou um aumento do risco de violência com o passar do tempo. Assim, foram testados e validados 20 itens, todos passíveis de modificação durante o tempo, subdivididos em sete grandes áreas: violência contra terceiros, comportamento suicida, auto-mutilação, vitimização, uso de substâncias, saídas não autorizadas e auto-negligência, o que dá uma característica diferente em relação aos demais instrumentos, já que todos os itens são modificáveis, o que se mostra bastante útil no acompanhamento longitudinal do indivíduo.

Os subitens da START são:

1.Habilidades sociais;
2.Relacionamentos;
3.Ocupação;
4. Recreação;
5.Auto-cuidados;
6. Estado Mental;
7. Estado emocional;
8. Uso de substâncias;
9. Controle da impulsividade;
10. Estressores externos;
11. Suporte Social;
12. Recursos materiais;
13. Atitude;
14. Adesão à medicação;
15. Adesão às regras;
16. Conduta;
17. Insight;
18. Estratégias de coping;
20. Tratabilidade do quadro.

A PCL-R (HARE, 2007) é uma escala que leva em conta os comportamentos, traços emocionais e características clínicas da Psicopatia, com finalidade específica de caracterizar o psicopata, em acordo com os comportamentos observados ou referidos.

Os itens da PCL-R são:

1. Loquacidade/charme superficial;
2. Autoestima inflada;
3. Necessidade de estimulação/tendência ao tédio;
4. Mentira patológica;
5. Controlador/manipulador;
6. Falta de remorso ou culpa;
7. Afeto superficial;
8. Insensibilidade/falta de empatia;
9. Estilo de vida parasitário;
10. Frágil controle comportamental;
11. Comportamento sexual promíscuo;
12. Problemas comportamentais precoces;
13. Falta de metas realísticas a longo prazo;
14. Impulsividade;
15. Irresponsabilidade;
16. Falha em assumir responsabilidade;
17. Muitos relacionamentos conjugais de curta duração;
18. Delinquência juvenil;
19. Revogação de liberdade condicional;
20. Versatilidade criminal.

A pontuação máxima da PCL-R é 40 pontos, sendo que cada item pode ter pontuação entre 0 e 2, de acordo com sua ausência, presença parcial ou presença total. Não há um ponto de corte específico para o diagnóstico que seja consensual na literatura mundial, porém quanto maior a pontuação maior a probabilidade do diagnóstico de psicopatia. Em um estudo conduzido em uma população carcerária brasileira, MORANA, 2003, encontrou um ponto de corte de 23 pontos.

A HCR-20 e a PCL-R já possuem versões validadas e estudadas no Brasil, por TELLES, 2009, e MORANA, 2006, respectivamente. A TTV e a START são instrumentos mais recentes, ainda não validados em nosso país, mas parecem adequados para o monitoramento e gerenciamento do risco de violência, visto que são focados nos itens que podem ser modificados com o passar do tempo, sendo

eventualmente sensíveis à terapêutica e às demais medidas diretamente relacionadas ao risco de violência.

Uma das grandes dificuldades na avaliação do risco relacionado aos transtornos mentais é lidar com a situação da não adesão e do não reconhecimento do adoecimento e, consequente manutenção do risco de violência, o que certamente suscita maior debate sobre a temática das internações involuntárias, medidas de segurança e tratamentos compulsórios. Sem dúvida, as temáticas que envolvem a imputabilidade penal, a periculosidade e o risco de reincidência criminal são polêmicas e complexas, mas sua discussão é necessária, até como um caminho para a aproximação entre o Direito e a Psiquiatria. A participação social não pode ser reprimida nem ignorada nessa seara, já que, em última análise, o debate é sobre liberdades individuais e direitos coletivos. Acredita-se que o uso dos instrumentos de avaliação de risco já devidamente validados e estudados é uma das possibilidades para o desenvolvimento de avaliações mais homogêneas e científicas, proporcionando uma qualificação na prática pericial, com destaque para os EVCPs.

2.2 A pandemia da COVID-19: repercussões na saúde mental e violência contra as mulheres e vulneráveis

A pandemia da *Coronavirus Disease 2019* (COVID-19), que já se estende pelo ano de 2021, com previsões de seguir até pelo menos 2022, é uma crise de saúde e social global grave, que afeta todo o planeta, não restrito aos sistemas de saúde (OMS, 2020). Desde o seu início, em Wuhan, capital da província da China Central, o mundo vivencia a maior crise no sistema de saúde das últimas décadas, superando outras graves epidemias recentes, como a *Severe Acute Respiratory Syndrome* (SARS, Síndrome Respiratória Aguda Grave), em 2002, e a pandemia de H1N1, em 2009 (BROOKS et al, 2020).

A dificuldade para se conseguir equipamentos e leitos necessários à condução dos casos de infecção pela COVID-19 teve como consequência a desestruturação ou mesmo falências em sistemas de saúde de todo o mundo. Essa incapacidade de gerir a crise ocasionou problemas para todos os países atingidos pela pandemia, ensejando recomendações de medidas restritivas, como quarentenas, isolamento e distanciamento social. Devido à gravidade e à intensidade das medidas, perturbações sociais e psicológicas afetaram a capacidade de enfrentamento de toda a sociedade, em variados níveis de intensidade (FIOCRUZ, 2020).

Além do medo de contrair a doença, a pandemia do COVID-19 tem provocado sensação de insegurança em todos os aspectos da vida, da perspectiva coletiva à individual, do funcionamento habitual da sociedade às modificações nas relações interpessoais (LIMA et al. 2020).

Assim, as medidas de controle associadas a uma tentativa de conter a pandemia, as modificações do funcionamento habitual e das relações interpessoais tendem, em conjunto, a aumentar a incidência de, ou mesmo agravar, transtornos mentais. Não suficiente, o adoecimento mental pode provocar um aumento da vulnerabilidade nos indivíduos para a instalação de outras doenças (LIMA et al. 2020; BARROS, et. al. 2020).

O adoecimento psíquico relacionado ao panorama pandêmico com manifestação de sintomas psicóticos é raramente descrito, havendo alguns relatos de caso e séries de casos em locais diversos no mundo (OLIVEIRA, 2021, D´AGOSTINO et al, 2020; VALDÉS-FLORIDO et al, 2020, SMITH et al, 2020).

Já com relação à psicose em consequência à infecção pela Sars-COV-2, há algumas descrições na literatura, inclusive com uma revisão narrativa sobre isso (TARIKU & HAJURE, 2020). Em geral, os resultados revelam que a resposta aos antipsicóticos é eficaz e o tratamento costuma ser breve, embora

não seja possível afirmar, de forma inequívoca, que a manifestação seja uma consequência da infecção pelo coronavírus. Complicações como quadros infecciosos secundários, insuficiência de múltiplos órgãos podem gerar quadros confusionais agudos, eventualmente com manifestações psicóticas de origem orgânica (PEREIRA & OLIVEIRA, 2019).

Um estudo controlado realizado na Inglaterra avaliou 361 indivíduos, procurando correlacionar o desenvolvimento de sintomatologia psicótica a diversos fatores durante o início da pandemia da COVID-19. Os autores verificaram que as pessoas empregadas, os estudantes, as pessoas que expressaram medo em relação a infectar-se pela COVID-19 e as que tiveram maior desconfiança sobre a política governamental experimentaram um aumento de risco para o desenvolvimento de paranoia e de alucinações (LOPES et al, 2020).

A reação de cada indivíduo frente a essas mudanças depende de sua história de vida, das suas características individuais, da comunidade em que vive, entre outros fatores. Há uma preocupação considerável com indivíduos considerados "vulneráveis", como os portadores de transtornos mentais, as crianças e as mulheres, especialmente as que já se encontram em algum tipo de situação de risco de violência (TANG et al, 2020).

Segundo a Organização das Nações Unidas (ONU), a violência sexual contra a mulher é definida como "Qualquer ato ou conduta baseado na diferença de gênero, que gere dano ou sofrimento, físico, sexual ou psicológico à vítima e morte" (WHO, 2000). O agressor provoca aterrorização, humilhação, degradação e busca dominar a vítima. A violência sexual frequentemente vem acompanhada de violência física em diferentes formas e níveis de gravidade. Esse conceito propicia uma discussão sobre a condição de fragilidade em que as mulheres estão colocadas diante do homem, com uma prevalência muito maior de violência sexual sofrida pelas mulheres, quando comparada aos homens (LIMA & DESLANDES, 2000).

A violência sexual pode ser dividida em intrafamiliar, extrafamiliar ou institucional. Na primeira, há convívio do agressor no mesmo ambiente da vítima, que geralmente é um membro da família nuclear (pai, padrasto, mãe, madrasta) ou da família extensiva (tios, avós, primos). A violência extrafamiliar ocorre quando o ato é realizado por indivíduo que não faz parte da família, podendo ser um conhecido da vítima, situação frequente. A violência institucional ocorre em instituições sociais que têm o objetivo de proteger os indivíduos, como escolas, creches e hospitais. A violência sexual mais notificada é a

extrafamiliar; porém, a intrafamiliar é a mais comum, tendo consequências extremamente danosas às vítimas (CABRAL et al, 2015; FLORENTINO, 2015).

Como já citado (WHO, 2020), a pandemia provocada pelo vírus da COVID-19 e as consequentes medidas de saúde pública tomadas globalmente, incluindo-se o isolamento social em diversas formas e intensidades, pode ter como consequência direta um aumento na ocorrência de violência sexual, visto que há uma convivência contínua das famílias em seus lares. Há estudos recentemente publicados sobre crescimento de violência doméstica (TELLES et al, 2020; BRADBURY & ISHAM, 2020; MOREIRA & PINTO DA COSTA, 2020), o que aumenta a possibilidade de ocorrência de violência sexual contra mulheres.

MAZZA et al, 2020, classifica como violência doméstica qualquer tipo de agressão, seja física, sexual, emocional e mesmo o "*stalking*". O aumento de sentimentos de frustração, agitação e agressividade em parte das pessoas, incluindo-se o potencial agressor, pode aumentar a chance de todas essas formas de violência. Existindo-se outros problemas no ambiente familiar, como adoecimento psíquico ou abuso de substâncias, esse risco aumenta, segundo os mesmos autores. ROESCH et al, 2020, apontaram um risco maior para indivíduos com transtornos mentais, sendo uma combinação ainda mais perigosa para essa população sofrer violência doméstica.

TANG et al. (2020) abordaram o impacto da pandemia na saúde pública, enfatizando os direitos sexuais e reprodutivos individuais, em face à necessidade de medidas de isolamento e de distanciamento. A saúde sexual das mulheres foi bastante impactada, observando-se um maior risco de infecções sexualmente transmissíveis, a limitação de disponibilidade de contraceptivos, o que amenta a angústia pela possibilidade de gestações indesejadas. Essas são algumas das dificuldades relatadas, levando a um aumento da violência de gênero, do abuso contra as mulheres e da violência doméstica.

Outra grande preocupação em relação à sexualidade feminina são as interrupções dos abortos legais em diversos países do mundo, como Estados Unidos da América e Itália, o esgotamento de estoques de contraceptivos em Indonésia, Moçambique e vários outros países (WENHAM et al, 2020). As consequências futuras disso são preocupantes, já que muitos casos de violência sexual terão como consequência gravidez não desejada e/ou não planejada, com um impacto psicossocial violento na vida dessas mulheres. Há, inclusive, diversos relatos de casos de mulheres que buscaram abortamentos por via ilegal e/ou insegura durante e após o surto do Zika vírus, gerando riscos para sua própria saúde,

especialmente nos países em que o acesso à saúde reprodutiva é escasso e precário, como Brasil, El Salvador e Colômbia (RILEY et al, 2020).

WENHAM et al, 2020, destacaram que as mulheres são as mais afetadas pela pandemia, considerando-se períodos prévios de crises. O impacto pós-epidemias de Ebola e Zika vírus, em que as perdas socioeconômicas foram maiores e mais duradouras para as mulheres em relação aos homens, foi notório. Na Serra Leoa e na Libéria, por exemplo, 63% dos homens que perderam seus empregos voltaram a trabalhar, enquanto apenas 17% das mulheres na mesma situação conseguiram um novo trabalho (BANDIERA et al, 2018).

Outra informação extremamente preocupante, no contexto da pandemia da COVID-19, é o impacto nos serviços especializados no atendimento de vítimas de violência sexual e de violência de gênero. Há uma estimativa de que uma quarentena de seis meses resulte em 31 milhões de casos a mais. Nos serviços criados para o acolhimento dessas vítimas, há barreiras naturais ao acesso que são aumentadas pela pandemia, visto que estes não são considerados como prioritários pelos governos locais. Os profissionais de saúde estão sobrecarregados pela pandemia, muitas vezes não conseguindo dar a atenção e atender com a minúcia necessária à identificação e ao bom acolhimento desses casos. O contexto pandêmico também pode afastar o usuário desse serviço por medo de contrair a doença (JOHSON et al, 2020).

No início da pandemia, no Reino Unido, após as primeiras 6 semanas de isolamento, observou-se uma redução superior a 50% dos encaminhamentos aos centros especializados de acolhimento às vítimas de violência. Houve uma restrição ao acesso de exames de DNA, antes disponível para qualquer vítima, passando a ser somente disponibilizados a vítimas que prestaram queixa à polícia e foram agredidas por desconhecidos ou por familiares, que não fossem o seu próprio parceiro. Sem a ocorrência policial, o exame forense foi limitado a situações em que “houvesse interesse público”. Outra grande mudança ocorrida nos serviços foi a necessidade de uso de diversos equipamentos de proteção, como máscaras, face-shields e capotes, que são uma barreira física e dificultam a vinculação da vítima ao profissional, tão necessária para o bom acolhimento e a adesão terapêutica. Alternativas como atendimentos por videoconferência muitas vezes também aumentam as barreiras (JOHSON et al, 2020).

No Quênia, diversos centros de referência para atendimento a essas vítimas se tornaram imediatamente hospitais para tratamento de COVID-19. Houve, ainda, pouca preocupação em informar a população de que alguns centros ainda estavam abertos. Nos primeiros três meses da pandemia, houve

uma queda abrupta de pessoas atendidas. Após esse tempo, o número “normalizou”; porém num perfil diferente do anterior: a maioria eram vítimas com menos de 16 anos de idade, possivelmente deixadas sozinhas e longe da escola no período pandêmico e houve um grande aumento nas vítimas de violência sexual perpetrada pelo próprio parceiro, com menos vítimas de estranhos, que era o perfil mais comum registrado pelos serviços naquele país (JOHSON et al, 2020).

Notadamente, há uma urgência de se consolidarem e de se planejarem ações para proteção a grupos vulneráveis, em especial mulheres e adolescentes, que podem sofrer sérias consequências a curto, médio e longo prazo. O treinamento dos profissionais da “linha de frente” para identificar possíveis vítimas, o uso de novas soluções para melhorar a efetividade do atendimento, além de maior colaboração intersetorial e interprofissional são obrigatórios para um melhor compartilhamento de informações e gerenciamento das situações de violência (TANG et al, 2020).

A violência sexual pode ter complicações a curto e a longo prazo, especialmente na falta de atendimento adequado, como as infecções sexualmente transmissíveis (Hepatites B e C, Sífilis, Gonorreia, Clamídia, Tricomonas e AIDS), gravidez indesejada (trauma físico e psicológico) e aborto inseguro. Além de sequelas físicas, a humilhação, a vergonha e a culpa tornam as mulheres violentadas sexualmente mais vulneráveis a outros tipos de violência, ao desenvolvimento de sofrimento psíquico e de transtornos psiquiátricos. As consequências psicológicas, embora mais difíceis de mensurar, afetam consideravelmente a qualidade de vida da maioria das mulheres e de suas famílias, levando a danos intensos e devastadores, muitas vezes irreparáveis. A literatura científica refere o Transtorno Depressivo Maior (TDM), o Transtorno de Ansiedade Generalizada (TAG), o Transtorno do Estresse Pós Traumático (TEPT), a Síndrome do Pânico, a somatização, o comportamento suicida e o abuso e a dependência de substâncias psicoativas como associados à vitimização sexual (DREZETT, 2003; PORTO et al, 2014).

A maioria das mulheres não registra queixa por constrangimento, medo de humilhação ou por temer a reação do parceiro, dos familiares, amigos ou mesmo das autoridades. O agressor comumente ameaça a vítima, procura fazê-la ser desacreditada perante a sociedade, sofrendo discriminação, preconceito, humilhação e abuso de poder, com insegurança para revelar o ocorrido. A revelação com o devido acompanhamento psicossocial favorece a superação dos sentimentos e das dificuldades, justificando-se, assim, a necessidade de divulgação dos serviços de atendimento especializado e dos benefícios preventivos e curativos para a saúde das vítimas (PORTO et al, 2014).

Revisando-se a literatura científica mais recente sobre esse tema, nota-se que há uma grande e justificada preocupação global com o aumento da violência sexual no período de pandemia e, inclusive, no pós-pandemia, como já observado em outros períodos e já existem dados mostrando esse crescimento, como citado. É absolutamente necessária uma sensibilização dos governos, dos profissionais e dos serviços de saúde, de assistência social e do sistema legal, para um olhar atento e cuidadoso, visando a uma ampliação ao acesso a serviços de apoio e de suporte, de forma criativa e verdadeiramente empenhada. Essas medidas são urgentes para não termos como consequência uma tragédia, com uma explosão de traumas, adoecimento psíquico e mortes decorrentes do aumento da violência sexual relacionada ao isolamento social e à pandemia do COVID-19.

2.2 Os homicídios sexuais: definições, classificações e introdução aos estudos comparativos

O estudo dos crimes sexuais é um tema ainda recentemente pesquisado, de maneira que suas características e pormenores não são completamente conhecidos de forma específica e detalhada. Trata-se de um tipo de comportamento violento e as razões e fatores relacionados a seus porquês ainda são objeto de estudos relativamente recentes.

O estudo dos homicídios sexuais desenvolveu-se bastante nos últimos 25 anos. O detalhamento relacionado a variáveis específicas, envolvendo características do ofensor, vitimologia e detalhes envolvendo o delito em si foram bastante estudados desde então. A própria definição de homicídio sexual não é prevista na legislação dos países, sendo os critérios descritos por RESSLER et al. (1988) os mais utilizados nos trabalhos sobre o tema. Esses critérios foram descritos como resultado de uma pesquisa realizada no FBI (Federal Bureau of Investigation), departamento de investigação federal estadunidense, após análises de homicídios com características sexuais, em um processo que envolveu entrevistas com ofensores e análise de vários itens envolvendo o delito. Segundo os autores, o homicídio sexual deve conter pelo menos uma das seguintes características:

(a) traje ou falta de traje da vítima;
(b) exposição das partes sexuais do corpo da vítima;
(c) posicionamento sexual do corpo da vítima;
(d) inserção de objetos estranhos nas cavidades corporais da vítima;
(e) evidência de relação sexual (oral, anal);
(f) evidência de atividade sexual substituta, interesse ou fantasia sádica, como mutilação dos órgãos genitais.

Naturalmente, é uma definição concebida em um contexto investigativo e policial já há mais de 30 anos; logo, é natural que novas pesquisas tenham ocorrido, desde aquela época, para uma melhor compreensão e estudo sistematizado desses homicídios.

É importante distinguir homicídio sexual de homicídio por parceiro íntimo, onde existe uma relação íntima clara entre o agressor e a vítima (STÖCKL et al, 2013) e de feminicídio, em que o agressor tem como alvo a vítima apenas pela motivação de gênero, simplesmente ser mulher (ZARA & GINO, 2018).

Os homicídios sexuais ocorrem menos frequentemente do que outras formas de violência sexual, mas, obviamente, o impacto é enorme e generalizado nas vítimas, nas famílias e em toda a sociedade. Os homicídios sexuais são estimados em menos de 1% de todos os homicídios nos Estados Unidos (CHAN

& HEIDE, 2009), 2,8% na França (HÄKKÄNEN-NYHOLM et al, 2009) e 3,7% no Reino Unido (KERR et al, 2013). Apesar dessa relativa baixa proporção, a grande repercussão faz com que o estudo do homicídio sexual seja importante para entender esse comportamento, prevenir sua ocorrência e lidar com esses criminosos de maneira mais adequada e eficaz.

Dada a sua baixa frequência e a relativa escassez de literatura sobre o assunto, as informações sobre esse crime são limitadas. Os estudos que exploram o perfil dos ofensores, as características das vítimas e as circunstâncias do crime são recentes e costumam ter uma amostra pequena (BEAUREGARD & MARTINEAU, 2013; CHAN & HEIDE, 2009).

STEFANSKA et al, 2015, compilaram uma revisão sistemática com 300 criminosos e BEAUREGARD & MARTINEAU, 2012, investigaram 350 assassinatos sexuais, que são dois dos maiores estudos detalhados sobre o perfil de homicídios sexuais.

Em razão da dificuldade de se estudar o crime e os diversos fatores ligados ao desenvolvimento sexual, as informações relativas aos traços de personalidade, às descrições do crime e o *modus operandi* diferem significativamente entre os estudos (BEAUREGARD, et al, 2017; BEAUREGARD & MARTINEAU, 2016; CHAN & HEIDE, 2016; DARJEE & BARON, 2018; PROULX et al 2007).

Estudos comparativos são relevantes e podem delinear de maneira mais clara as diferenças entres os homicídios sexuais e outros delitos. SKOTT et al, 2018, fizeram uma análise comparativa recente dos homicídios ocorridos na Escócia, a fim de perfilar as características desses crimes, especialmente comparando-se os homicídios sexuais, homicídios não sexuais e outros crimes sexuais. Um resultado importante deste estudo foi a aparente maior proximidade dos homicídios sexuais a outros crimes sexuais do que a outros homicídios. CHOPIN & BEAUREGARD, 2019, confirmaram essa maior semelhança, mas, na verdade, atualmente, o conceito que vem se consolidando é de que o homicídio sexual se trata de uma categoria à parte.

Apesar de bastante relevantes, os estudos comparativos possuem algumas limitações, que precisam ser observadas. Embora não seja a regra, pode ocorrer uma situação em que um assassino sexual com história de ofensas sexuais prévias não seja um homicida sexual "puro", bem como pode ocorrer situações em que o assassino sexual tenha cometido homicídios não sexuais previamente (CHAN & HEIDE, 2009). Alguns assassinos sexuais podem ter vítimas agredidas sexualmente, que não foram mortas, além de também poderem matar vítimas sem motivos sexuais, durante suas carreiras criminais.

Assim, os estudos comparativos entre os homicídios sexuais e os homicídios não sexuais são importantes para a identificação de semelhanças e de diferenças entre esses grupos, melhorando-se as evidências científicas, sabendo-se da alta relevância social desse tema. Uma análise pormenorizada

desses crimes poderá esclarecer as características dos mesmos, permitir uma avaliação do risco de violência inerente ao criminoso, qualificar o acompanhamento de indivíduos condenados e identificados como perpetradores de crimes dessa natureza e até auxiliar em medidas possivelmente preventivas. A ação da polícia, da justiça, de programas de cuidado e de reabilitação também devem ser embasadas no estudo do perfil desses ofensores e das características do delito cometido. O manejo de toda a situação será mais eficaz, caso se tenha fundamentação técnica.

Existem propostas para subclassificação dos homicídios sexuais, já que há um indicativo de que existem diferentes perfis dentro desse grupo. RESSLER et al (1986) propuseram uma divisão entre "organizados" e "desorganizados", após análise e entrevistas de assassinos seriais sexuais no FBI. A cena do crime fornece muitas informações, pois se ela é desorganizada, caótica, se há sinais de atitudes incomuns ou bizarras, se o crime ocorre com muita brutalidade e a arma utilizada é encontrada no local, esse conjunto de fatores fornece características impulsivas e de falta de planejamento prévio, sendo, por isso, o assassino denominado "desorganizado". Esse tipo de crime pode caracterizar um assassino com um histórico de vida em um ambiente instável e desorganizado, menor nível intelectual, socialmente mal adaptado, algumas vezes delirante e com impotência sexual. Esse homicídio é compreendido por esses autores, em uma última análise, como o resultante de uma explosão de raiva (RESSLER et al, 1986).

Ainda segundo RESSLER et al.(1986), a cena do crime "organizada", por sua vez, evidencia ordem e planejamento. A vítima geralmente é uma desconhecida do ofensor e existem sinais de ações premeditadas e artifícios para que se evite a identificação do assassino. Esse tipo de assassino deixa poucos rastros, muitas vezes utiliza ferramentas para imobilizar a vítima, estando as características eróticas e ritualística dos crimes claramente presentes, além de haver elementos sádicos mais frequentemente. Geralmente, a arma do crime não está no local, sendo escondida pelo próprio assassino. Esses assassinos são inteligentes, socialmente competentes, geralmente empregados, casados ou vivendo com um companheiro/companheira, não levantando suspeitas sobre si, em um momento inicial. São considerados calmos e vigilantes, passam por eventos estressores antes do assassinato, mas costumam ficar calmos durante o crime.

Outra tipologia destinada a explicar o comportamento de criminosos homicidas é a de HOLMES & HOLMES (1998). No seu estudo, foram entrevistados 110 assassinos seriais, descrevendo-se cinco categorias de homicidas sexuais: Visionário, Missionário, Hedonista (subdividido em "luxurioso" e o "*thriller*", movido pela emoção/ação, excitação) e o tipo movido por Controle/Poder. A principal crítica a essa classificação é a característica empírica em que os subtipos foram criados, por informações básicas extraídas da análise das entrevistas (SEWALL et al, 2013).

Tipologias envolvendo as características sádicas também são frequentemente propostas. BEAUREGARD et al, 2007, estudaram 36 homicídios sexuais, tendo realizado revisões de arquivos institucionais, interrogatórios e entrevistas, definindo grupos de assassinos sádicos e não sádicos, mas furiosos. LANGEVIN et al, 1988; PROULX et al, 2007, também já publicaram estudos considerando-se a tipologia dos assassinos sexuais sádicos, contrapondo-se aos não sádicos.

No aspecto legal, conforme DUQUE (2004), a análise do ato delituoso pode ter uma natureza no enfoque motivacional (finalidade de satisfação sexual como motivo) ou, ainda, a análise estritamente legal, quando há natureza de um relacionamento sexual propriamente dito, em qualquer de suas formas (enfoque legal).

VALENÇA et al (2015) fizeram uma análise do perfil de ofensores sexuais brasileiros, especificamente no estado do Rio de Janeiro, buscando analisar questões legais, com destaque para a possível dúvida técnica sobre presença de transtorno mental associado. Embora os comportamentos dos criminosos fossem desviantes, o perfil destes não foi consistente com a presença de alguma doença mental, nos termos da legislação brasileira, ou outra condição passível de inimputabilidade, como as psicoses, as demências, o retardo mental ou outras doenças mentais graves. Embora alguns ofensores tenham apresentado transtornos de personalidade e problemas relacionados ao abuso de substâncias, a regra geral foi de serem considerados imputáveis, sem comprometimento das capacidades de entendimento nem de determinação. Assim, o perfil geral desses ofensores foi delimitado como: caucasianos, do sexo masculino, trabalhadores em tempo parcial e sem doença mental.

No Brasil, houve mudanças no Código Penal, no que diz respeito aos delitos sexuais, trazidas pela Lei n. 12.015, de 7 de agosto de 2009. O artigo 213, atualmente classificado como crime hediondo, passou a ter a seguinte redação: “Constranger alguém, mediante violência ou grave ameaça, a ter conjunção carnal ou a praticar ou permitir que com ele se pratique outro ato libidinoso”. Portanto, a partir dessa nova redação, qualquer pessoa (homem, mulher ou criança) pode ser sujeito passivo do crime de estupro. Criou-se a figura da vítima vulnerável (menor de 14 anos), inclusive com o tipo penal do Estupro de vulnerável (Art. 217-B) (CUTRIM et al, 2018).

No que tange aos homicídios, nossa legislação também se modificou e foi aprimorada com a inclusão explícita do feminicídio, por meio da Lei nº 13.104, de 2015. Essa lei incluiu no Código Penal Brasileiro, inciso VI, § 2º, do Art. 121 (homicídio), “quando cometido contra a mulher por razões da condição de sexo feminino". O §2º-A, do art. 121, do referido código, complementa o supracitado inciso ao preceituar que há razões de condição de sexo feminino quando o crime envolve: I - violência

doméstica e familiar (o art. 5º da Lei nº 11.340/06 enumera o que é considerado pela lei violência doméstica); II - menosprezo ou discriminação à condição de mulher.

Tais mudanças comprovam, também a nível nacional, a relevância do estudo dos crimes sexuais e, sobretudo, dos homicídios sexuais. Conhecer as características desses crimes, bem como os perfis do ofensor e da vítima, podem contribuir para a identificação desses ofensores e, futuramente, com o desenvolvimento de modelos preditivos e mesmo de perfis criminais específicos, facilitar o trabalho policial e até atuar na prevenção de novos crimes.

3. OBJETIVOS

Esta pesquisa teve por objetivo estudar e analisar as relações entre a psiquiatria, o direito e a violência, sob vertentes diversas, conforme a divisão por capítulos.

3.1 Objetivos Específicos

a) Estudar as relações entre violência, transtornos mentais e institucionalização prolongada, levando-se em conta aspectos clínicos, históricos, culturais e sociais.

b) Analisar os fatores associados à internação prolongada de pessoas com transtornos mentais com e sem antecedentes de violência e envolvimento legal.

c) Descrever casos brasileiros de parricídio, matricídio e filicídio associados à presença de transtornos mentais, discutindo a avaliação da responsabilidade penal aplicável em cada caso.

d) Avaliar os fatores relacionados à cessação de periculosidade em indivíduos que cumpriram medida de segurança, após perpetração de delitos, através do estudo de laudos psiquiátricos oficiais realizados por peritos psiquiatras, levando-se em consideração os itens presentes nos principais instrumentos de avaliação de risco existentes.

e) Analisar o estado atual da arte em relação aos reflexos do isolamento social e o possível incremento de violência sexual contra mulheres.

f) Analisar os homicídios sexuais na Austrália e na Nova Zelândia, estabelecendo comparações a outros homicídios não sexuais em um modelo controlado, traçando-se perfis desses crimes e criando-se modelos preditivos.

4. HIPÓTESES

a) Há aspectos específicos envolvidos no risco de violência, como história prévia de violência, abuso de substâncias e um transtorno mental clinicamente não controlado. A formação da equipe de saúde assistente pode colaborar com a ocorrência ou não de violência nesse contexto de institucionalização.

b) Um perfil de indivíduos com história prévia de comportamento violento e histórico positivo para envolvimento legal pode estar mais associado a internações prolongadas e risco de violência. Outros fatores, como idade, sexo masculino, estado civil solteiro, baixa escolaridade e baixa qualificação profissional, além da presença de transtorno mental sem controle clínico adequado, também podem se relacionar a institucionalizações prolongadas.

c) Os homicídios cometidos contra membros da própria família, no caso de o acusado possuir doença mental com manifestações psicóticas, podem estar associados à inimputabilidade. No caso de o acusado ser portador de algum transtorno de personalidade, esses homicídios podem ser associados à semi-imputabilidade. Havendo nexo com o delito e necessidade de tratamento, é provável que a Justiça brasileira opte por instituir medidas de segurança, em vez de sentença prisional.

d) Os itens dos instrumentos de avaliação de risco que se referem à avaliação clínica, bem como os associados à análise de fatores sociais/apoio pessoal parecem ser os mais utilizados nas avaliações pelos peritos oficiais.

e) O isolamento social relacionado a medidas necessárias para a contenção da pandemia está associado a um aumento da violência sexual contra as mulheres.

f) Os homicídios sexuais devem diferir dos não sexuais, além dos aspectos já estabelecidos em literatura e controlados na pesquisa (gênero e idade de agressor e vítima), nas dimensões: perfil do agressor; características da vítima e suas atividades no momento do crime; cena do crime e local de recuperação do corpo da vítima.

5. METODOLOGIA

A estratégia de pesquisa utilizada nesta tese foi a elaboração de artigos científicos, com o propósito de responder ao objetivo geral e aos objetivos específicos apresentados, bem como testar as hipóteses aventadas. Desse modo, os artigos foram organizados em três capítulos.

O primeiro capítulo se refere a estudos envolvendo transtornos mentais, violência, institucionalização, responsabilidade penal e cessação de periculosidade. Foram redigidos quatro artigos, sendo uma revisão sistematizada de literatura, dois estudos de campo transversais e uma análise de série de casos.

O artigo 1, intitulado "Institucionalização prolongada, transtornos mentais e violência: uma revisão científica sobre o tema", foi publicado na Revista Científica *Saúde e Sociedade* e é um trabalho que envolveu uma revisão de literatura sistematizada por meio de uma busca em importantes bases de dados de pesquisa, utilizando-se as palavras-chave: "institucionalização", "transtornos mentais", "violência". A análise dos resultados se deu por meio de agrupamento das pesquisas encontradas e incluídas na revisão por meio de dois grupos principais, os que envolveram "Estudos relacionando fatores ligados à predição/risco de violência e institucionalização" e "Estudos relacionando risco de violência e desassistência/desinstitucionalização".

O artigo 2, intitulado "Fatores associados à institucionalização prolongada de doentes mentais com e sem antecedentes de violência e envolvimento legal: um estudo transversal", foi publicado na Revista Científica *International Journal of Offender Therapy and Comparative Criminology*. Trata-se de um estudo transversal realizado com 34 indivíduos internados por longo período no Instituto de Saúde Mental do Distrito Federal. Foram analisados 56 itens por meio de revisão de prontuários hospitalares e demais registros de saúde, avaliando-se dados demográficos e sociais, antecedentes de violência, envolvimento legal prévio, histórico médico, uso de substâncias e outros que pudessem se relacionar a um maior tempo de institucionalização. Para essa avaliação, além da análise descritiva, foram utilizados testes estatísticos por meio do software IBM SPSS versão 26, sendo o teste de correlações de Pearson o escolhido para as variáveis quantitativas, enquanto a análise por regressão linear, com o uso do teste *R Squared* foi o utilizado para análise das variáveis categóricas. Uma análise descritiva foi realizada com a separação dos grupos de pesquisa em com antecedentes legais e sem antecedentes legais.

O artigo 3, intitulado "Matricídio, parricídio e filicídio: as doenças mentais graves ou os transtornos de personalidade estão relacionados a tais cirmes?" foi publicado na Revista Científica

"*Journal of Forensic Sciences*" e é uma série de casos envolvendo homicídios violentos do tipo matricídio, parricídio e filicídio, em que os periciados apresentavam algum transtorno mental. Para a análise dessa série de casos, os mesmos foram estudados, identificando-se os diagnósticos dos acusados, a presença de nexo entre o delito e o transtorno mental, bem como a decisão judicial. Com essas informações, houve discussão embasada em literatura científica atualizada, a fim de se aprofundar, com exemplos clínicos reais, questões envolvendo a responsabilidade penal, inimputabilidade e semi-imputabilidade em razão de doença mental ou perturbação da saúde mental.

O artigo 4, intitulado "O Exame de Verificação de Cessação de Periculosidade no Distrito Federal: análise dos laudos realizados na Seção de Psicopatologia do Instituto Médico Legal da Polícia Civil do Distrito Federal nos últimos dez anos" é um estudo transversal, realizado por meio de um corte retrospectivo de laudos médicos de Exames de Verificação de Cessação de Periculosidade (EVCP) realizados no Instituto Médico Legal do Distrito Federal-Brasília. Através do levantamento junto ao arquivo da Instituição, foram extraídas informações dos laudos (dados sociodemográficos, características clínicas, tipo de delito, características históricas e a pesquisa de itens relacionados à avaliação de risco de violência presentes nos principais instrumentos com essa finalidade existentes atualmente e que estivessem presentes nos EVCPs). Para a análise estatística, foi utilizado o software IBM SPSS versão 26, com o uso do teste do Qui-quadrado e valor de $p<0,05$, sendo considerado significativo.

O segundo capítulo foi criado durante o período da pandemia da COVID-19, que impactou profundamente a vida de todos, inclusive o bom andamento desta tese de doutorado. Este capítulo é composto pelo artigo 5, intitulado "Violência sexual e isolamento social: reflexos da pandemia do COVID-19". Trata-se de uma atualização de literatura, no modelo de revisão narrativa, porém a estratégia de busca desses artigos foi o banco de dados PubMed/MEDLINE. Desse modo, unindo-se a literatura atualizada encontrada e trabalhos clássicos sobre a temática de violência sexual contra as mulheres, o artigo foi desenvolvido como atualização de literatura em um modelo de comunicação breve. Trata-se de um capítulo breve que trouxe um aspecto que relaciona diretamente a pandemia da COVID-19: a repercussões envolvendo violência contra a população feminina.

O último capítulo desta tese corresponde ao artigo 6, intitulado "O que diferencia os homicídios sexuais dos homicídios não sexuais? um estudo comparativo de caso controle". Esse artigo é resultado do estágio no exterior realizado pelo autor desta tese (período "*Sanduíche*") na

cidade de Melbourne, Austrália, no Centro de Ciências Forenses e Comportamentais da Universidade de Swinburne. Inicialmente um projeto de pesquisa foi escrito e submetido à CAPES, em parceria internacional, em março de 2019, sendo aprovado para ser executado pelo período de seis meses no exterior. Assim, a execução da pesquisa começou em novembro de 2019, com previsão de encerramento em abril de 2020. Contudo, no início de março de 2020, a pandemia da COVID-19 assolou o mundo, de modo que o autor desta tese necessitou retornar ao Brasil antes da conclusão da pesquisa, visto que diversos países do mundo, incluindo-se a Austrália, iniciaram o fechamento total de suas fronteiras naquele mês. No caso da Austrália, especificamente, o bloqueio das fronteiras permanece até os dias de hoje, mais de um ano após o início desse processo. Por isso, o trabalho continuou a ser desenvolvido no Brasil, por meio de acesso remoto à base de dados de pesquisa, além de reuniões virtuais com a equipe de pesquisa australiana.

Esse trabalho foi bastante desafiador, por motivos diversos. A literatura científica sobre homicídios sexuais é um tema ainda incipiente em pesquisa, sendo que estudos comparativos com outros homicídios ainda não foram realizados de maneira pareada e controlada. Além disso, foi a primeira experiência de pesquisa deste autor fora do Brasil, em idioma estrangeiro. A delicadeza e a sensibilidade do tema foram outros desafios significativos, já que a leitura detalhada desses tipos de crimes é bastante incômoda, visto a extrema violência em que são frequentemente realizados, o que chega a impactar, mesmo estudiosos da área.

Para iniciar a execução da pesquisa, mais barreiras foram encontradas. A base de dados do sistema judicial australiano e a do neozelandês não possuem uma organização capaz de separar os tipos de homicídio. Além disso, a base de dados fonte de informação para a pesquisa é segmentada, segundo os diferentes estados australianos e, ainda, de acordo com a instância judicial do processo. Desse modo, não foi possível encontrar uma descrição melhor para a busca dos casos necessários à pesquisa do que a clássica comparação de "Procurar uma agulha no palheiro". Para encontrar os casos, foi necessário adotar uma primeira estratégia básica de usar, em cada segmentação dessas bases de dados, termos que pudessem facilitar encontrar casos, como "homicide", "murder" e "sexual murder" e vários outros parecidos, com o objetivo de se encontrarem casos na base legal de ambos os países que correspondessem a homicídios sexuais, segundo os critérios de Ressler (RESSLER, 1988). Dessa maneira, iniciou-se a busca de casos e, após o primeiro mês de pesquisas, foram encontrados 60 homicídios sexuais, em que minimamente houve as informações gerais do crime e dados demográficos básicos, como idade e sexo do agressor e da vítima, além de local/estado e ano em que o crime foi julgado. Em casos muito antigos, sequer foi possível

encontrar a idade da vítima/ agressor, visto que parte dos dados processuais não estão divulgados nas sentenças e nos demais conteúdos disponibilizados para o público.

O segundo e o terceiro mês da execução da pesquisa foram dedicados a encontrar pelo menos outros 60 homicídios não sexuais, em que houvesse concordância do sexo, mesma faixa etária da vítima e do agressor e também que tivesse sido julgado no mesmo estado, de forma a se ter uma amostra pareada por algumas variáveis. Dessa maneira, seria possível realizar um estudo comparado e controlado desses crimes. Essa etapa foi extremamente desafiadora, especialmente porque logo se percebeu que os homicídios não sexuais possuem uma característica demográfica, principalmente em relação à autoria e à vitimologia que são muito diferentes dos homicídios sexuais. Nos homicídios sexuais, em geral, tem-se ofensores homens jovens, de faixa etária entre os 20 e 40 anos de idade e as vítimas costumam ser mulheres jovens, com menos de 30 anos de idade. Os homicídios não sexuais, por outro lado, são cometidos por homens entre 30 e 50 anos de idade e as vítimas em geral são homens da mesma faixa etária. Deste modo, a imensa maioria dos homicídios encontrados nas bases de dados do sistema legal australiano e neozelandês não atendeu aos dados básicos estabelecidos para um estudo comparativo controlado.

Após o terceiro mês de pesquisa, foram encontrados 48 homicídios não sexuais que puderam ser pareados aos sexuais; além disso, outros 8 homicídios sexuais foram encontrados durante essa busca de homicídios não sexuais. Com essa amostra, cujo n foi considerado razoável, iniciou-se uma nova etapa da pesquisa, em que os dados referentes aos homicídios encontrados foram estudados em detalhe e "codificados". Para os homicídios sexuais, foram analisadas 300 variáveis, enquanto nos homicídios não sexuais as variáveis foram reduzidas a 200, excluindo-se os de características exclusivas de crimes sexuais e agrupando-se alguns itens para serem analisados como variáveis binárias, do tipo "sim" ou "não". Essas variáveis foram divididas em pequenas categorias, a saber: elementos da ofensa, características demográficas da vítima, atividade da vítima na ocorrência do crime, características demográficas do ofensor, adoção de precauções, envolvimento de veículo, características da cena de contato (abordagem), características da cena do crime, características da cena em que o corpo foi encontrado, características gerais da cena, tipo de relacionamento entre a vítima e o ofensor, características do crime, características gerais da cena, presença/ausência de "troféu" (lembrança/gratificação), tipos e meios de utilização de armas no crime, antecedentes criminais do ofensor, critérios de Ressler, critérios SeSas (escala para avaliar componente sádico), história de adoecimento mental do agressor, história de desenvolvimento do agressor e "miscelânea" (itens gerais e outras

observações pertinentes). Esses itens são inspirados em trabalhos realizados e publicados sobre essa temática (DARJEE, R., & BARON, 2018; SKOT et al, 2018).

Do terceiro ao sexto mês da execução da pesquisa, o planejamento foi realizar a codificação detalhada de cada um dos homicídios encontrados, para posteriormente escrever o artigo científico referente ao estudo comparativo. Esse processo de codificação encontrou muitas limitações, visto que o material processual aberto ao público pela base de dados legal é muito divergente entre cada estado australiano e Nova Zelândia, sendo que muitas das informações desejadas não estavam disponíveis para consulta, a depender do estado em que ocorreu o delito, ou mesmo a depender de cada processo em si. Foi realizada uma consulta oficial para a solicitação de acesso integral ao material processual, ao menos daqueles processos em que havia uma grande lacuna de informações, porém não se mostrou viável de ser realizado no período sanduíche, já que havia uma série de procedimentos administrativos a serem realizados e requisitos a serem atendidos, o que impediria a conclusão da pesquisa durante o período sanduíche. A alternativa adotada foi ampliar a busca das informações sobre os casos para consultas a publicações jornalísticas e a sites especializados em crimes, visando ao menos à aquisição daquelas informações fundamentais. Para considerarmos confiável a informação pesquisada, no caso de ela não constar no material processual oficial, ela deveria aparecer explicitamente em pelo menos três sites ou publicações jornalísticas conceituadas diferentes, caso não estivesse no material processual disponível ao público. Quando houve divergência ou desconfiança sobre a veracidade de determinada informação, ela foi desprezada. Essa pesquisa em sites de publicações jornalísticas e sites sobre crimes permitiu também o encontro de novos casos viáveis para serem incluídos na pesquisa. Com essa nova estratégia, foi possível encontrar mais dados sobre os homicídios sexuais e os não sexuais, o que fez o número total subir para 78 homicídios sexuais, sendo que 49 homicídios não sexuais estavam devidamente pareados e codificados.

No quinto mês de execução da pesquisa, já com aproximadamente 95% das codificações realizadas, o retorno precoce do autor ao Brasil foi necessário, conforme já explicado. Assim, o autor permaneceu buscando novos casos para completar o pareamento e as codificações e eis que se surpreendeu com um site leigo que listava diversos homicídios na Austrália (sem qualquer diferenciação em relação ao tipo), de modo que o número total de homicídios (sexuais e não sexuais), bem como o encontro de informações mínimas necessárias ao pareamento a casos previamente excluídos (sexo e faixa etária de ofensores e vítimas) foi tendo um progressivo aumento.

Ao final de junho de 2020, três meses após o retorno ao Brasil, o número final de casos de homicídios sexuais chegou a 142. Naturalmente, todos esses novos casos necessitaram ser codificados e pesquisados nas bases legais e bases extraoficiais, com o cuidado de obter informações confiáveis. Além disso, foi necessário buscar novos casos de homicídios não sexuais correspondentes, o que é complexo, conforme explicado. Para ampliar a possibilidade de análise e ajustar o pareamento da amostra, optou-se por três tipos de pareamento sequenciais. O primeiro foi um triplo pareamento ("triple match"), em que faixa etária e gênero de ofensores e vítimas, além do estado em que ocorreu o crime, foram os mesmos nos dois grupos de homicídios. O segundo tipo de pareamento considerou faixa etária e gênero de ofensores e vítimas, desconsiderando o estado em que o crime ocorreu. Por fim, o terceiro tipo de pareamento considerou apenas o gênero de ofensores e vítimas. Com essa estratégia, foram incluídos 89 homicídios não sexuais com "triple match", 118 homicídios com "duplo match" (gênero e faixa etária) e 142 foram pareados apenas por gênero de ofensores e vítima. Desse modo, o número total de casos a serem codificados aumentou para 284.

Dessa maneira, o processo de codificação foi finalizado no mês de outubro de 2020. Com uma amostra expressivamente maior do que a inicialmente projetada, a execução desta pesquisa teve seu nível de dificuldade de execução muito aumentada, especialmente pelo fato de o autor ainda ter outros cinco artigos para redigir, traduzir, revisar e enviar para publicação, além de ter também todos os seus compromissos profissionais e pessoais, sem possibilidade de dedicação integral ao trabalho, como aconteceu no período em que esteve na Austrália.

A metodologia escolhida para a análise dos dados desta pesquisa foi a mais complexa de todos os artigos desta tese. Ela consistiu em uma primeira análise envolvendo o agrupamento das variáveis contínuas, bivariadas e multivariadas em planilhas a serem estudadas por meio de testes estatísticos adequados para cada uma delas. O software utilizado foi o IBM SPSS versão 26, sendo os níveis considerados significativos, quando o $p<0,05$. Todas as variáveis independentes foram inicialmente comparadas a variáveis dependentes, por meio de análise bivariada, com testes de qui-quadrado, incluindo-se a simulação de Monte Carlo ou correção de continuidade quando pelo menos uma célula tinha uma frequência menor que 5, a fim de garantir que nesses casos os resultados não seriam devidos ao acaso.

Após essa análise, as variáveis que se mostraram estatisticamente significativas foram utilizadas como preditoras para análises do tipo regressão logística. As 101 variáveis significativas foram separadas em quatro categorias: 1- Características do ofensor; 2-Características da vítima e

relacionamento com o ofensor; 3-Características da cena do crime; 4-Características do local de recuperação do corpo da vítima. Assim, foram realizadas regressões múltiplas nessas categorias, de modo a se verificarem modelos preditivos para cada uma dessas dimensões. Ao final, as variáveis que compuseram esses quatro modelos preditivos foram agrupadas em um quinto modelo, utilizando-se a ferramenta *forward stepwise*.

Naturalmente, pela estratégia de pesquisa adotada nesta tese, os resultados, discussão e conclusão de cada um dos artigos encontram-se no corpo do texto dos mesmos, nos capítulos correspondentes.

6. DESENVOLVIMENTO

6.1 Capítulo 1

6.1.1 Artigo 1: Prolonged institutionalization, mental disorders and violence: a scientific review on the topic

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Abstract

This study is a review of institutionalization, mental disorders and violence. A systematic search was performed in major databases, focusing on studies from the last twenty-two years. The results were divided into two groups: 'studies on factors related to the risk of violence/prediction and institutionalization' and 'studies on the risk of violence and deinstitutionalization/inadequate mental treatment'. We found that mental illness is not directly associated with high risk of violence. Specific details of the institutionalization and assistance with deprivation of liberty are related to violent behavior. We concluded that humanized, multiprofessional approaches and trained staff, combined with the management of real risk factors of violence can contribute to a better health assistance and reduce the need for institutionalization.

Keywords: Institutionalization; Mental Disorders; Violence; Forensic Psychiatry; Commitment of Mentally Ill.

Introduction

The relation between mental health disorders and violence is a subject dating back to Antiquity, being currently more studied with some degree of systematization, although still permeated by controversial interpretations. The concept of mental health disorders, intrinsically related to what was called "madness" in the past, brings in its more contemporary conception the idea of a morbid variation of the normal, which may harm the individual's global performance in areas such as social, occupational, family and personal, and/or the people with whom they live (Alencar; Rolim; Leite, 2013).

The beginning of the development of classifications related to dangerousness, especially after the creation of the International Association of Penal Law in 1889, is another key point regarding this concept. This association established that the following would be deemed dangerous: "1) repeat offenders; 2) alcoholics and the disabled of any kind; 3) beggars and vagrants" (Garófalo 1878 apud Mecler, 1996, p. 27). From these lines, the extent of the prejudice and stigma shed on the people who presented variations from what was considered normal or were impaired in their psychic development is evident, since they would present major "anomalies" in behavior that supposedly correlated with an increased risk of violence, namely, the "degree of danger." That is reflected in the Brazilian penal system, as well as in dozens of other countries around the world. In its article 22 (later commuted into article 26 in its 1984 revision), the 1940 Brazilian Penal Code established that criminals suffering from mental health disorders were "dangerous" (Bruno, 1991).

Before that, as known and reported in history, the way of dealing with people suffering from so-called "mental illnesses" ultimately became a kind of incarceration. Psychiatric institutions created to treat patients with mental health disorders turned into a sort of permanent shelter. Similarly, the so-called "judicial asylums," institutions that housed people suffering from mental health disorders who had committed crimes, also became permanent shelters. Thus, regardless of having committed crimes, these individuals were perceived as a part of the asylum itself, or "belonging to the institution," and remained so, even after most of those institutions were closed.

Thus, in this study, individuals who experience or have experienced some type of situation where they were completely bound to a psychiatric institution or equivalent are called "institutionalized," as well as this process is referred to as "institutionalization." The constant process of modification, not limited to physically structural issues but involving changes in mentality, in a culture that broadly relates psychic illness within the society and is more impactful on mental health disorders situations, is known as "deinstitutionalization. Improving the quality of mental health treatments (not only psychiatric) is only possible through public policies aiming, in fact, at deinstitutionalization. In a broad aspect, that means transforming and revising concepts, prejudices, stigmas, and other factors concerning the psychic illness process with the offer of other mental health care devices, such as Psychosocial Care Centers and outpatient monitoring.

Throughout history, institutionalization was the measure adopted to also deal with people suffering from mental disorders, a broader term encompassing classic mental illnesses, especially psychoses, but also referring to those "outside the norm," as happens in behavioral disorders, cognitive

deficits, and other difficulties within the psychic field. For this reason and due to the lack of individualized, multidisciplinary, and dignified treatment, such institutionalization devices started being abused and used in indiscriminate ways, giving rise to serious consequences for many patients' health and life, as well as their families'. The lack of resources and scientific knowledge at the time served as important reinforcements for situations that were inhuman and ineffective at times.

Finally, combining this historical context and the old-fashioned treatment of the time, the legislation facilitated psychiatric hospitalizations progressing towards the institutionalization for indefinite periods for people who were mentally ill and committed an offense until there was a "cessation of dangerousness" (Brasil, 1940, art. 97, § 1º). The idea of presumed risk generated a serious distortion of a system intended to treat and rehabilitate the individual and, paradoxically, ended up serving as a means of imprisonment; that is, institutionalizing them for long periods (Arbex, 2013; Confessor Júnior, 2018; Correia; Passos, 2017).

From this point of view, we can reflect on the infinite aspects and classifications of violence, according to the definition of the World Health Organization (OMS, 2002, p. 5): "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation." It is noted that the violence goes far beyond the physical aspect, and can arise, for example, in the form of a threat, causing deprivation and changes in the individual's development. For this reason, in this article, the relationship between violence and mental health disorders will be addressed under the supposed risk posed by this population's dangerousness, reflecting a great and historical stigma, and the various types of violence that they suffer, or may be subject to will also be considered and evaluated, knowing the broad definition of WHO.

Several studies have sought to associate the risk of violence with mental health disorders, but many have described small or specific samples, such as populations exclusively selected from custody hospitals or even prisons, resulting in an inadequate analysis of the mental health disorders themselves (Adshead, 1998; Flannery Junior et al., 2000; Kramp; Gabrielsen, 2009; Moscatello, 2001; Oliveira et al., 2017; Short et al., 2013). On the other hand, there are other studies demonstrating relations contrary to this (Fazel; Yu, 2011; Ghoreishi et al., 2015; Mecler, 2010; Oliveira et al., 2016). Violence in individuals with mental disorders can be certainly prevented through psychiatric treatment and clinical management regarding this aspect (Valença et al., 2011).

In the last 20 years, the development of standardized assessment instruments has become a priority, aiming to improve the validity and reliability of predictions regarding the risk of violence. The expectation is that these instruments will generate reliable data on the probability that patients may commit violent acts under certain circumstances.

There are also institutions that absorb mentally ill patients and shelter them for prolonged periods both in Brazil and worldwide. Sometimes, this population comes from different backgrounds, with some patients arriving from old asylums that have been closed. These patients received a "safety measure," with protective and therapeutic goals, however, due to several distortions within the legal and aid systems, they have been kept hospitalized in these institutions for many years.

After receiving a security measure by court order, the individual must pass a new expert examination aimed to assess how dangerous they are. Such evaluation is carried out by an official state expert. The examination to verify the cessation of dangerousness must be carried out at the end of the minimum period established by the judge (between one and three years) and repeated annually until the cessation of dangerousness is determined. It is important to note that, within this context, dangerousness is a legal – instead of medical or psychological – concept, implying the ability to predict the risk of future criminal behavior by the person subjected to the security measure (Mecler, 2010).

As a result, the criteria assessed for dangerousness verification extend beyond a psychiatric assessment, which is a relevant part of a broader context and deserves to be discussed transdisciplinarily.

This study aims to carry out a review of the scientific literature on the relevant and contextualized subject of violence, mental disorders (broader term), and institutionalization, taking clinical, historical, cultural, and social aspects into account.

Methodology

This is a literature review study, and, for this purpose, the main scientific databases related to the topic were used. The terms operated are the following health descriptors: "Institutionalization," "mental disorders," "violence," as well as their equivalents in Portuguese and Spanish. The bases used were PubMed, Latin American and Caribbean Health Sciences Literature (Lilacs), Scientific Electronic Library (SciELO), and Virtual Health Library (Bireme). Additionally, other articles were sought in languages other than English, Spanish, and Portuguese, using the same strategies. At first, no time limit

had been set, as all available data were searched in all databases. After that, we decided to restrict the analysis of the results to the last twenty-two years, seeking to provide an insight into the subject until 2020.

The selection of articles to be included in this review was done by reading the abstracts found with the goal to evaluate whether the articles were related to the subject of prolonged institutionalization/hospitalization of people with mental disorders and their possible correlation with violence. From there, the information contemplating the general and specific objectives already described has been extracted. There was no delimitation as to the type of article, as the purpose was to conduct a review on what knowledge has been produced about this topic in the last twenty-two years. Within the databases described, the research used the descriptors present in all three terms:

The total of 155 articles were found in Pubmed, 101 of which were published in the last twenty-two years. Of these, 58 contemplated the subject of this work and were studied and evaluated.

The total of 35 articles were found in the Bireme database, 23 of which were published in the last twenty-two years, with 11 covering the subject of this work.

The search in Scielo's database found only one article containing the three present descriptors, but its subject did not contemplate the objectives of this work. Thus, there was no evaluation of any Scielo publications.

Therefore, 124 abstracts of articles published in the last twenty-two years were initially read, then 69 articles related to the topic described, were selected. Four of those were listed under two databases and six articles were excluded from the analysis for being written in Danish, Polish, and Norwegian. Thus, the final number of total articles evaluated was 59.

The types of articles found and analyzed were: 1 randomized clinical trial, 1 case-control, 7 systematized reviews, 21 non-systematic reviews, 31 miscellaneous (reports, editorials, comments, etc.).

Results

The regions with the highest concentration of research were Europe and the United States, and the specialized magazines in which most of these articles were published were also from these areas.

As to the sociodemographic profile of this population, at least four studies were found which explicitly observed data on this topic (Crocker; Côté, 2009; Flannery Junior et al., 2000; O'Grady, 2004;

Short et al., 2013). The common aspect found was a population of young male adults, single, with low or no income, low level of education, unemployed, and with a history of mental health disorders, although many individuals have never been under treatment. That is, a very disadvantaged population, exposed to several destabilizing factors. To systematize the analysis of the results, the main studies were condensed into two groups: the first, seeking to describe factors related to the prediction/risk of violence through correlation with institutionalization, and the second, seeking to assess the risk of violence and/or the risk originated from the lack of assistance to deinstitutionalization.

Studies relating factors linked to the prediction/risk of violence and institutionalization

With regard to historical items and the possible relationship with institutionalization and/or violence, Douglas, Guy, and Hart's (2009) meta-analysis used 204 studies, with 166 independent variables. The central (median) trend in effect sizes indicated that psychosis may be associated with a 49-68% increase in the risk of violence. However, there was a wide dispersion between effect sizes attributed to methodological factors, such as community or institutional samples, definition of psychosis (diagnosis, quantification, and type of symptoms), comparison group (psychosis compared with externalization versus internalization versus absence of disease) mental). The data show how specific, punctual, and diverse the presentation of violent behavior and psychotic conditions can be.

Steinert (2002a) carried out a non-systematic review to investigate the risk of violence prediction. The "history of violence" predictor was the only isolated and robust one. Other predictors that were also prominent are positive symptoms (delusions and hallucinations) and other psychotic symptoms. Clinical variables analysis is impaired, as pharmacological and therapeutic interventions applied specifically for hospitalized patients influenced this assessment. According to the study, the predictors with greatest potential were male, young age, psychotic symptoms, and alcohol abuse.

In another literature review also dated from 2002, the same author studied the prediction of risk of violence in patients with severe mental health disorders and in individuals without mental health disorders (Steinert, 2002b). He determined that it would be necessary to separate the predictors of hospitalized or institutionalized patients from those of outpatients and people without mental health disorders. The results of the review were: people without mental health disorders, as well as severely ill patients who are not hospitalized or institutionalized, have the same predictors of violent behavior: criminal history, male, young age, and substance abuse. For hospitalized or institutionalized patients, violent behavior during hospitalization is closely related to the severity of psychopathological symptoms.

Such variables were not highly significant in outpatients and non-institutionalized patients. In other words, the work showed that there is no increased risk of violence associated with mental health disorders for individuals living within the community, whether mentally ill or not. Factors related to the institutionalization itself or the type of assistance may be found in other works such as the one described below.

Flannery Junior et al. (2000) a cohort study was carried out on people who had left institutions for the mentally ill with violent behavior in Massachusetts. Their sociodemographic profile was initially characterized as: 554 men and 472 women, 87% Caucasian, 20–80 years old (average 41), and primary schizophrenia diagnosis (71%). Next, the occurrence of several types of aggression, whether physical, sexual, verbal, and non-verbal intimidation in two periods, was evaluated: 1991–94 (first period) and 1994–98 (second period). Eighty assaults on the assistance team were reported in the first period, and 39 in the subsequent period. The type of aggression in the first period had the following profile: 30 physical assaults (37.5%), 7 sexual assaults (9.7%), and 42 verbal assaults (52.5%). In the second period, there were 22 physical assaults (57%), 4 sexual assaults (10.2%), and 9 verbal assaults (23.1%); that is, there was a significant decrease in incidents. The profile of the aggressors studied in the two periods was quite similar: male, young, and suffering from psychotic symptoms.

The authors of the same study also described the profile of the victims of the attacks, getting to important conclusions: they were professionals in direct contact with the inmates, lacking specialized education and adequate training, under acute stress (69%) and other mental illnesses, such as sleep disorders, hypervigilance, as well as the presence of intrusive memories (48%). Based on these results, the institution chose to train the hospital staff after the first period of the study using the ASAP – "Assaulted staff action program" – a program aimed at employees who are victim of aggression. A good part of the significant reduction in the number of aggressions that occurred in the post-training period may be attributed to the training. This study proved the relevance of training health care professionals, calling for a look also to the professional and to those who assist the patient, moving past the observation of violence from the patient's point of view, as a sick professional can also instigate violent demonstrations.

In turn, Warburton (2014) carried out a cross-sectional study on psychiatric patients in the state of California. According to him, physical aggression was the main reason for hospitalization and the main impediment to discharge in various services. There would be three main motivations for aggression: poor impulse control, planned predatory behavior ("signs" – "I don't like," "I want to assault," "I want

to kill"), and positive psychotic symptoms. Proposals were made to improve this issue, including the assessment of the risk of violence; customized treatments based on the type of aggression: dialectical behavior therapy for impulsivity, safety interventions in predatory aggression, and antipsychotic medication for psychotic symptoms; monitoring of substance abuse; independent forensic assessment of the clinic, and care for the environment and hospital layout.

Studies relating risk of violence and lack of assistance/deinstitutionalization

Short et al. (2013), in a case-control study, the criminal records of 4,168 schizophrenics (1975–2005) who were not institutionalized were compared to a random sample of 4,641 individuals from the Australian community. Compared to the community controls, patients with schizophrenia spectrum disorder were significantly more likely to have a record of violence (10.1% vs. 6.6%) as well as suffer violent sexual assaults (1.7% vs. 0.3%). Another finding observed was that the recorded victimization rate more than doubled in patients with a spectrum of schizophrenia but remained constant within the community.

People with schizophrenic spectrum disorders are particularly vulnerable to victimization for violent crimes. Although the comorbidity with substance abuse and crime increases the chances of victimization, they may not fully explain the increase in the rates concerning these individuals. According to this work, deinstitutionalization may have contributed, in part, to the unintended consequence of the increase in victimization rates among mentally ill patients.

Kramp and Gabrielsen (2009) also sought to analyze the relationship between the reorganization of the psychiatric treatment system and the growing number of patients involved in crimes such as manslaughter, arson, and other violent actions perpetrated by individuals with mental health disorders. Using Danish records, the positive or negative annual growth rate was estimated in social and community psychiatry (explanatory variables), as well as the prevalence and incidence of forensic patients involved in crimes (response variables) from 1980 to 1997 in each of the Danish municipalities. There was an indication that the closure of vacancies in hospitals did not have an immediate effect on the number of forensic patients or serious crimes. However, according to the authors, the comparative analysis showed that, over time, the decrease in the number of psychiatric beds was significantly related to the growth in rates of crimes such as manslaughter and arson committed by forensic patients, hence the importance of the availability of hospitalization devices for psychotic patients whose behavior involve some risk of violence.

Videbech et al. (2010) assessed the health situation in therapeutic residences in Denmark. The authors found a group of people suffering from serious mental health disorders, in addition to poorly treated physical illnesses. A high rate of violent episodes and psychotic behavior was observed in these patients, besides a great number of frequent short hospitalizations. When establishing a comparison of this group with a population control not suffering from mental health disorders, the authors found a two-fold higher prevalence of metabolic syndrome in institutionalized individuals in relation to the control population. The hypothesis brought to light by the study was that an unhealthy lifestyle associated with psychopharmacological treatments would result in a higher risk of cardiovascular events. Thus, the authors propose a mandatory regular screening for physical diseases as a means to guarantee the patients' health. They also believe that those patients should ideally be kept in a long-term psychiatric ward, besides getting more incisive actions from the justice system regarding serious cases.

Wahlbeck et al. (2011) studied a cohort of patients admitted to psychiatric hospitals in Finland, Sweden, and Denmark between 1987 and 2006, and sought to assess their life expectancy, among other observations on the health of these patients, with the main outcome being up to fifteen years after hospital discharge and the control group comprised by non-sick population. Patients with mental disorders had a mortality rate three times higher than the non-sick population. Women lived 15, and men 20 years less than their respective controls. During the deinstitutionalization era, life expectancy among people suffering from mental disorders decreased in all three countries. The determinants of mortality found included an unhealthy lifestyle, neglect of body care, and a "culture" of not taking physical diseases into account when approaching psychiatric patients. People with mental disorders are also more often unemployed, single, and marginalized. Stigma raises great barriers to the access to health care. The results point to a greater need for actions aimed at promoting health, improving the system, and preventing suicide and violence within the Nordic health system.

A historical review carried out by Manning (2009) assessed the situation of psychiatric patients tutored by the Australian State in the Kew Cottages home between 1925 and 2008. Founded in 1887, Kew Cottages was Australia's oldest, and also their largest specialized institution for people with intellectual disabilities. Kew Cottages was originally conceived as a place of benevolent care and education for children. However, its isolated location, resembling that of a "Lunatic Asylum," together with the use of physical security measures, granted it a reputation as a place of incarceration. Despite the introduction of reforms in the mid-twentieth century to provide residents with greater freedom, the

precarious living conditions, very strict regulations, violence, and abuse contributed to the development of a prison environment within the institution.

Lamb and Weinberger (2013) conducted a review of recent publications, evaluating whether patients with severe mental health disorders had criminal bounds. Their work found that patients who presented these behaviors often received inadequate or unstructured treatment, with no social control or comprehensive monitoring within the mental health system, if needed. The public health systems demand greater funding and accountability to care for these patients. These situations can be treated and are certainly avoidable.

Silver (2006) carried out a non-systematic review on violence and mental disorders and their theoretical bases. According to the author, the theories of "criminal careers" and "local life circumstances" need to be studied and revised to consider the adoption of a new organized and systematized structure that takes into account the patient's changes over time. This would greatly contribute to a better understanding of the determinants of violent behaviors among people suffering from mental health disorders who live in the community. The author concluded that the proposition of an organized treatment system based on research and evidence, managed by standardized instruments with rigorous documentation of patients' clinical and criminological contexts, the assessment of family members and other people involved in their social context and which, combined to a structure establishing rewards in the face of progressive individual improvements, for example, would provide a good model for the effective reduction of the risk of violence among people with mental disorders.

As further discussed, the latest studies show us that strategies that take into account the dynamics of the individual, as well as the environment and other determinants of violence, and the deinstitutionalization process can lead to a greater chance to understanding the violence process without being limited to the institutionalization/deinstitutionalization dichotomy.

Discussion

The articles found showed a concern/discussion regarding the issue of violent behavior and mental health disorders; the presence or absence of those factors, while associated; and the issue concerning the institutionalization/deinstitutionalization and its consequences. Systematic reviews, including a meta-analysis (Douglas; Guy; Hart, 2009), found very large heterogeneity in the samples, the criteria used, and the great biases inherent from assessments to determine the risk of violence, with the topic demanding a multidisciplinary approach.

In the studies included in this review, the "history of violence" factor appears as a significantly isolated item, and this information is corroborated by several other authors (Mecler, 2010; Oliveira et al., 2017; Teixeira et al., 2007). However, such information in no way helps to prevent the first violent episodes and does not provide any information about which factors might actually give rise to the risk of violent behavior, so that it can be modified and dealt with.

In fact, when considering exclusively the historical aspect of previous violent behaviors, there is a contribution to the increase of the stigma against the mentally ill, who will then be perceived as dangerous and lacking the ability to socialize or recover.

Goffman (1988) brings significant data directly related to the establishment of signs (cut, marks, or even burns) in individuals with "bad moral status," physical disorders, or anything strange or less desirable than the "normal." As shown by the author, fulfilling a norm, or simply supporting them is a way of exercising prejudice. The feeling of inferiority will only generate more insecurity and stigma on both sides.

Personal experiences, especially narratives of self-reports, are capable of triggering some kind of change and motivation within those people who are segregated/stigmatized. This allows for the "discredited," or even the "discreditable," to show that something different than what is expected by society may take place (Goffman, 1988) since the differences or difficulties faced by the mentally ill are usually stigmatized.

Thornicroft (2006) describes real situations experienced by people with mental disorders, such as significant restrictions on basic civil rights in the United States, difficulty in applying for rent or even buying their own home, restrictions on the use of swimming pools in certain clubs, driving a vehicle, or obtaining a visa. Historically, in several states of the U.S., the right to vote was also restricted and inaccessible to individuals suffering from mental health disorders. In the same text, there are examples of mentally ill victims of violence, both physical and sexual.

The greatest vulnerability of the mentally ill to the violence addressed by Thornicroft (2006) is in line with some of the articles in this review, as well as others on the subject, such as Short et al. (2013), Wahlbeck et al. (2011), Abdalla-Filho & Souza (2009), Teixeira et al. (2007), and Gattaz (1999).

Scheirs et al. (2012) carried out a cross-sectional study at a Dutch institution to research variables that were most related to the need for physical or chemical restraint in patients with intellectual disabilities. The authors concluded that no sociodemographic variable was statistically significant and

that there are greater predictors of more relevant violent behavior, such as low adaptive functioning, challenging non-violent behavior, and a higher intellectual level (within their sample of patients with intellectual disabilities). Institutionalization seems to have caused the harmful phenomenon of frustrating individuals with better intellectual capacity, given the limitations and barriers of the institutionalized and enclosed environment.

The characterization of the results of this review, in which the works are almost exclusively focused on the assessment of the violence perpetrated by the patient, with a rare in-depth evaluation of the factors which gave rise to this violence and that are not dependent on the individual, reinforces the old-fashioned character of this thought. Few studies dealt with the violence suffered by institutionalized people and, whenever they are carried out, they end up comprising historical reviews, especially from the asylum period. The awareness that this violence persists nowadays, not only in its physical form, but also through coercion, prejudice, and disdain, characterizing typically institutional violence, is extremely important.

In 2006, 2013, and 2015, Valença et al. sought to relate factors to the presence of violent behavior with regard to risk prediction and prevention of the manifestation of this behavior (Valença; Moraes, 2006; Valença; Nascimento; Nardi, 2013; Valença et al., 2015). Clinical criteria were decisive in these studies, mainly the presence of productive symptomatology, relapse, lack of insight, and cognitive distortions. This proves that adequate clinical control is fundamental to avoid recurrence within the mental patients' population.

Regarding the prediction of violent behavior, Oliveira et al. (2017) concluded that the use of validated instruments and the development of a semi-structured interview with the purpose of assessing the risk of violence in psychiatric patients in custody would be ways of circumventing or, at least, reducing possible distortions. Also according to the authors, research that provides data to help the identification of individuals suffering from mental disorders who are at risk of violent behavior, as well as their proper treatment, can contribute to the prevention of this conduct, as well as its expression within the social environment. As a consequence, they could allow for a better characterization of groups and risk situations, clarifying the specific motivations related to the manifestation of violent behavior in individuals with mental disorders.

A more careful analysis of the publications by Videbech et al. (2010), Kramp and Gabrielsen (2009) or, still, Fuller Torrey (2015), intended to correlate the deinstitutionalization with a process of

increasing violent crimes committed by mental patients. As demonstrated by the articles in this review (Glied; Frank, 2014; Lamb; Weinberger, 2013; Manning, 2009; Silver, 2006), situations of violence and risk are punctual and involve the minority of patients. Historically, the situation of institutions founded on an approach focused on punishment, incarceration, and physical restrictions can influence behaviors that involve violent responses. Considering the idea of re-institutionalizing patients, even though (and obviously) using a model with better infrastructure, might look like a backward solution. The historical analysis of these institutions is clear in the aspect in which they came up with a model quite different from what they have ultimately become. Initially, they were called nursing homes, convalescence homes, spas, etc.

Foucault (2001), Correia and Passos (2017), and Arbex (2013) deal with the subject of restrictions, institutionalization, and difficulties and distortions of asylum models for psychiatric treatment. There are several reports of mistreatment, unnecessary prolongations of hospitalizations, and inadequate and distorted therapeutic proposals. A nefarious consequence was the increase in institutional violence and a huge number of deaths which could have been prevented.

The stigma resulting from inadequate therapeutic approaches is portrayed very clearly by the patients themselves. Nascimento & Leão (2019) published an important qualitative work in which it is clear how much the mentally ill perceive themselves as stigmatized and victims of prejudice. Recovery strategies, which can be understood as a recovery process experienced differently by each individual, seeking their recovery in the most active and participatory way possible, is undoubtedly an important factor for overcoming the effects of stigma and other negative effects of the presence of mental health disorders (Nascimento; Leão, 2019; Serpa Junior et al., 2017).

It is important to highlight how Flannery Junior et al. (2000) investigated the profile of aggressions carried out by people who had left a psychiatric institution. The innovation of this work was to think from the perspective of the professional and not to merely associate violence and the patient. In fact, the authors identified a profile of the professionals who were victims of violence: those with inadequate education or training backgrounds, and who suffered from mental illnesses, such as acute stress, sleep disorders, hypervigilance, and other psychic disorders. According to this study, an intervention focused on the professional team contributed to a steep decrease in the aggressions, which dropped to under half the previous number over the observation timespan (four years), despite the increase in the number of hospitalizations in the same period. That is, there are measures to be taken to

prevent violent behavior and they are not limited to the patient itself but associated with several other factors.

Thus, it can be considered that the most plausible alternatives, the ones with a greater chance of preventing violence among the mental patients population and with a higher incidence of re-socialization and good clinical control, are the adequate training of staff and creation of systematic, standardized models that take the evolution and dynamics of the process related to violence into consideration, as addressed in different studies, including Silver's (2006), Mecler's (2010), Valença, Nascimento and Nardi's (2013), and Oliveira et al's. (2017).

There are robust scientific studies in place, including systematic reviews and meta-analysis, proving that mental health disorders are not the most important factor in assessing the risk of violence, or even an isolated factor leading to it (Abdalla-Filho; Engelhardtb, 2003; Achá et al., 2011; Bonta; Law; Hanson, 1998; Ghoreishi et al., 2015; Mecler, 1996; Menezes, 2001; Oliveira et al., 2017; Valença; Moraes, 2006; Valença; Nascimento; Nardi, 2013; Whittington et al.. 2013).

Several studies have investigated the relationship between mental health disorders and violent behavior. Menezes (2001) found that the absence of psychiatric treatment prior to the crime was the main variable related to violent behavior, highlighting, then, the possibility of it being preventable.

In Brazil, one of the situations in which we are confronted with violence and institutionalization is when a mentally ill person commits a crime and is deemed unimputable, according to Article 26 of the Brazilian Penal Code. In this case, the person will be held in custody by the Brazilian State and may remain institutionalized for decades, even if as a result of a not so serious crime, due to being considered a potentially dangerous individual. The presumed dangerousness only ends with the Examination to Attest the Cessation of Dangerousness, which must be carried out by an official expert psychiatrist. Mecler (2010) and Oliveira et al. (2016) researched hundreds of Brazilian psychiatric reports and identified that, in most of these exams, the psychiatric expert does not seem to subject his report to a standardization and systematization that takes the most relevant points in the risk of violence into consideration, in disagreement with what is presented in the scientific literature comprised in this review.

This situation calls for great reflection concerning the Examination to Attest the Cessation of Dangerousness, as its lack of systematization and standardization regarding the data collection hinders not only the analysis of the data but also the quality of the exam, which many times fails to address some relevant factors for an efficient analysis of the risk of violence. It was based on this, and after discussions

on the subject together with managers and clinical staff, that the Instituto de Perícias Heitor Carrilho, the place where all the evaluations for the cessation of dangerousness in the state of Rio de Janeiro are carried out, implemented the Multiprofessional and Psychosocial Care Expert Examination (Empap) in October 2017.

This exam provides a new model in accordance with scientific, historical, and cultural assessments, as well as all the advancement in health and legal knowledge, taking into consideration the principles of dignity and international human rights regulations. Empap was conceived from a multidisciplinary perspective, treating some central points in an objective and explicit way, considering historical items, criminology, social and clinical factors, and the perspective for the future from the expert's point of view and the psychosocial support which the patient should receive upon release of the security measure (Costa et al., 2018).

It is prejudiced, stigmatizing, and contrary to scientific evidence to consider the mentally ill as individuals at greater risk of violent behavior compared to the general population. Of course, there are situations in which, especially if left untreated, they may become violent, but those characterize specific contexts, with treatable and changeable factors. Quality and humanized care, in which prolonged hospitalization and institutionalization are avoided, are certainly excellent means to reduce the risk of violent behavior by these individuals.

The identification of risk factors associated with violent behavior is essential to achieve an adequate assessment in relation to mental health disorders, without referring strictly to the prolonged, archaic, and stigmatizing hospitalization/institutionalization model, when perceived as the only possible alternative.

The application of standardized instruments and a systematic assessment based on technical and scientific knowledge can provide more reliable data to predict and avoid the risk of violence within this population or even avoid the abusive enforcement of the security measure. The combination of the organization of a standardized, holistic, and dynamic health treatment system, will allow for the offer of adequate monitoring and actual re-socialization, without the reinforcement of the stigma and archaic thinking leading to the conclusion that institutionalization is the only possible solution.

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Authors' contribution

Oliveira wrote and revised the initial version of the text. Valença revised the final version of the manuscript. Both authors contributed to the formatting of the article and to the bibliographic research.

6.1.2 Artigo 2: Factors associated with prolonged institutionalization in mentally ill people with and without a history of violence and legal involvement: a cross-sectional study

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ABSTRACT

Background: This is a cross-sectional study carried out on 34 individuals hospitalized for a long period in the Federal District, in Brazil.

Aims: To evaluate factors related to prolonged institutionalization in mental patients with history of violence and criminal records.

Methods: Individuals found were assorted into two groups: with and without criminal records. We analyzed 56 items by reviewing medical records and health records. Demographic and social data, history of violence, criminal involvement, medical history, substance use, and other aspects related to long hospitalizations, by reviewing medical and health records.

Results: We found a profile of male individuals: single, male, with an average age of 47.6 years, low education, and little professional qualification from correctional facilities or long-term psychiatric clinics and hospitals. Most men had a history of aggressive behavior, a leading psychiatric diagnosis of psychosis, and an issue with polypharmacy. Two factors showed statistical significance and were highly related to longer institutionalizations: polypharmacy and records of hospitalization for violent behavior.

Discussion: Further studies with these populations are needed to increase knowledge on the subject. They can help health care systems to improve and provide broad, humanized and quality assistance with multi-professional teams, aiming to reduce prolonged hospitalizations.

Key-words: Violence. Institutionalization. Mental disorders. Prolonged Hospitalization

Significant Outcomes: Polypharmacy and previous violent behavior are related with long hospitalization. Institutionalization in mental health people are poor, single, low education and totally forgotten by society. We have a lack of studies about institutionalized people and the system is cruel with their mental and physical health.

Limitations: Lack of information, small population (it´s not a sample, it´s a full population), cross-sectional study has intrinsic limitation in analyses.

Data availability statement: The data that support the findings of this study are available from the corresponding author upon reasonable request. (the author needs to ask the Brazilian ethics committee, which needs to authorize the release of the data, since it is sensitive information.).

Introduction

Studying mental disorders and violence can be a controversial matter because it entails methodological limitations, e.g., former, unreliable, and indirect diagnoses. Psychoactive substance abuse and other comorbidities are often found in mentally ill patients which are usually related with violence. (Teixeira et al., 2017) Finding an adequate definition for violence proved to be a complicated task, as questions regarding psychiatric care and stigmatization may lead to misunderstandings and misconceptions about mental health (Kramp & Gabrielsen, 2009).

Violence and mental illnesses are risk factors commonly found in specific places, such as hospitals and prisons (Adshead, 1998; Flannery, 2000; Mecler, 2010; Moscatelo, 2001; Oliveira et al., 2017; Short et al., 2013;). However, studies show that this relationship is present in other contexts as well (Fazel et al., 2011, Ghoreishi et al., 2015, Kramp et al., 2009; Mecler, 2010; Oliveira et al., 2017; Short et al., 2013). Violence can be prevented, especially when mentally ill patients are under appropriate multidisciplinary monitoring and clinical management (Valença et al, 2011).

In the past, involuntary admissions were a common practice for mentally ill patients with behavior changes. Such actions harmed both patients and families (Arbex, 2013; Manning, 2009). The lack of out-of-hospital treatments, information, and unreliable health care resulted in adverse consequences.

A recent study assessed Denmark's therapeutic residences regarding health care practices (Videbech et al., 2010). Researchers studied a group of people with severe mental illnesses who did not have their physical illnesses properly treated. There was a high incidence of sudden episodes with

violence and psychotic symptoms, and an elevated frequency of short hospital stays. Researchers found a twice higher prevalence of metabolic syndromes in institutionalized individuals with high cardiovascular risk than in the control group without mental disorders.

Wahlbeck et al., 2011 studied a group of patients admitted to psychiatric hospitals in Finland, Sweden, and Denmark between 1987 and 2006. They evaluated life expectancy and other health indicators up to fifteen years after hospital discharge and compared them to a non-patient control group. Compared to patients without mental illnesses, the mortality rate among hospitalized patients was three times higher, i.e., 15 years less for women and 20 years less for men. The determinants of mortality were unhealthy lifestyle, inappropriate bodily care, and the "habit" of not taking care of patients' physical diseases. As pointed out in many studies people with mental illnesses are often unemployed, single, and marginalized (Mecler, 2010; Moscatelo, 2001; Oliveira et al., 2017; Short et al., 2013). It can generate stigma that influences their access to health care. Hence, the urgent need to promote health care for this population.

Hodgins, 1996, in a systematic review, evaluated the relationship between severe psychiatric disorders and criminality. It was found that patients with criminal records and mental disorders virtually always received inadequate treatment, were not under social control, nor had a full follow-up. Those situations can be prevented if public health systems have more funding and accountability for the duty of care.

Institutionalized patients benefit from approaches in which health care professionals see the patient as a person, understand the environment they live in, and pinpoint other determinants of violence. Previous situations, old-fashioned treatments, and repressive laws steered a modification from psychiatric hospitalizations to mentally ill criminals' institutionalizations. Patients were often admitted for an indefinite period or until "they were no longer dangerous". The assumption of a risk factor caused a serious misconception about the rehabilitation system, which led patients to be locked up or institutionalized for extended periods (Arbex, 2014; Correia & Passos, 2017; Oliveira & Valença, 2020).

Until today, some institutions admit the mentally ill for longer stays. These people come from various places, e.g., shelters, asylums, custody facilities, or penitentiary hospitals (when they are under the State's custody). Patients are admitted for an indeterminate time. First, the court establishes a minimum hospital stay, i.e., from one to three years. Then, defendants are evaluated on whether they are

still dangerous after this period. Patients may spend many years in hospital care if the opinion of a forensic psychiatrist indicates a high level of dangerousness.

According to Brazilian legislation, the Cessation of Danger Examination (EVCP, in Portuguese) is an exam performed by an official psychiatrist expert at least once a year. Medical expert examinations must be conducted at the end of the minimum period set out by the court, repeated every year until there is no risk of danger or when the court requests it (Oliveira et al., 2016). In this context, dangerousness is a legal concept, not a medical or psychological one, which predicts an individual's future behaviors under safety measures (Mecler, 2010). Therefore, the EVCP criteria go beyond psychiatric evaluation; it is part of a broader context to be discussed in a comprehensive and transdisciplinary way.

Aims of the Study

This paper aims to analyze factors associated with longer hospital stays of psychiatric patients with or without records of violence and criminal involvement by means of a cross-sectional study at a long-term care institution.

Method

In this study, we analyzed patients admitted to the Casa de Passagem (halfway house) of the Mental Health Institute (ISM/DF), in Brasilia, Federal District, Brazil.

The ISM/DF is part of the Federal District Health Department and receives patients at the Psychosocial Attention Center (CAPS, in Portuguese) and the outpatient clinic. It also has a halfway house with 34 patients – 28 men and six women – at the moment. Some are former patients from other psychiatric institutions that closed down. The majority has mental disorders and comes from judicial psychiatric hospitals. They were incapable of understanding their actions when they committed a crime. Hence, they were not subject to indictment at the time and are held in custody. If not found dangerous, they are transferred to the ISM. Today, the name “halfway house” contrasts with its real scenario, for it resembles a long-term care institution. The ISM was meant to be a transitory and temporary place for those who had been in the judicial psychiatric system for a long time and need to be reintegrated into society.

All medical records are kept in hard copies in the halfway house. Every medical problem and report are there. Also, patients are assisted by doctors, nurses, social workers, and psychologists.

The first phase of this study was carried out through documental analysis. Using a specific questionnaire, we evaluated 56 aspects, including sociodemographic variables, history of violence, legal involvement, length of stay, medical record, use of psychoactive substances, among others that could implicate longer hospital stays.

The second phase consisted of data compilation. We used a Microsoft Excel spreadsheet to input the group profile, organize and observe similarities. We conducted a qualitative and quantitative descriptive analysis with the information found. For the statistical analysis, we used tools in IBM Statistical Package for Social Sciences (SPSS) software version 27.0.

The research started after the approval of the local Ethics Committee via Plataforma Brasil, through the CAAE 61040216.9.0000.5553 opinion.

Results

During the survey, we analyzed 34 medical records. Of these, 44.1% (15) were from the psychiatric unit in the Federal District, where individuals with mental disorders and criminal involvement are detained. The remaining 55.9% (19) were from regular institutions, e.g., public and private psychiatric hospitals. The general panorama of sociodemographic data collected is listed below in Table 1.

Table 1. Sociodemographic sample data (n= 34)

Gender	
Male	28 (82.4%)
Female	6 (17.6%)
Origin	
Psychiatric unit	15 (44.1%)
Former private practices	10 (29.4%)
Public psychiatric hospitals	7 (20.6%)
Home	1 (2.9%)
Hostel	1 (2.9%)
Average age	
Men	47.3 years
Women	48.8 years
Place of birth	
Braslia	6 (17.7%)
Bahia	4 (11.7%)
Ceara	2 (5.9%)
Goias	2 (5.9%)
Maranhao	2 (5.9%)
Paraiba	2 (5.9%)
Piaui	1 (2.9%)

Rio de Janeiro	1 (2.9%)
Not informed	14 (41.1%)
Marital status	
Single	18 (52.9%)
Married	1 (5.3%)
Not informed	15 (44.1%)
Education level	
Middle school dropout	7 (20.6%)
High school graduate	4 (11.7%)
Kindergarten	2 (5.9%)
Illiterate	2 (5.9%)
Higher education degree	1 (2.9%)
Not informed	18 (52.9%)
Profession	
Hodman	2 (5.9%)
Bricklayer	2 (5.9%)
General services	2 (5.9%)
Street vendor	1 (2.9%)
Delivery man	1 (2.9%)
Mechanic	1 (2.9%)
Driver	1 (2.9%)
Teacher	1 (2.9%)
Accounting assistant	1 (2.9%)
Not informed	22 (64.7%)
Premorbid employment bond	
Formal	6 (17.7%)
Informal	17 (50%)
No bond	11 (32.3%)
Income	
Up to 1 minimum wage or no income	17 (50%)
Retirement income over 1 minimum wage	1 (2.9%)
Not informed	16 (47%)
Religion	
No religion	16 (47%)
Catholics	3 (8,8%)
Protestants	1 (2,9%)
Spiritist (*Umbanda*)	1 (2,9%)
Not informed	13 (38,2%)
Substance abuse	
Only tobacco	10 (29,4%)
Alcohol + tobacco	2 (5,9%)
Only alcohol	1 (2,9%)
Alcohol + tobacco + illicit drugs	3 (8,8%)
No substance use or not informed	18 (52,9%)

Group of individuals from the criminal justice/correctional system

In the group of fifteen individuals from the psychiatric unit, 10.7% (2) were female, and 86.7% (13) were male. Among those, 13 individuals (86.7%) were first offenders, and 12.5% were repeat

offenders, having committed a crime twice. Most frequent crimes were homicide or attempted homicide (56.5%), theft or robbery (25%), and bodily harm (12.5%). Just two individuals were already under care when they committed a crime (12.5%). Only four medical records had information about age – one was a minor (under 18 years old), and the other three were adults (above 18 years old) according to Brazilian law.

Regarding criminal involvement, 66.7% (10) committed a crime alone, and 33.3% (5) had other parties involved. In the expert evaluations, no diagnosis was present or attached to medical records. Only one of the medical records mentioned psychotic symptoms during misconduct, which was described as "other psychotic symptoms", and the expert opinion stated, "schizophrenic psychosis". We verified that 12.5% (2) were under psychiatric treatment before committing a crime, and it is the same percentage of insight/recognition of a psychiatric illness. On the other hand, 40% (6) do not believe they are mentally ill or need treatment. Medical records revealed that 40% (6) of hospitalized patients had behavior disorders, and 83.3% (5) of these had been hospitalized more than four times.

Use of substances was another indicator. According to the data found, 46.7% (7) of individuals used substances, 26.7% (4) had an alcohol abuse background, and 40% (6) were smokers. It was found that 26.7% (4) used illicit substances; 13.3% (2) used marijuana, and one, cocaine. No information about the amount used was found.

Among psychiatric diagnoses, 80% (12) of individuals had schizophrenia, 13.3% (2) had bipolar disorder, 13.3% (2) had mild mental retardation, and one had a delusional disorder. Some individuals were diagnosed with more than one mental illness.

Furthermore, 40% (6) of patients have other medical diagnoses. Systemic arterial hypertension (SAH) and diabetes mellitus were the most prevalent comorbidities, corresponding to 33.3% (5). Other health problems were hepatic steatosis, syphilis, and scrotal hernia.

Behavior changes in these individuals were evaluated, and reports of current violence episodes (in the last 30 days) were found in 33.3% (5) of individuals. In the investigation about onset of violent behavior, it was found that a patient was already violent before being diagnosed with a mental illness. Two patients only showed violent behavior after a psychiatric diagnosis. Lack of detailed descriptions prevented an in-depth analysis. According to patients' medical records, self-injury and self-mutilation were also common, for one patient attempted suicide, and three of them did not. However, the suicide attempt with poison happened before the patient was institutionalized.

Data indicate that 60% (9) of individuals showed hetero-aggressive behavior, in which assaults were described in 88.9% (8) of patients. There was one sexual assault report and one verbal assault report. In these situations, 87.5% of victims were first degree relatives, 33.3% were extended family, 26.5% were health care professionals, and 26.7% were unknown. Similarly, there was an assault report against another patient (i.e., several reports of multiple assaults or victims). Assaults usually happened at the victim's residence (50% of the time), which was also the offender's residence (37.5% of the time). In 50% of the assaults, there was no description of where they took place.

We identified only one individual with a child abuse history, in which the victim's mother was the perpetrator.

Group of individuals without police/criminal records

Among individuals without police/criminal record, 21% (4) were female, and 79% (15) were male. Diagnoses found were schizophrenia in 73.7% (14) of individuals, mental retardation in 10.5% (2), and bipolar affective disorder in only one individual.

Within this group, 26.3% (5) presented violent behavior. In 10.5% (2) of the group, violence was described as present "only in crises". Eighty percent (4) of individuals improved after drug treatment, according to observations.

In this group, 10.5% (2) showed self-injurious behavior. There was no such report in other groups, and in 21% (4), this behavior was expressly denied. No suicide attempts were reported. Heteroagressive behavior was observed in 36.9% (7) of individuals, with a prevalence of assault, corresponding to 85.7% of those described. Threats were another form of violence described in one of the individuals. Victims were identified in 5 of those cases (71.4%). In 4 of those cases, the victims were family members (80%). There was one case against a health professional (20%) and another against a hospitalized patient (20%). In 5 cases, there was a prevalence of gender, i.e., 4 were women (80%), and one was a man.

In this group, 42.1% (8) of individuals did not believe they had a psychiatric disorder nor that they needed treatment, 47.3% (10) had already been hospitalized due to behavior changes, without detailed clinical conditions.

Substance use was another item analyzed. We identified that 52.6% (10) used some kind of substance, such as cigarettes. Among these, 52% were lifelong smokers, and 26.3% were new smokers. Alcohol was used by 10.5% (2), and only one individual reported previous use of illicit drugs.

Comparative statistical analysis between groups and longer hospital stays

We had to confirm many aspects of our statistical analysis. The first key point was to verify if extended hospital stays had any connection with previous criminal records. The data found in the descriptive analysis showed an average hospital stay of 83.3 months for those with police/criminal records and 102.5 months for those without police/criminal records. We excluded three individuals from the sample – two because there was no hospital time listed in their medical records, and one because an individual was stayed only for a few weeks. Thus, the minimum time estimated was 17 months and the maximum was 192 months. We used version 26 of IBM SPSS software to perform the analysis. Moreover, Pearson's correlation coefficient was chosen to calculate quantitative variables. In the linear regression analysis, we used the R Squared test for categorical variables. Tables 2 and 3 show the analyses:

Table 2. Statistical analysis of quantitative variables x length of stay

	R (Pearson coefficient)	p value	n
Age	0.192	0.318	31
Quantity of psychotropic drugs used	0.145	0.437	31
Total quantity of medication used	0.416	0.020	31

Table 3. Statistical analysis of categorical variables x length of stay

	R-squared (linear regression)	p value	N
Criminal records	-0.942	0.354	31
Gender	0.306	0.098	31
Diagnosis	-0.026	0.878	31
Heteroaggression	-0.209	0.297	31
Lack of Insight	-0.005	0.977	31
Records of hospital admission for violent behavior	-0.502	0.008	31
Substance abuse	0.174	0.429	31
Alcohol abuse	-0.273	0.176	31
Illicit drug abuse	-0.036	0.850	31

We observed a statistical significance in the variables "total number of drugs in use" and "records of hospital admission for violent behavior" when $p<0.05$ was considered. The male variable presented a tendency to relate to longer periods of hospital stay, with a $p=0.098$. Since we had a small number of women in our sample, it was challenging to make a comparison.

Discussion

The general profile of individuals hospitalized was men. The average age of these men was 47.6. They came from correctional facilities, former psychiatric clinics, or public hospitals, in which they stayed for the long term. Most of them were single, had low education levels, no professional qualification, no income, or very low income. This profile is in line with literature on the subject (Flannery, 2000; Mecler, 2010; O'Grady, 2006; Oliveira et al., 2017; Short et al., 2013). Neglect and marginalization of individuals is a striking characteristic. There was no significant statistical difference in intergroup comparisons, and that may be due to the small number of individuals and a population with chronic diseases with similar clinical and demographic features.

Substance abuse was described in 52.9% of individuals' medical records, which might be underestimated due to lack of information. Also, absence of records is the main limiting factor of this research, and, unfortunately, it is observed in several other studies on the subject (Kramp et al., 2009; Mecler, 2010; Moscatello, 2001; Oliveira et al., 2016). It is known that substance abuse is a risk factor for violent behavior and dangerousness (Elbogen et al., 2009; Hodgins et al., 1996; Swartz et al., 1998). Despite that, greater substance use and a longer average hospital stay was noted in the group without criminal records. The group without criminal records, which comprised those coming from health care institutions, even from some extinct ones, had more detailed clinical conditions in their medical charts. There was a lack of information in the other group, which comprised individuals from strict facilities, such as custody houses or judicial asylums. Since the latter had their freedom restricted, they had much lower access to substances than the others. On the other hand, official experts attested that dangerousness had ceased in convicted felons. The halfway house was meant to be a transitional housing, with shorter average hospital stay.

The halfway house in the Federal District is a unique and paradoxical case. It was designed to be a place of transition for individuals coming from the correctional system. However, it was not able to completely fulfill this goal. As time went by, it has also become a place to shelter people who were not from the correctional system and were hospitalized for prolonged periods. This way, it did not accomplish the idea that carries its name: to be a transitory place.

Individuals' epidemiological profiles from the criminal justice/correctional system are similar to the general ones and reflect a recurrent population. Although 25% have been convicted of theft or robbery, most individuals were also accused of homicide. It is a significant percentage, and these are the

two most observed crimes in other studies (Mecler, 2010; Oliveira et al., 2017; Valença et al., 2015;). Freedom is a crucial point in the discussion about mental health patient institutionalization. The question lies in whether it is appropriate or fair that an individual's freedom is restricted when he/she has not committed a violent crime. Some penal systems worldwide do not even consider the possibility of holding an individual in this situation (Abdalla-Filho, 2006). The Anglo-Saxon forensic system is cautious in analyzing the degree and risk of the dangerousness of the crime itself (Abdalla-Filho, 2003; Darjee et al., 2017).

Furthermore, it was observed that 33.3% of crimes involved multiple parties. Patients with schizophrenia or other primary psychoses tend to be immersed in their delusions, hallucinations, or delusional beliefs, being prone to commit crimes. We could not identify who the other parties were. On the other hand, many people with cognitive limitations/intellectual disabilities are coerced into committing illicit acts. However, those diagnosed with intellectual disability totaled only 13.3% of the group, while 80% were diagnosed with schizophrenia, an unexpectedly high number of crimes involving third parties (Oliveira et al., 2017; Darjee et al., 2017).

Forty percent of individuals showed a lack of awareness, while 40% had already been admitted for psychiatric reasons. Not only that, but 83.3% of these were institutionalized more than four times. This factor seemed to be a determinant for extended hospital stays, psychiatric clinical worsening, and violence/relapse risks, as seen in statistical analysis.

These data reveal possibility of mental illnesses being associated with some violent incidents that intrinsic to some disorders. In cases in which there is insight impairment, non-adherence to therapy is voluntary. Thus, those individuals who show a behavioral picture, whether psychotic or pathological impulsiveness or even a non-recognition of their illness, with egosymptomatic characteristics, might be more frequently associated with violent and criminal involvement (Abdalla-Filho, 2006; Varshney et al., 2016). Personality disorders, especially psychopathy and some psychotic patients without understanding the need for treatment, could be a harm to them and others. Violence is not necessarily directed only at other people.

For this reason, it is important to discuss whether involuntary and compulsory treatments for these patients is necessary, while preventing the risk of violence.

The greatest challenge in dealing with non-adherence and non-recognition of illness, and consequent risk maintenance, is psychopathy. Psychopathic individuals can have an intermittent criminal

connection since the nature of this personality disorder is a lack of empathy and predatory and parasitic behavior (Morana et al., 2006). There is no effective treatment for psychopaths. Therefore, prevention through compulsory "treatments" is not an option. Upholding high-risk psychopaths for prolonged periods or continuous imprisonment is not a humanitarian measure. Even though society, especially victims and their families, are harmed because of them.

Thirty-three percent of individuals showed behavior changes in the previou thirty days analyzed. In total, we observed that 60% of them attacked third parties, of which 88.9% were assaults. The history of violence and criminal records are preponderant factors in risk of violent episodes, or criminal acts are recurrent (Fazel et al., 2011; Moscatello, 2001; Oliveira et al., 2017). Victims' profile was similar to others found in the literature, with most of them being female and first-degree relatives. The majority of assaults happened at the victim's residence.

We observed that 40% of the group had general medical diagnoses related to metabolic syndromes, such as hypertension, diabetes melittus, and hepatic steatosis. That is an alarming number because it can decrease their quality of life and reduce life expectancy. Thus, it is necessary to have rehabilitation with varied activities and preventive or physical reconditioning programs. Some psychotropic medications have side effects, such as metabolic syndromes; hence, health care teams must be attentive to these issues (Sun et al., 2018).

The group of individuals without a criminal record also had an epidemiological profile similar to the general one. The percentage was lower for those with violent behavior but without a police record. Nevertheless, it was still relevant, for it was a key factor for keeping patients at the hospital. Additionally, it is important to highlight that 80% of these individuals have improved with drug therapy. According to scientific literature, violence and mental illnesses can be avoided, for they are preventable and treatable (Oliveira et al., 2017; Reinal et al., 2016; Valença et al., 2011).

Victims of individuals with aggressive behavior were mostly first-degree relatives (88.9%) and women (80%). There were also two cases – a health care professional and a patient who were assaulted. Although they should not be "fixed", data reinforce how much a violent background is supported in risk assessment, as seen in several studies (Adshead, 1998; Short et al., 2013; Varshney et al., 2016) and nuances related to mental illness as previously discussed.

Pharmacotherapy showed what it was expected from the situation. There was a prevalence of an anxiolytic prescription, and antipsychotics were often combined. Polypharmacy of both psychotropic

and other drugs was very frequent. The two items with more emphasis on the increased institutionalization period were a higher total of drugs prescribed and the history of psychiatric hospitalization for violent behavior, with statistical significance, as shown in the results.

These two aspects seem to reflect the severity of psychiatric and general medical conditions. In some cases, polypharmacy is a "heroic attempt" to control an individual's condition. The evaluation of the history of psychiatric hospitalization for violent behavior reinforces the good predictive factor of historical items in assessments. Nonetheless, with due care to establish an evaluation in which a historical evolution of the condition is observed, individuals do not face the risk of already being "condemned" by their unchangeable past.

It is important to know new evaluation tools and understand how they work. This way, we can better assess risk of violence. They are very useful and tend to emphasize changeable factors. New models, such as START (Webster et al., 2009) and the Two-Tiered Violence Risk Estimates Scale (Mills et al., 2013) show an evolution in the contraposition of "static" and well known models, such as HCR-20 (Webster et al., 1995) and PCL-r (Hare, 1991).

Although this work did not find multiple factors associated with institutionalization, we realized that polypharmacy and the history of psychiatric hospitalization for violent behavior are directly linked to an increased hospital stay. They cannot be described as the causes of institutionalization, but they provide a glimpse of patient profiles, which meet the historical variable continuously present in scientific research on the subject, as demonstrated throughout this study.

This work carried out a detailed description of institutionalized patients. We evaluated and assessed the information collected. Since minorities are often segregated, this study was limited due to lack of record information and the small number of individuals studied. With a larger group, we could show other aspects that are directly connected to longer hospital stays, for many similarities and characteristics were also found.

Finally, these people have to be understood and studied from a scientific and critical point of view. They should be well-assisted, not only with medication but also with therapeutic treatments that embody physical and psychosocial aspects. Human beings should be treated as a whole. People with a mental health condition should not be seen as mere patients who deserve to live in confinement without extra activities.

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6.1.3 Artigo 3: Matricide, parricide, and filicide: are major mental disorders or personality disorders involved? Assessment of criminal responsibility in brazilian cases

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Abstract

Violence committed by individuals with severe mental disorders has become a growing focus of interest among physicians, law enforcement officials and the general population. Homicide involving relatives, specially parricide, matricide and filicide, despite the relatively low incidence of these crimes, maybe be enigmatic, so forensic psychiatrist are frequently called on the courts to answer questions about insanity and criminal responsibility. The current study aims to describe Brazilian cases of parricide, matricide and filicide associated with presence of major mental disorders and personality disorders, discussing the assessment of criminal responsibility in each case. The case series described were specifically related to people with mental illness, as Bipolar Disorder, Schizophrenia and Borderline Personality with comorbidity of drugs abuse. Two of them were considered not guilty by reason of insanity and the other one was considered partially criminally responsible, according to Brazilian Law and Forensic Psychiatric Reports of the cases. The justice determined compulsory psychiatric treatment for all of them. The question of criminal responsibility of individuals with mental disorders is challenging for criminal justice, psychiatry and society. Adequate treatment is mandatory to prevent crimes involving mental disorders, as shown in literature. The verification of criminal responsibility is essential for persons' adequate referral in any system of criminal law, thus protecting human rights and referring those who need psychiatric treatment.

Keywords: Homicide. Murder. Aggression. Mental disorders. Personality disorders. Filicide. Matricide. Parricide. Psychotic disorders.

Highlights

- Homicides involving first-degree family members are difficult to study
- Matricide, parricide and filicide described have a relationship with major mental disorders and personality disorders
- Filicide is comprehensive and may have a lower association with mental disorders than matricide and parricide
- Adequate psychiatric treatment is mandatory to prevent crimes involving mental disorders

Violence committed by individuals with severe mental disorders has become a growing focus of interest among physicians, law enforcement officials, and the general population. For several decades, there has been a debate in the psychiatric and legal literature on association between violence and mental disorders (1, 2).

Traditionally, the homicide rate is considered a "thermometer" for the prevailing degree of violence. The main approaches for investigating this relationship are studies of homicidal individuals, since homicide is considered the most serious expression of violence in a given society.

Homicide of parents by their own children is called parricide and is an infrequent form of domestic violence, committed predominantly by male children (3). Matricide is when the mother is murdered, and patricide when the father is murdered. Filicide is the murder of children by their parents. Despite the relatively low incidence of these crimes, forensic mental health professionals are frequently called on by the courts to answer various legal questions such as insanity, competence to stand trial, diminished capacity, and criminal responsibility. Parricidal and filicidal acts, whether or not resulting in the victim's death, cause a brutal break in family functioning, with transgression of the bonds of filiation considered sacred in our society.

Parricide is a rare event. According to North American and European statistics, parricide accounts for fewer than 4% of all homicides (4). However, it is important to note that parricide represents 20% to 30% of all homicides committed by psychotic individuals(5). More than 80% of parricide cases involve a son who kills his father(6). Parricides perpetrated by daughters are rare, with a son-to-daughter ratio between 5 and 10 to 1(7).

In a Canadian study (8) on parricide covering a 15-year period (1990 to 1995) examining archives and police reports on suspected cases and psychiatric records, it was found 64 cases, of which 37 (57.8%) were patricides and 27 (42.1%) matricides. In both offenses, the most frequent mental disorders were schizophrenia and other psychotic disorders (54.2% of matricides and 46% of patricides), followed by depression (16.7% of matricides and 13.9% of patricides), and intoxication with psychoactive substances (4.2% of matricides and 5.6% of patricides). Of the perpetrators, only four (6.3%) were women, three of whom committed matricide. Of these, two presented with psychotic disorders and one intoxication with psychoactive substance.

Weissman and Sharma (6) studied a sample of 29 incarcerated parricidal offenders and 26 parricidal individuals committed to psychiatric hospitals in the United States. They found that 96% of the hospitalized individuals had acted under the command of a delusional system involving the victim. The incarcerated individuals presented with psychosis (48%) and depression (21%) as the principal diagnoses. This study stands out for the large number of psychotic individuals who were sentenced to prison.

Another study (9) assessed a sample of 39 individuals (36 men and 3 women) admitted to forensic centers in Canada and considered not guilty by reason of insanity (NGRI) by the court after psychiatric evaluation. Twenty-three had committed parricide and 16 attempted parricide. Of the victims, 20 were fathers, 17 were mothers, and in 2 cases both parents had been killed. Most of the offenders were single (85%), not working at the time of the offense (74%), and living most of the time with the victims (56%).

Many of the patients were not taking psychotropic medication at the time of the crime. As for psychopathology, 20 patients (51%) had persecutory delusions associated with the criminal act. Command hallucinations were present in 14 (36%) of the cases. The principal diagnosis in the sample was schizophrenia. Fifteen of the patients (38%) had not been identified by the mental health systems. The sample's profile involved patients who lived with the victims, were unemployed, and presented with severe psychopathology.

In a study of parricidal individuals committed on grounds of security to a forensic hospital in Porto Alegre, Brazil (10), the individuals were 18 to 48 years of age, predominantly single, unemployed, and with low schooling. In ten cases, only the biological father was killed, in one case the stepfather was killed, in six cases only the biological mother was killed, and in one case both biological parents were killed. The psychiatric diagnoses were: schizophrenia (n=11), antisocial personality disorder (n=3), moderate intellectual disability (n=2), bipolar disorder (n=1), and substance use disorder (n=1). Eleven patients presented with psychotic motivation for perpetrating the crime, and three committed the murder under the influence of drugs.

An extensive study (11) over the course of 24 years in the United States found that 55% of the parricides were patricides and 45% were matricides, the majority of which were committed by sons. This illustrates that daughters are less prone to murdering parents.

Resnick, 1969, (12) described the types of homicide committed by a parent against his or her child. Neonaticide is a murder of a newborn child in the first 24 hours of life; infanticide is a murder of an older child until on-year-old. Filicide is a generic term used for murder of one's own children.

In a recent systematic review (13), the incidence of neonaticide varied from 0.07 (Finland, 1980 to 2000) to 8.5 per 100,000 births (Austria, 1975 to 2001). High incidence rates were also found in Lithuania and Estonia (more than five neonaticides per 100,000 births). A study on this topic in Tanzania (Africa) reported 27.7 neonaticides per 100,000 births, a large difference compared to the above-

mentioned European countries. Sociocultural factors such as stigma and religion may influence the differences between countries. It´s very common the media characterize mothers who kill their children as either "mad" or "bad". It´s necessary to evaluate each case and decide what happened individually. (14)

Resnick (12) examined the psychiatric literature on murder of children, studying 131 cases of filicide. The data were collected from a variety of sources and countries over the course of centuries (1751-1967). He described five categories that are still cited today:1) altruistic filicide, in which the individual believes that the child or family is experiencing a situation from which there is no possible escape, or that there is an imminent condemnation. The mental disorders most frequently associated with this group are depression, including psychotic depression, and schizophrenia (15); 2) filicide associated with acute psychosis, which involves the murder of children by parents who suffer from severe mental disorders at the time of the offense. The main characteristic of this group is the absence of a rational or comprehensible motive (such as punishment, revenge, or secondary gain); 3) filicide of an unwanted child, frequently related to illegitimacy or a child conceived in an extramarital relationship; 4) accidental filicide, which may result from abuse or neglect. The child's death is due to a beating, and in many cases the parents did not actually intend to kill their child; and 5) filicide related to revenge against the other spouse. This group is characterized by severe personality disorders, chaotic conjugal relations, and prior history of self-injury (6).

The biological parents are the perpetrators in most cases of filicide, contrasting with the popular belief that tends to incriminate stepmothers and stepfathers as the main perpetrators. In a retrospective study in Finland, 59% of filicides were committed by mothers, 39% by fathers, and only 2% by stepfathers (16). Moreover, fathers and mothers who kill their children have higher rates of serious suicide attempts and completed suicide. According to Bourget & Gagné, 2002, women who commit this type of homicide are more likely than men to commit suicide after killing the child (17).

The current study aims to describe Brazilian cases of parricide, matricide and filicide associated with presence of major mental disorders and personality disorders, discussing the assessment of criminal responsibility in each case. The study is part of a research project called Mental Illness and Violent Behavior, approved by the local Institutional Review Board. Subjects signed an informed consent form to participate in the study. The psychiatric diagnoses of the cases were established according to the DSM-IV criteria for mental disorders and personality disorders (18).

Case 1. "A", female, 28 years, native of Rio de Janeiro, white, single, with no profession, complete primary schooling, living with her mother at the time of the offense.

In the year 2006, while the examinee was living with her mother, she stabbed her mother several times with a sharp instrument, causing her death. In her own version of the offense, she reported, "I was sick in the head, I went to the dance and met a boy and took him home and he asked for my hand in marriage, and my mother wouldn't allow it, and he told me to stab her with the knife, and I did that." The individual had a history of four previous psychiatric hospitalizations, the first at 21 years of age, when she was hearing voices, got agitated and broke objects in the house, and wandered the streets naked. Mrs "A", while using prescribed psychiatric medication, had a good relationship with her mother. However, when she stopped taking her medication, a month before the offense, she started to be violent with her mother. There was no history or report of alcohol and/or psychoactive substance use. Upon psychiatric examination, she displayed exalted and irritated mood, pressured speech, and racing thoughts. She also reported having heard voices on the days prior to the crime. Her established psychiatric diagnosis was bipolar disorder type I, manic episode, with psychotic features.

Case 2. "B", male, 26 years, single, with no profession, complete primary schooling, living with his parents at the time of the crime.

In the year 2010, following a trivial argument with his father, the individual struck his father on the head several time with a board, killing him. There was a change of behavior eight months before the crime that included withdrawal, talking to himself, and saying that he was being threatened by neighbors and the police. There was no report of previous aggression against his father and no history of previous psychiatric treatment.

Upon psychiatric examination, "B" displayed persecutory delusions, claiming that his father's killers were the police (who actually came to the crime scene after the fact). He claimed that the police had laid an ambush for him, and that he had tried to defend his father, thereby creating a new version for the crime (imaginative delusion). There was a reference to auditory hallucinations: "voices of the police". He also displayed a formal alteration of thought, impairing the concatenation of ideas and concepts (disaggregation) and evident affective impoverishment, verbalizing this discourse with little variation in his facial expression or tone of voice. His established psychiatric diagnosis was schizophrenia.

Case 3. "C", female, 28 years, incomplete secondary schooling, sales attendant, living with boyfriend at the time of the crime. Accused of having poisoned her two-year-old son with rat poison, which she had at home. According to the case file, the crime was committed out of revenge against the boy's father for having broken up with her and entered a relationship with another woman.

The report included alcohol and cocaine use. "C" had worked at several jobs for short periods, but always ending in misunderstandings with her bosses, in which she considered herself treated unfairly by them. History of two previous suicide attempts, ingesting medicines after breakups in previous relationships, which were all unstable and turbulent.

Upon psychiatric examination, "C" displayed an irritable mood, referring alternatingly to feelings of emptiness, then of great rage against her former boyfriend for the fact that she was incarcerated. She

reported that she had thought of committing suicide right after killing her son, because she was desperate after being abandoned by her boyfriend. No delusions or hallucinations were present.

Affective instability and mood reactivity, a pattern of unstable relationships, recurrent suicide attempts, and impulsiveness supported to the diagnosis of borderline personality disorder.

Discussion

In Brazil, the criterion adopted by the penal code (19) for assessment of criminal responsibility is biopsychological: responsibility is only Ruled-out if the agent, at the time of the crime and due to mental illness or intellectual disability, was incapable of understanding (knowing the act's illegality) and determination (being free to choose between carrying out and refraining from the crime). The biopsychological model requires verification of a causal nexus between the abnormal mental state and perpetration of the crime. In other words, the abnormal mental state must be contemporary with the offense, and it must partially or completely deprive the offender of either of the aforementioned psychological capacities (intellectual or volitional). According to Brazilian penal code, there is also the possibility of cases with limited criminal responsibility, resulting from partial impairment of cognitive or volitional functions. In cases of limited responsibility, the courts can also order the individual's compulsory treatment.

In the first case, the forensic psychiatric assessment found "A" not guilty by reason of insanity (NGRI), and she was involuntarily committed. A mental illness was present (bipolar disorder), in which the alterations in affect, thinking, and behavior entirely impaired the Person´s capacity for understanding the unlawful of his acts and to control himself and not commit the crime, according to Brazilian law. The crime's immediate precipitating factor appears to have been a verbal misunderstanding between the patient and her mother. For Clark (20), due to the high likelihood that individuals accused of matricide present with mental disorders, a detailed examination by a forensic psychiatrist is crucial during the criminal proceedings.

There are few case studies in the literature involving bipolar women that have committed parricide. In one of them, Chamberlaim (21) described a 20-year-old woman who killed both parents during a manic episode with delusional ideation and paranoid and grandiose content. This patient was ruled NGRI and hospitalized involuntarily.

Psychopathological variables also appear important in violent or homicidal behavior in individuals with severe affective disorders. Manic patients may present with sudden and severe unpremeditated violence, resulting from persecutory ideation or frustration and confrontation with limits (22), as in the case presented here. Although some studies described the relevance of a disturbed family dynamic as a cause of matricide (23), this aspect was not illustrated in the present case, since "A" stated that she had a good relationship with the victim, her mother. An important caveat is that this information was only furnished by the patient herself.

Not surprisingly, considering the demographics of individuals that kill their parents, most of the literature focuses on male perpetrators (4, 5, 9). However, analyses of parents killed by their children in the course of 24 years showed that parricides by women also deserve attention. Daughters accounted for 14.5% of the children arrested for killing their parents from 1976 to 1999 (11). More studies focusing specifically on women that have killed their mothers are necessary to better identify this group's psychopathological features.

In case 2, there was a causal nexus between the mental illness and parricide, so "B" was ruled NGRI in the forensic psychiatric assessment. Most of crimes committed by individuals with schizophrenia occur in the family setting and in the initial phase of the disease, as in this case. The case illustrates the importance of paranoid ideation in the violent behavior. "B" displayed persecutory delusions in relation to neighbors and the police.

Various studies have shown that the risk of violent behavior can increase in patients presenting with paranoid ideation (24). Other studies have found an association between auditory hallucinations and

persecutory delusional ideas and motivation for homicide (25-27). More severe paranoia is associated with increased aggressiveness, even after controlling for factors like impulsiveness, command hallucinations, treatment with antipsychotics, substance abuse, age, and gender (28).

Hodgins and Klein (29) identify at least two trajectories for the emergence of violent behavior in schizophrenia: one includes patients without a prior history of violence, who present this behavior at the beginning of the illness, where positive symptoms (delusions and hallucinations) explain the violence; the other trajectory includes patients with chronic criminogenic disposition who have displayed violent and antisocial behavior since childhood, independently of mental status. The case of "B" appears to illustrate the first trajectory.

Studies with samples of young people have suggested that the criminal act is a response to chronic abuse in childhood (30). However, adult perpetrators frequently have a history of severe mental illness and little or no history of parental abuse[4], as in the cases presented here. In these cases of parricide, the criminal act is perpetrated after sudden emotional stress, without premeditation or deliberation.

Personality disorders have also been observed in parricidal individuals, but only in specific samples. In an article by Liettu, *et al* (3), the researchers conducted a retrospective review of 86 cases of matricidal men and 106 patricidal men in Finland from 1973 to 2004, to verify the presence of mental disorders in these offenders. The patricidal offenders were less likely to have a psychotic disorder then the matricide offenders. For this reason, the patricidal men are less frequently ruled not criminally responsible, when compared to the matricidal offenders. This study also found prevalence of personality disorders even in patricidal men and it increases the risk of violence against their parents, even if they´re not always considered not guilty by reason of insanity. Another study (31) found an increased risk of violent behavior in individuals with borderline personality disorder in a one-year follow-up, especially in relation to friends and family members.

As for case 3, "C" was considered partially criminally responsible. The forensic psychiatric assessment reported impaired volition and incapacity to control aggressive impulses. She was also involuntarily committed. A study (32) found that filicidal mothers, compared to patricidal daughters, received more sentences of involuntary hospitalization than incarceration, as illustrated by this case. There are few studies in the literature on the association between borderline personality disorder and filicide. In a case series study (33) of 10 filicidal parents, the main diagnoses were mood disorders. However, there were four cases of borderline personality in the sample.

Kauppi *et al* (16) conducted a retrospective study and found 65 filicides of older children. Psychosis or psychotic depression was diagnosed in 51% of the maternal filicides and 20% of the paternal filicides. Personality disorders, mostly with borderline characteristics, presenting with immaturity, impulsiveness, and precarious emotional control, was the most frequent condition, either as the single diagnosis or as a comorbidity with depression and alcohol abuse, in 67% of the paternal filicides and 41% of the maternal filicides. Some cases of personality disorder in this sample received a reduction in criminal responsibility. Mental stress caused by marital strife preceding the aggression was reported in 74% of these mothers. Fifty-eight percent of the murdered children were boys. One study has suggested[35] that filicidal mothers are more likely to kill their sons, overrepresented among older victims of filicide. Case "C" illustrates several of these aspects. On the other hand, men are also much more likely to commit familicide, which means killing their wives and children before commiting suicide. The common motivation includes financial struggles, imminent separation or custody disputes, and careful planning of the murders (14). In other words, we are facing crimes that involve control and power, associated with frustrations. Since men are positioned in a macho society, when that status quo collapses, it can trigger extreme and barbaric reactions such as familicide.

Various studies have found a chronic pattern of interrupted contact with mental health services, while in others, the violent behavior appears to coincide with the mental disorder's onset, before the

offender has made contact with these services[36]. These findings point to the fact that the patients with violent behavior were not in regular psychiatric treatment before manifesting this behavior, which may have contributed to the offense in the three cases presented here as shown in other Brazilian studies (36-38).

Parricides tend to be a tragic conclusion of highly conflictive relations between individuals with untreated severe mental disorders and their parents. Qualitative studies like this are relevant because they can emphasize the phenomenology of this crime's perpetrators. Absence of treatment or nonadherence is an important contributing factor to parricide.

Mental healthcare professionals should increase the surveillance of patients that present with persecutory delusions related to their parents, history of illness with chronic evolution and violent behavior in the acute phases, reports of threats toward family and friends, and absence or refusal of psychiatric treatment. It is important for social support and mental health services to be made available to families.

Access to hospitalization when indicated or to alternative homes (protected homes, therapeutic communities) for individuals with mental disorders, when necessary, could help reduce the incidence of parricide and filicide and improve the quality of life for parents and children in many of these families.

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6.1.4 Artigo 4: Cessation of dangerousness status in Brazil: an analysis of 144 reports from Federal District Coroner's Office in the last 10 years

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ABSTRACT

Objective: The aim of this study is to evaluate factors related to cessation of dangerousness of individuals under safety measures, through the study of psychiatric reports. **Methods**: This is a cross-sectional study, conducted through a retrospective analysis of expert psychiatric dangerousness cessation reports issued by the Federal District Coroner's Office, Brasília, Brazil. By examining official files, information was extracted from the reports (socio-demographic data, clinical characteristics, type of crime, historical characteristics and the search for items related to risk assessment present in instruments such as HCR-20, PCL- R, TTV, START and others) and submitted to statistical analysis and then compared to other studies on the subject. **Results**: The items most considered by the experts were those referring to PCL-R, START and the 'non static' part of HCR-20 and TTV. For the non-cessation of dangerousness, we´ve found: presence of inflated self-esteem, pathological lies, absence of remorse, superficial affection, insensitivity, fragile behavioral control, promiscuous sexual behaviour, early behavioural problems, lack of realistic long-term goals, impulsiveness, failure to take responsibility, juvenile delinquency. For the cessation of dangerousness, the following characteristics were significant: presence of social skills, presence of relationships, balanced emotional state, presence of impulse control, absence of external triggers, presence of social support, presence of material resources, organized attitudes, adherence to rules, non-conduct conflicting with the law, good coping strategies, treatability of the disorder, involvement with treatment and adherence. **Conclusion**: The systematization and standardization of forensic psychiatric reports needs to be well established and the use of risk assessment instruments are essential to support a correct decision by the expert regarding the cessation or non-cessation of dangerousness.

Key-words: Violence. Mental disorders. Forensic Psychiatry. Commitment of the mentally ill. Insanity defense. Prolonged Hospitalization.

INTRODUCTION

The development of concepts related to dangerousness and criminal involvement emerged at the end of the 19th century, with the Positive School of Criminal Law being a key concept of Modern Criminal Law. This concept came in conflict with the classical law, according to which, in a more objective or even "simplified" way, the penalty imposed corresponded with the severity of the crime (Mecler, 2010).

The development of Modern Criminal Law was largely based on Positivism. According to Modern Law, the penalty for a crime depended on the individual who committed the crime with factors involved in the genesis and occurrence of the crime, highlighting criminogenesis and criminodynamics, in order to conduct an in-depth analysis.

Criminogenesis studies the conditioning and possible triggers for the crime. The most scrutinized categories were divided into environmental/social, biological, and psychological factors (Jeffery, 1959). To use a medical analogy, Criminogenesis is comparable to "searching for the etiology of the crime." Environmental/social aspects include items such as economic status, educational level; biological aspects include gender, age, and individual constitutions that are not fully determined by genetics. Psychological aspects include items related to the individual's personality or changes in his/her development, such as intellectual disabilities, personality disorders, psychoses, or changes resulting from neurobiological disorders, such as encephalitis and epilepsies.

Criminodynamics refers to factors related to the development of criminal behavior, and seeks to explain the occurrence of the criminal act itself and its dynamics. According to some definitions, the criminal aspect is disregarded and the action in itself is scrutinized (Mendes, 1979).

From this new perspective of understanding crimes and the consequent application of sanctions or alternative mechanisms, it is necessary to study etiology and development of criminal behaviors. With

sufficient technical knowledge, better decisions regarding the crime and its repercussions, or even possible preventive measures, may be taken.

The association between mental illness and crime has been an object of research, and there is no decisive consensus in scientific literature that persons with mental illness are predisposed to crimes (Mitjavila & Mathes, 2012; Stuart, 2003).

Acts of violence committed by individuals with mental illness do not solely depend on biological factors, but on social factors as well, including early exposure to violence, poverty, age, psychoactive substances abuse, and psychological stress (Bonta, Law, & Hanson, 1998; Varshney, Mahapatra, Krishnan, Gupta, & Deb, 2016; Volavka & Swanson, 2010).

Substance abuse, a history of personal abuse, and lack of familial support are predictors of violent behavior according to several studies and cannot be disregarded (Menezes, 2001; Moscatello, 2001; Oliveira et al., 2017; Telles, Day, Folino, & Taborda, 2009; Whittington et al., 2013; 14). Often, patients with mental illness have these predictors, which should be considered in risk assessments.

Positive Law considers the contributing factors for the occurrence of an offense. The Brazilian legislation, from the Penal Code of 1940 (Brazil, 1940), established the possibility of a "Safety Measure" in substitution of penalty in specific situations. This preventive measure serves as a social protection as well as treatment for the individual, until the dangerousness ceases (Carrara, 1998).

In 1984, the Brazilian Penal Code was reviewed (Costa, Selles, Oliveira, Marques, & Mecler, 2018) and the possibility of "Safety Measure" became exclusive to individuals with mental illness or intellectual disability. The criteria to avail of this provision is the biopsychological aspect, that is, it is necessary that the individual be incapable of understanding (being unaware that the act is illegal) and determination (being free to choose between carrying out and refraining from the crime). This model also requires verification of a causal nexus between the abnormal mental state and perpetration of the crime. It means that the abnormal mental state must be contemporary with the offense, and it must

partially or completely deprive the offender of either of the aforementioned psychological capacities (intellectual or volitional). The mental illnesses taken into consideration in Brazilian Law are Psychosis or Dementia in advanced-stage. In some cases, there is also a possibility of limited criminal responsibility, resulting from partial impairment of cognitive or volitional functions. In cases of limited responsibility, the courts can also order the individual's treatment or even reduce the duration of the penalty/sentence. Such commutations are possible (but not obligatory) in certain personality disorders, impulse control disorders, and mood disorders (Valença et al, 2021).

In instances where the culpability of the person who committed the wrongdoing is doubtful, it is mandatory to conduct a psychiatric examination by an official expert. Once when the requirements described earlier have been officially demonstrated, the judge may choose to apply the Safety Measure. This may be in the form of compulsory hospitalization with psychiatric treatment or outpatient psychiatric treatment. The Safety Measure has an initial duration of at least one to three years, as decided by the judge. Despite its therapeutic purpose, its name appears to suggest that it is solely intended to ensure the society's safety.

For the person under Safety Measure to return to society, he/she needs to be evaluated by an official psychiatrist through a Dangerousness Cessation Examination. This examination shall be conducted upon completion of the minimum duration fixed by the judge and shall be repeated annually, or at any time with a court order, until the dangerousness of the individual is considered ceased. Dangerousness is understood as a legal concept, and implies the ability to predict the future behavior of the individual (Mecler, 2010). The safety measure has a preventive purpose, especially and exceptionally, considering a possible but not demonstrated risk of new unlawful practice by the individual with mental illness (Mecler, 1996).

Using scientific knowledge from research and instruments of risk assessment of violence is important to good quality psychiatric reports. In the last three decades, several instruments have emerged

and are being improved. The main ones with possible applicability in the assessment of dangerousness are: HCR-20(Historical, Clinical and Risk Management), PCL-R (Psychopathy Checklist – Revised), TTV (Two-Tiered Violence Risk Scale), START (Short-Term Assessment of Risk and Treatability), and VRAG (Violence Risk Appraisal Guide).

In this study, the above instruments and their items were utilized in the analysis, along with factors possibly contributing to criminogenesis and criminodynamics of unlawful acts, including the Mecler Criteria,, which was the result of two major studies (Mecler, 2010; Oliveira et al., 2017) focused on dangerousness cessation examination conducted in Brazil, specifically in Rio de Janeiro, in which hundreds of forensic reports conducted during the 1990s and 2010-2014 were analyzed.

Reviewing the current technical-scientific knowledge about dangerousness cessation in Brazil, we understand that new studies on this theme are necessary to identify the factors associated with the cessation of dangerousness used in Brazil and if they are aligned with recent studies about risk of violence or criminal recurrence.

The aim of this study is to evaluate factors related to dangerousness cessation in individuals which were in Safety Measure, through the study of psychiatric reports carried out by official experts, considering the items present in the main existing risk assessment instruments.

METHODS

This cross-sectional study used retrospective data from all the dangerousness cessation reports (*Exame de Verificação de Cessação de Periculosidade* – EVCP) issued in the last 10 years in Brasília, Brazil. All EVCP performed during this period were analyzed. The project was approved by the national ethics committee, with registration CAAE 12500619.1.0000.8927, and evaluation number 3.400.471. Informed consent was not required considering the secondary nature of the data.

We studied the reports of offenders declared not guilty by criminal courts of Brasília, because of insanity, and others also not guilty, because of partial impairment of cognitive or volitional. They were

all committed to at least a year in Safety Measure. The experts were experienced State-appointed professional forensic experts using ICD-10, according to Brazilian Law. One-hundred and forty-four EVCS reports were analyzed.

The reports of offenders declared not guilty due to insanity by criminal courts of Brasília (Brazil) and who were institutionalized for at least one year in a custody hospital were studied. The researchers did not access the report which verified the insanity, which is always conducted before the EVCP.

Data were collected by the research team composed of psychiatrists with extensive experience in forensic psychiatry and trained researchers. A standardized questionnaire elaborated by the authors for data collection was used. The data from the questionnaire were reviewed by one or more forensic psychiatrists before the analysis.

The standardized questionnaire asked the following information: sociodemographic variables (gender, age, ethnicity, marital status, naturalness, origin, education, profession and occupation, socioeconomic status, family support), psychiatric diagnosis, crime committed (as codified in the Brazilian Penal Code), conclusions of the reports ("dangerousness ceased" or "did not cease") and the presence or absence of items scientifically studied and related to the risk of violence/recidivism, validated in instruments. To be considered present, the item should be described in the report.

These items were described in the HCR-20 (Historical, Clinical and Risk Management), PCL-R (Psychopathy Checklist – Revised), TTV (Two-Tiered Violence Risk Estimates Scale), START (Short-Term Assessment of Risk and Treatability) and VRAG (Violence Risk Appraisal Guide) instruments, and Mecler Criteria. It is important to highlight that the items were searched in the reports considering if they were described. None of the instruments were usually applied.

The Mecler Criteria was created in a pioneering study by Mecler in 1996, in which the EVCPs were extensively studied through a qualitative research. This researcher examined the criteria that were most commonly associated with cessation of dangerousness and used this information to elaborate a

scale. After determining the relevance and applicability of the criteria studied, a table was created, in which the most common items were: active psychotic symptoms, lack of insight, negative symptoms, failure of previous supervision, inadequate behavior in the institution, opinion expressed by the assistant health team, treatment adherence, substance abuse, history of drug dependence, and history of psychiatric treatment. As in the studies by Mecler (2010) and Oliveira et al (2017), these observations were collected and grouped as they were found in the reports.

HCR-20 and PCL-R have validated versions and have been studied in Brazil by Telles et al (2009) and Morana, Stone, and Abdalla-Filho (2006). TTV and START are newer instruments, not yet validated in our country, but suitable for monitoring and managing the risk of violence, since they are focused on the items that can be modified.

Data Analyses

The data were initially stored in Microsoft Excel (version 365), and were later transposed and analyzed through the R Studio Software Version 1.2.133. The results were presented with 95% confidence interval.

The associations between the predictive variables (independent variables) and the cessation of dangerousness (dependent variable) were evaluated through a chi-square test under the null hypothesis that there is no difference between each variable. The exact test of Fisher was used over the same assumptions when required due to small sample sizes. The age was tested with the Wilcoxon rank sum test with continuity correction. Odds ratios of significant relations were calculated with unconditional maximum likelihood estimation and confidence intervals determined by the mid-p exact method. For the evaluation of statistical significance, a value of $p<=0.05$ was considered statistically significant.

RESULTS

Socio-demographic items and descriptive analysis

Among the 144 EVCPs analyzed, dangerousness had ceased in 73 of them (50.7%). Considering the reports without dangerousness cessation (71), 11 of them gave some concession to the individual, such as monitored outputs or indicated transfer to a non-custodial health unit. Thus, in 60 reports (41.7%), there was no progression or modulation of the regimen. The main socio-demographic variables are described in Table 1, as the results of the statistical analysis.

Table 1. Regimen progression and sociodemographic variables

Variable	Total	%	Missing*	Dangerousnes Ceased	Not ceased	p
Dangerousnes			0	73	71	
Regimen progression						
Yes	84	58,33%		73	11	
No	60	41,67%		0	60	
Sociodemographic variable						
Gender						0,058[2]
Male	139	96,53%		68	71	
Female	5	3,47%		5	0	
Place of birth			0			0,165[1]
DF	79	54,86%		38	41	
MG	11	7,64%		8	3	
GO	10	6,94%		5	5	
Outros	44	30,56%				
Hospitalization			0			0,898[1]
Hospitalized	116	80,56%		58	58	
Non- hospitalized	28	19,44%		15	13	
Ethnicity			33			0,747[1]
Black	7	6,31%		5	2	
Brown	98	88,29%		54	44	
White	6	5,40%		3	3	
Age			0			<0,001[3]
Mean	35,35					
Median	33					
SD	9,50					
Marital status			12			0,064[2]
Single	107	81,05%		53	54	
Married	19	14,39%		14	5	

Divorced	4	3,03%	3	1	
Widower	2	1,52%	0	2	
Scholarity			113		1,000[2]
Incomplete elementary school	21	67,74%	9	12	
Complete elementary school	2	6,45%	1	1	
incomplete elementary school	6	19,35%	3	3	
University education	2	6,45%	1	1	
Family support	103	0,72%	78	25	0,005[1]

[1] Pearson´s Chi-Squared with continuity correction of Yates, [2] Exact test of Fisher.[3] Wilcoxon rank sum test with continuity correction

.

Psychotic disorders were the most common condition, with 46 (41.44%) of the reports describing the diagnosis. Schizophrenia was the main reported psychosis (60.87%). Mental/behavioral disorders due to drug use were the second most common condition, occurring in 21 (18.92%) of the reports, followed by personality disorders in 19 (17.12%) reports. The most common personality disorder was antisocial personality disorder, which was 47.37%. There was lack of medical diagnosis in 33 (22.9%) cases. No statistical difference was identified when correlating diagnosis to cessation of dangerousness, as shown in Table 2.

Table 2. Diagnoses x cessation of dangerousness

Psychiatric diagnosis	Total	%	Dangerousnes ceased	Dangerousnes not ceased	p
Psychotic	46	41,44	20	26	0,1576[2]
Mood	7	6,31	4	3	
Personality	19	17,12	6	13	
Substance	21	18,92	14	7	
Sexual	2	1,80	0	2	
Organic	2	1,80	1	1	
Mental retardation	14	12,61	9	5	
OCD	1	0,90	0	1	
No diagnosis	33				

[2] Exact test of Fisher

There was no information regarding the nature of crimes committed in 71 (49.31%) reports. The most common crimes were homicide, robbery, and bodily injury, as shown in Table 3.

Table 3. offense committed x cessation of dangerousness

Offense commited	Total	%	Dangerousness ceased	Dangerousness not ceased
Robbery	27	36,99	10	17
Bodily injury	15	20,55	5	10
Rape	10	13,70	3	7
Corruption of minors	6	8,22	2	4
Theft	4	5,48	1	3
Kidnapping	4	5,48	1	3
Rape of children/ vulnerable people	2	2,74	1	1
Drug trafficking	1	1,37	1	0
Fraud	1	1,37	0	1
Depredation	1	1,37	1	0
Robbery	1	1,37	0	1
Bodily injury	1	1,37	0	1

Exact test of Fisher *p=0,9575*

When risk measurement instruments were examined, it was observed that in most reports, they were not systematically used. Most of the items that compose the scale were not in the reports, as observed in Table 4.

Table 4.Evaluation of scale items and the relation with cessation of dangerousness.

	dangerousness			
Scale	Ceased	Not Ceased	Missing values	P[1]
Items of PCL-R				
Loquacity	5	13	126	0,068
Inflated Self-Esteem	5	15	124	0,025
Need for stimulation	58	42	86	0,324
Pathological lie	8	26	110	< 0,001
Controller	12	19	113	0,192
Lack of remorse	8	34	102	< 0,001
Superficial affection	11	29	104	0,001
Insensitivity	7	29	108	< 0,001
Parasitic lifestyle	10	20	114	0,053
Fragile behavioral control	25	43	75	0,003
Promiscuous sexual behavior	7	26	111	< 0,001
Early behavioral problems	20	39	85	0,001
Lack of realistic long-term goals	11	27	106	0,003
Impulsivity	11	26	107	0,006
Irresponsability	21	29	94	0,178
Failure to take responsibility	12	29	103	0,002

Many short-term marital relationships	3	3	138	0,972[2]
juvenile delinquency	14	26	104	0,031
Revocation of probation	5	6	133	0,962
criminal versatility	4	10	130	0,144
Items of HCR				
previous violent behavior	10	12	122	0,762
Early age at first violent incident	2	8	134	0,054
Instability in relationships	8	25	111	0,001
Job problems	4	4	136	1
Problems with substance use	41	32	71	0,244
Mild mental illness	21	21	102	1
Psychopathy	3	17	124	0,001
Early misfit	16	22	106	0,300
Personality disorder	11	18	115	0,183
Failure in prior supervision	7	10	127	0,564
Lack of insight	16	36	26	0,004
negative attitudes	8	22	114	0,006
Active Symptoms of Major Mental Illness	19	37	88	0,002
impulsivity	11	26	107	0,006
No response to treatment	4	16	124	0,007
unworkable plans	8	10	126	0,753
Exposure to destabilizing factors	9	8	127	1
lack of personal support	49	29	66	0,003
Non-adherence to treatment	39	21	84	0,006
Stress	3	15	126	0,005
Items of START				
Social Skills	19	8	117	0,004
Relationships	19	4	121	0,002
Recreational	7	3	134	0,327[2]
Self care	65	57	22	0,219
Mmental state	56	43	45	0,056
Emotional state	58	43	43	0,022
Substance use	35	36	73	0,869
Impulse control	36	20	88	0,015
External trigger	20	32	92	0,042
Social support	47	30	67	0,013
Material resources	47	25	72	< 0,001
Attitudes	53	32	59	0,001
Pharmacological adhesion	42	29	73	0,066
Adherence to rules	42	24	78	0,007
Conduct	48	33	63	0,031
Plans	40	33	71	0,406
Coping	49	31	64	0,008
Treatability	54	34	56	0,002
Items of VRAG				
Items of PCL-R > 10	6	20	118	0,004

Maladjusted school behavior in Elementary school	12	16	116	0,476
Separation from parents before 16 years of age	9	7	128	0,837
Failed behavior on previous parole	13	14	117	0,937
Antecedents of other non-violent offenses	24	25	95	0,905
Absence of marital bond	52	51	41	1
Schizophrenia diagnosis	19	14	111	0,483
Injury to the victim during the commission of the crime	22	27	95	0,410
History of alcohol abuse	29	32	83	0,631
Male victim in crime	14	12	118	0,900
Items of TTV				
Part A				
Antisocial behavior in childhood	1	3	140	0,363[2]
Antisocial behavior in adolescence	10	20	114	0,053
Early age at first conviction	2	8	134	0,054[2]
Previous arrests	20	20	104	1
Previous convictions for violent behavior	14	10	120	0,551
Failure in community Aupervision	12	12	120	1
Alcohol abuse history	29	32	83	0,631
Failure to complete high school	15	17	112	0,772
Criminal association	2	7	135	0,095[2]
Interpersonal difficulty	47	52	26	0,334
Parte M				
Job	16	14	114	0,905
Financial status	-	-	-	
Substance abuse	35	36	73	0,869
Mental health issues	61	63	20	0,552
Family instability	14	18	112	0,490
Criminal association	2	7	135	0,095[2]
Leisure	8	6	130	0,821
Involvement with the treatment	17	4	123	0,004
Humor	62	57	13	0,606
Presence of social support	47	30	67	0,013
High crime environment	47	49	48	0,68
Stressors	3	15	126	0,005
Planilha Mecler				
Productive symptoms	18	23	103	0,399
Insight	39	27	78	0,092
Negative symptoms	10	12	122	0,762
Failure in prior supervision	7	10	127	0,564
Inappropriate behavior in the institution	1	8	135	0,111[2]
Assistant team opinion	14	6	124	0,105

Personal support	49	29	66	0,003
treatment adherence	39	21	84	0,006
substance abuse currently	41	34	69	0,409
History of substance use	2	2	140	0,972[2]
history of psychiatric treatment	20	23	101	0,636

[1] *Pearson´s Chi-Squared with continuity correction of Yates,* [2] *Exact test of Fisher.*

The variables considered significant for non-cessation of dangerousness, according to the expert decision, were: younger age, 12 items of PCL-R (presence of inflated self-esteem, pathological lying, absence of remorse, superficial affection, insensitivity, fragile behavioral control, promiscuous sexual behavior, early behavioral problems, absence of realistic long-term goals, impulsivity, failure to assume responsibilities, and juvenile delinquency) one item of VRAG (presence of more than ten items of the PCL-R,), one item of TTV (presence of stressors), 10 items of the HCR-20, which included all five clinical items (lack of insight, negative attitudes, active symptoms of important mental illness, impulsivity and lack of response to treatment), three items of risk management (lack of personal support, non-adherence to treatment attempts, presence of stress) and two historical items (psychopathy and instability in relationships).

The variables considered significant for the cessation of dangerousness, according to the expert decision, were: 12 items of the START (presence of social skills, presence of relationships, balanced emotional state, presence of impulse control, absence of external triggers, presence of social support, presence of material resources, organized attitudes, adherence to rules, lawful conduct, good coping strategies, and treatability of the disorder) and two items of the second part of the TTV (involvement with treatment, presence of social support) and two items of the Mecler Criteria (presence of personal support and treatment adhering).

DISCUSSION

The reports have no systematized standard and the instruments described were unutilized. Outpatient treatment are the most recommended nowadays, whenever possible. An expressive number for dangerousness not ceased reports may generate concern and stigma for patients with mental illness. The majority of the diagnoses were for psychotic disorders (35.2%), followed by personality disorders (15.9%). Oliveira et al (2017), in a retrospective study in a similar population, found more than 50% psychotic individuals and about 5% with personality disorders. Personality disorders usually are refractory to treatment, while psychotic disorders commonly show better response to medication. Considering this, it is possible to suppose that the profile of individuals in this study is less likely to cease dangerousness in a shorter period of time; however, it is still a significant divergence. Another aspect to consider is the non-standardization of the exam format and the lack of use of specific instruments—an issue that deserves further scrutiny. The forensic examinations are difficult, but as demonstrated, there are already standardized instruments to risk evaluation for this purpose.

The results showed a statistically significant difference for the decision for non-cessation of dangerousness for 12 items that compose the PCL-R scale, in addition to individuals with more than 10 of any items of PCL-R and the presence of stressor factors. This profile shows that the diagnoses of Antisocial Personality Disorder is decisive for the non-cessation of dangerousness in our study.

The evaluation of risk assessment instruments items showed the relevance of PCL-R for individuals with psychopathic characteristics, directly related to non-cessation of dangerousness. Morana (2006) defined psychopathy as the lack of empathy, having predatory and parasitic behavior, with very high criminal recidivism. It could explain the absence of cessation of dangerousness in most of the individuals. This researcher found a cutoff point of 23 points in her study conducted in a Brazilian prison population (23b).

On the other hand, it is worth reflecting that it would be even more appropriate to keep the individual with this condition (psychopathy) in Safety Measure for a long period, since there is no

treatment or satisfactory prognosis for this condition. The coexistence of psychopaths and mentally ill people, such as psychotics or patients with severe mental disabilities, can even be harmful, since psychopaths, being usually predatory, tend to exploit ill people and even hinder the progress of therapy, as observed in a case described (Oliveira, Mecler, Chalub & Valença, 2016).

There is no correct answer or definitive solution for these individuals, but the presence of psychopathy or PCL-R typical items are relevant, which must necessarily be considered in the forensic psychiatry evaluation. Psychopathy should directly interfere with criminal responsibility and according to Abdalla-Filho (2016), there is a lack of consensus among experts in this aspect, if there is a diagnosis of personality disorder, especially with regard to the antisocial group or specifically the psychopath. One possible solution would be to provide separate living spaces for psychopaths and individuals with major mental disorders.

The HCR-20 proved useful for risk assessment, with ten items having statistical significance, with wide emphasis on clinicians items (all items) and risk management items (3 of 5), although there was minimal mention of the historical aspect (half of the instrument) in the reports and appear to have been disregarded. This risk assessment characteristic focused on the clinical part is similar to previous Brazilian studies (Mecler, 2010; Oliveira et al., 2017). These findings indicate that the experts are highly effective in evaluating the current state, but it appears to neglect important historical aspects that the scientific studies has already shown as relevant.

There are few citations in the reports of items related to the severity of the crime, criminal history, and even psychiatric history. Such items are crucial in violence risk assessments (Abdalla-filho, Chalub, & Telles, 2016; Nicholls, Brink, Desmarais, Webster, & Martin, 2013; Webster, Douglas, Eaves, & Hart, 1997; Whittington et al., 2013). It is appropriate to reflect that historical items are static and immutable and, hence, dynamic items should be prioritized. However, there is insufficient data to state that they should be completely ignored. Hence, the importance of them being present in the reports.

Substance abuse is considered a risk factor for violent behavior and criminal involvement (Elbogen, 2009; Johnson, 2009). In this research, as well as in the previous ones on EVCP, there was no statistical significance regarding the non-cessation of dangerousness in individuals with substance use disorders. Information on substance use appears relatively low in expert reports, which can influence the low statistical power, especially if we consider the evaluation of substance use in the past. However, as this population is complying with a safety measure, it is already natural that they are in abstinence due to their condition as inmates. Certainly, historical data need to be well delimited and explained in the expert reports, as well as the other antecedents.

Considering the variables which were significant for cessation of dangerousness, items related to the current state referred or observed were noticed, specially well-adapted social relationships, balanced emotional state, adherence to rules and treatment, involvement with treatment and treatment of the disorder, in addition to the presence of personal and social support.

Continuing with this analysis, the START items were widely observed as decisive for the cessation of dangerousness, with 12 of 20 items considered statistically relevant according to the experts. Two items from the second part of the TTV (which considers the current state) and two from the Mecler Criteria were also considered relevant. START instrument is the result of a study by the Canadian research group that also develops the HCR-20. In a new context, the group sought to refine the risk assessment considering valuing items that are modifiable to make this new instrument appropriate in the assessments of risk of violence and criminal recidivism, after the establishment of therapeutic proposals. In Brazil, it seems to be an adequate possibility for EVCPs after safety measures, with the existence of items suggesting a good validity in our research.

Additionally, it is noted that items that were relevant in previous studies, according to qualitative and quantitative analysis (Mecler Criteria) were not equally important for the reports of the present study. This appears to reinforce the hypothesis that the lack of standard and systematization in the organization

of the reports leave them with a subjectivity that makes it difficult to establish comparisons or even adjustments to establish a higher quality and identify flaws and virtues.

The presence of familial support and treatment adherence were significant items in this study for the cessation of dangerousness. The experts considered such information as important in the decision to cease dangerousness, which reinforces the broad need for social, family support and continuity of treatment, as observed in the studies by Mecler (2010) and Oliveira et al (2017). These are relevant aspects that meet the recent scientific literature, which values and qualifies specific instruments, focusing on issues aimed at rehabilitation (Mills & Gray 2013; Nicholls et al., 2013; Oliveira & Valença, 2020).

Considering the criminal responsibility, the Brazilian Penal Code (CPB) classifies the individual as "totally incapable of understanding the illicit nature of the fact or of determining itself according to this understanding" (CPB, Article 26). Individuals with mental illness, retarded mental development, and incomplete mental development can be considered attributable if there is a link between the disease and the crime and the impairment of understanding and determination of the individual.

The other possible situation in CPB partial impairment, which occurs when the individual presents mental health disturbance (where personality disorders are framed), as well as impairment of his determination (ability to choose between practicing and not practicing a criminal act or "controlling" himself in the face of the impulses of his personality), but with maintenance of his understanding (understanding of the unlawful act), of course, after being proven of the nexus between the impairment and the crime. In this situation, it is the judge's prerogative to opt for the security measure, or even for reduction of up to one third of the sentence.

With regard to semi-imputability, the legal solution for the psychopath is quite complex, since it is a condition in which effective treatment is unknown. Thus, the safety measure is not effective, and as previously described, can even hinder the rehabilitation of the mentally ill, who generally remain in the same position despite being in Safety Measure. The reduction of the penalty is a problem, since it would

be a kind of "benefit" to the individual known to be more dangerous and with a high chance of criminal recidivism, released early. Therefore, there is debate regarding whether maintaining imputability would be the most appropriate step, from legal and medical points of view.

If partial impairment—which includes some psychopaths who receive safety measure—be excluded from Brazilian legislation, it would also avoid some problems, as described earlier when they share the living environment with mentally ill individuals. However, even if this occurred and the psychopaths are criminally responsible, which would result in their arrest after convictions, a segregated environment (therapeutic or not) appears to be a necessity with regard to both security and for overseeing such dangerous and complex individuals.

The lack of empathy, the predatory and parasite behavior of psychopaths are characteristics that invariably lead to criminal relapse (Morana, Stone, & Abdalla-Filho, 2006). According to Hare (2007), the psychopath's criminal behavior stems from a freely exercised choice.

Coelho, Pereira, and Marques (2017) discussed the theme from a legal perspective, making a wide review of jurisprudence and literature of the topic. Regarding this aspect, their impression is that the judges have found a "solution" for cases of properly diagnosed psychopaths, that, after the execution of the sentence, they are banned civilly and then subjected to compulsory hospitalization. A question arises with this: Is it lawful to determine an indefinite duration of incarceration (similar to a "life sentence?") for these individuals, thinking exclusively for the safety of the community? Legal, medical, social, and philosophical aspects cover intensely and immeasurably the solutions found, reinforcing the continuity of discussion of this topic.

Discussion about criminal responsibility, dangerousness and risk of criminal recidivism are a "separate chapter" in forensic psychiatry and needs to be addressed in this research, considering the relevance of the data. A greater approximation of law and psychiatry can help to approach this theme better and, with social participation, since this discussion is not exclusively medical or legal. There is a

wide divergence in forensic psychiatry systems in the world, and lack of consensus is not exclusive to a particular region (Abdalla-Filho & Bertolote, 2006).

The findings of this research reveal that the systematization of reports and the use of risk assessment instruments, with special emphasis on the latest START and TTV should decisively contribute to improved quality of risk management assessments and in the cessation of dangerousness exams.

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6.2 Capítulo 2

6.2.1 Artigo 5: Sexual violence and social isolation: reflections of the COVID-19 pandemic

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- Em análise por periódico indexado PUBMED/MEDLINE, ISI

ABSTRACT

This is an update of the literature about the reflexes of social isolation and increased sexual violence against women. It was found reduction of reproductive rights, economic crisis provoking sexual exploitation, forced imprisonment at home and an increase in sexual aggression in women who already have intimate relationships with violent partners. There is an increase in cyber-abuse in children, especially in girls due to the increased use of the Internet without the supervision by parents. Also an enormous dismantling of several centers specialized in women victims of violence around the world took place. The embarrassment and fear of speaking and reporting are increased with isolation, since there is less contact with family, friends and health system protection network. It is necessary to raise awareness among governments, professionals and the protection network to protect those women, with more support to prevent an explosion of cases of trauma, feminicides and post-pandemic illness.

Keywords: Pandemic. Sexual violence. COVID-19.

According to the United Nations (UN), sexual violence against a woman is an "act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering that generates damage or suffering, physicist, sexual or psychological to the victim and death"[1]. Perpetrators intimidate, humiliate, harass, and try to overpower women. Sexual and physical violence often happen in different ways and levels. This concept provides a glimpse into how women find themselves in delicate situations, leading to a much higher prevalence of victimization and sexual violence among women[2].

There are three types of sexual violence: intrafamily, extrafamily, and institutional violence. Intrafamily violence occurs when the perpetrator, who is usually a member of the nuclear family (e.g., the father, stepfather, mother, or stepmother) attacks the victim. However, the perpetrator can also be a member of the extended family (e.g., an uncle, a grandparent or cousin) who interacts with the victim in the same environment. Extrafamily violence happens when the perpetrator, who is not part of the family or is an acquaintance, attacks the victim. Institutional violence occurs in social institutions that should protect individuals, such as schools, day-care centers, and hospitals. Of these three, extrafamily violence is the most reported one; however, intrafamily violence is the most common, having extremely harmful consequences to the victims[2,3].

The COVID-19 pandemic and public health measures implemented worldwide, such as social distancing, can increase sexual violence incidence. Social distancing measures lead to uninterrupted or high coexistence and cohabitation of families. Recent studies suggest a general growth of domestic violence[4-6]. Thus, a relevant update emphasizing sexual violence against women during the pandemic should be carried out.

There is a significant concern about the surge of domestic violence during the pandemic. Due to confinement and isolation, anxiety levels are high, people are annoyed and on edge. Chances of transgenerational transmission of traumas and various types of violence escalate, contributing to mental illnesses and substance abuse[7]. Besides, the risk of victimization might be even more eminent among individuals with mental disorders[8]. It is essential to provide extensive training to mental health workers, legal and law enforcement personnel to recognize possible situations of violence[7,9].

Compared with the same month last year, domestic violence calls to the Chinese police department tripled in February 2020; around 90% of new cases are directly linked to the pandemic[10]. In the UK, records between March and April 2020 show that the number of deaths from domestic

violence has more than doubled compared to the average of the last ten years[9]. In other epidemics, such as Ebola and Zika, there have also been spikes in violence against women, causing social and economic impacts[11]. Also, women and children are more likely to be subject to physical and sexual violence because they are vulnerable groups. That is why victims of violence should be able to report and access protection programs.

Although children seem to be little affected by the virus, their psyche can be hurt due to outdoor activity restrictions, school closures, monotony, stress, and risk of domestic violence. In Africa, after the Ebola epidemic, sexual exploitation of children and adolescents intensified, especially for those from lower social classes[11]. Moreover, another problem connected to the pandemic is "cyber abuse." Several people are now working from home, and children often have more unsupervised access to the Internet to watch school content, such as online classes. Thus, they are more vulnerable to inappropriate, sexual content, and can be approached by perpetrators in the worldwide web[12]. We need safety actions in place to avoid that. The main measures to protect children from sexual violence and mental illnesses involve implementing stricter laws, social and material safeguards that meet children's needs, parental monitoring and disciplining procedures related to Internet, television, and cell phone access. Situations in which children become victims of abuse can be tackled with closer surveillance and inappropriate content control.

Comparing to the previous crisis, women are the most affected group by the pandemic. In March 2020, there was a 57% rise in calls to domestic abuse assistance in Malaysia. Post-epidemic impacts of the Ebola and Zika viruses, followed by socioeconomic losses, were far more significant and long-lasting for women[13]. In Sierra Leone and Liberia, 63% of men who had lost their jobs were employed again, while only 17% of women in the same situation obtained new work[14].

Moreover, there is great concern regarding female sexuality. The interruption of legal abortions is underway in several countries around the world, such as the United States and Italy. There is a lack of contraceptive supplies in Indonesia, Mozambique, and other countries. Future consequences are somber. Many cases of sexual violence will result in unwanted and unplanned pregnancies, with significant psychosocial impacts on these women's lives[14].

Another issue is the impact of the COVID-19 pandemic on specialized care services for victims of sexual and gender violence. It is estimated that a six-month quarantine will result in more than 31 million cases of sexual violence[13]. There are already barriers to access support services

because they are not always a government priority. It is harder to get assistance in this pandemic. Health care professionals, burdened with COVID-19 patients, struggle to provide the necessary care to identify and take cases of violence. Besides, the fear of catching the virus prevents individuals from accessing mental health services.

The UK has 47 centers specialized in assisting victims of sexual violence. Data show a decrease of over 50% in these services during the first six weeks of social distancing this year. Before the pandemic, forensic examinations and DNA collection were available for all victims of sexual violence. However, they are now available only to those who filed a police complaint and have been attacked by strangers or family members other than their partners. Another major change in health care was the mandatory use of personal protective equipment (PPE), such as masks, face-shields, and surgical gowns. Although necessary, they are an obstacle in patient-provider relationships, which affect trust building. Other alternatives, such as videoconferencing calls, can also be a barrier to establish a connection between patient and physician[15].

Not only that, but sexual violence can lead to short and long-term complications, such as STDs, e.g., Hepatitis B and C, Syphilis, Gonorrhea, Chlamydia, Trichomoniasis and AIDS, unwanted pregnancies, physical and psychological traumas, especially without adequate professional health care. Beyond physical sequelae, humiliation, shame, and guilt make sexually abused women more vulnerable to other types of violence, mental disorders, and psychiatric symptoms. Psychological consequences, which are much more difficult to assess, affect most women and their families' well-being, leading to severe, devastating, and irreversible damages. Among these are: Major Depressive Disorder (MDD), Generalized Anxiety Disorder (GAD), Post Traumatic Stress Disorder (PTSD), Panic Disorder, somatization, suicidal behavior, and psychoactive substance abuse and dependence[1,11].

Most victims of sexual violence do not press charges, and reasons for not reporting vary from shame to fear. They might fear their partners, families, friends, and even the authorities. Perpetrators usually threaten victims and try to discredit them before society. They make them suffer, discriminate and humiliate them. Perpetrators are driven by power and are likely to perpetuate the abuse. During the pandemic and social distancing, it is important to highlight that women have little or no contact with their families and friends, lack of access to health systems, and other protection services.

Consequently, women spend more time with their abusive and stressed partners, who get angry and frustrated easily.

It is paramount that governments, health care professionals, social assistants, and workers in the justice system are sensitive to these issues. It is necessary to look after victims of violence and to broaden access to support services in a creative way that truly works. These measures are urgent. Only in this way can we prevent a boom of traumas, mental illnesses, and deaths resulting from increased sexual violence related to social distancing in the COVID-19 pandemic.

COMPLIANCE WITH ETHICAL STANDARDS

On behalf of all authors, we affirm there is no potential conflict of interest. This research doesn´t involves humans or animals, so it´s not necessary an informed consent.

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6. Capítulo 3

6.3.1 Artigo 6: What differentiates sexual homicide from nonsexual homicide a case controlled comparative study

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- Em análise para subumissão a periódico indexado PUBMED/MEDLINE, ISI

ABSTRACT

Objective: The aim of this study is to compare sexual (SH) and non-sexual (NSH) homicides in Australia and New Zealand considering aspects of: offender profile, victimology, crime scene, and body recovery scene characteristics in 207 variables. **Method**: Bivariate analyzes and logistic regression are performed to test and demonstrate possible differences between those two types of homicide in controlled samples. **Results**: There are 101 significantly different items between the groups. The study shows some differences between the aggressor's and the victim's lifestyle in each type of homicide, differences in relation to the aggressor's approach to the victim, and the victim's activity before the crime. Death caused by strangulation or suffocation, brutal murder with excessive violence (‘overkilling’), the presence of sadistic behavior, the use of multiple weapons and the history of some previous sexual offense are significantly more frequent in sexual homicides.The logistic regressions describe models to predict if a homicide is sexual based on four dimensions: aggressor’s profile; characteristics of the victims and their activities at the time of the crime; crime scene; and body recovery scene. The fifth logistic regression unifies the previous four, creating a general predictive model that shows whether a homicide in which, simultaneously: victim and aggressor did not know each other previously, the duration of the crime was greater than one hour, the victim was at work moments before the crime, the crime scene was a room or accommodation (bedroom/room used to sleep) and the victim was found naked in a place where it would not be possible to hear the victim, is probably a sexual homicide. **Discussion**: Our research reinforces the hypothesis that sexual homicide is a specific crime and very distinct from other homicides and even other non-sexual crimes. We also find new information in predictive models which can be useful to investigation and prevention. Constructing models is a promising strategy, but still quite new. **Key-words**: Sexual homicide, sexual offender, nonsexual homicide,

INTRODUCTION

Sexual homicide is a topic which started to be studied in the 1980s, but in the last 10-25 years, there was more development with an increase in the number of research. Further exploration is required to better understand the characteristics of those who perpetrate these crimes. It is only recently that factors related to the motivation and commission of sexual violence have been the object of study.

Sexual homicides occur less frequently than other forms of sexual violence, but has a widespread impact on victims, families and society. Sexual homicides are estimated to be less than 1% of all the homicides in the United States (Chan & Heide, 2009), 2.8% in France (Häkkänen-Nyholm et al, 2009) and 3.7% in the United Kingdom (Kerr et al, 2013). Despite this small proportion, the wide repercussions mean that the study of sexual homicide is of importance in order to understand this behaviour, prevent its occurrence and inform the management of perpetrators.

A widely used operationalised definition of sexual homicide is the FBI criteria, described by Ressler et al. (1988), where a case must contain at least one of the following characteristics: (a) victim's attire or lack of attire, (b) exposure of the sexual parts of the victim's body, (c) sexual positioning of the victim's body, (d) insertion of foreign objects into the victim's body cavities, (e) evidence of sexual intercourse (oral, anal), or (f) evidence of substitute sexual activity, interest, or sadistic fantasy such as mutilation of the genitals (Ressler, 1988). This definition, conceived in a US police investigative context, was the first widely disseminated criteria and has contributed to the investigation and research of this rare and specific crime. However, continuous research is required to allow the field to better conceptualise, understand and investigate sexual homicide, as Chan, 2015, considered different conceptualisations, since Ressler´s definition and Stefanska et al, 2020, also investigated very recently.

It is important to distinguish sexual homicide from intimate partner homicide, where there is a clear intimate relationship between offender and victim (Stöckl et al, 2013), as well as femicide, where the offender targets the victim based solely on the fact that the victim is female (Zara & Gino, 2018). If there´s no sexual aspect clearly found in the crime, it´s not a sexual homicide.

Given the infrequency of sexual homicide and the relative paucity of literature around this subject, there is limited information on the characteristics of sexual homicide and those who perpetrate this violence. Studies exploring offender profiles, victim characteristics and circumstances of offending are recent and often in small sample size (e.g. Beauregard & Martineau, 2013; Chan & Heide, 2009). Stefanska, A. R. Beecha and A. J. Carter, 2016, compiled a systematic review within 300 offenders and

Beauregard and Martineau, 2012 investigated 350 sexual murders which are two of the largest detailed studies in the profiling of sexual homicides. Also, recently, Stefanska et al, 2020 studied 361 sexual killers in United Kingdom.

Further to this, factors linked to sexual development, personality traits, how a crime is reported, and modus operandi differ significantly across studies (Beauregard, DeLisi, & Hewitt, 2017; Beauregard & Martineau, 2016; Choon & Heide, 2016; Darjee & Baron, 2018; Proulx, Beauregard, Cusson, & Nicole, 2007).

Larger studies will allow for better evaluation of specific characteristics linked to these crimes and comparative studies, between sexual and non-sexual homicides, utilising a well-controlled, paired method will allow for verification of similarities and differences between groups, alongside higher scientific and social relevance.

According to our knowledge, six studies comparing sexual homicides (SH) and non-sexual homicides (NSH) have been published.

The first survey was conducted in South Africa, published by Abrahams et al, 2008, comparing 561 "rape homicides" to 2876 non-sexual homicides in South Africa. It was a retrospective national study in a proportionate random sample of 25 medico-legal laboratories to identify all homicides in 1999 of women over the age of 13 years. The mortuary file, autopsy report, police record and interviews with police were analysed. ‘Rape homicides’ had more white and itinerant victims, occurrence was more often in public places, and there was a greater age difference between the offender and the victim compared to non-sexual homicides, as well as a greater proportion of victims who were strangers to the offender. Strangulation and asphyxiation were more common in the sexual homicide group (Abrahams et al, 2008).

The second study, published by Häkkänen-Nyholm et al, 2009, made a comparison between 18 sexual homicides and 615 non-sexual homicides in Finland. Those perpetrating sexual homicide were significantly more likely to display: sadistic characteristics, greater psychopathy, antisocial personality disorder and highter rates of substance abuse. Victimology showed that sexual homicide victims were younger and there was a greater presence of strangulation, transportation and disposal of the victims’ body (Häkkänen-Nyholm et al, 2009).

The third study, published in 2016 by Chan & Beauregard, analysed 74 sexual homicides and 96 non-sexual homicides in a Canadian federal prison, in which the characteristics of maladaptive personality traits and the presence of paraphilias were studied, with significant differences between

samples. Sexual homicide offenders had more deviant sexual fantasies, more personality disorders traits, more victim selection of choice and they also mutilate their victims more then nonsexual homicides.

The fourth, published by Abrahams et al, 2017, a retrospective national mortuary study which included all children of both genders and all adult female victims of homicide in the year 2009 in South Africa. They found 494 cases of sexual homicide in which strangulation was the most common manner of death of both children and female victims. 92% of female children were victims of sexual homicide in comparison to 1% of the male population. One in five female homicides in Africa were sexual in nature. Reducing mortality as a result of this is an important policy goal for South Africa at present.

The fifth study, carried out in Scotland, written by Skott, Beauregard and Darjee, 2018, compared 89 male sexual homicide offenders to 306 male nonsexual homicide offenders, both groups were controlled in that all victims were female. Sexual homicide offenders showed greater rates of sexual deviancy and shared a number of demographic characteristics, including; white ethnicity, younger age and current employment. The use of strangulation and destruction of sexual evidence was significantly associated with sexual homicide (Skott et al, 2018).

The most recent study, published in 2019 (Chopin & Beauregard) analysed and compared 1736 cases in a French national police database, with 463 nonsexual homicides (NSH), 173 sexual homicides (SH) and 1,100 violent sexual assaults (VSA). Differences between the groups were found in the victimology, characteristics of the offender and modus operandi of the crime. SH victims were frequently; single, had low rates of substance use, were more socially isolated and were more likely to be attacked while playing, jogging or walking. Other two groups were less likely to be attacked while taking part in domestic activities and had greater rates of substance use than SH victims. In comparison to NSH offenders, SH offenders tended to be; male, young, suffer from a paraphilic disorder, exhibit sexual dysfunction and have a sexual collection. They were also more engaged in social activities, were less likely to use substances and were less engaged in criminal activities. SH were more likely to occur when offender and victim were strangers and occurred more frequently in a place of residence or entertainment locations. Beating was more common in SH than other groups and weapons were less likely to be removed from the crime scene, suggesting that those who commit sexual homicide can be regarded as a different group from other forms of homicide and even other categories of sex offences.

Detailed analysis of sexual homicide is required in order to better comprehend the characteristics of these crimes. In order to improve the reliability of the analysis in comparative studies, the present

research compared a sample of sexual homicides and sample of nonsexual homicides across Australia and New Zealand. Given that the age and gender of offenders and victims appear to be very different in previous comparative studies, we constructed a more homogeneous sample in characteristics between the two groups and then looked for similarities and differences in SH and NSH, 'already having taken into account the absence of such confounding factors.' For example most sexual homicides involve the killing of women by men and most sexual nonsexual homicides involve men killing men, but some comparative studies have not taken this into account.

The aim of this study was to compare SH to NSH in Australia and New Zealand to ascertain offender, victim and offence characteristics that differentiate these groups, while controlling for offender and victim gender.

METHOD

Sample and Procedure

The sample was collected from AustLII and NZLII, a publically available database provided by the Australasian Legal Information Institute, and the New Zealand Legal Information Institute. AustLII and NZLII are public legal data which includes Supreme Court case law for Australia and New Zealand respectively. As murder cases are always dealt with in Supreme Courts in Australia, these databases specifically were the focus of the search. There are Supreme Court databases available for each Australian state as well as for New Zealand, with cases archived from 1964 to present. Files available include reports, sentencing judgements, appeals. In an effort to have as robust a sample as possible, any case with enough information to be coded was included in the analysis, regardless of whether the legal files available referred to an initial trial or appeal.

Initial searches utilised terms like "homicide", "murder", "sexual murder", "penis and murder", "rape and murder", "violent homicide" and other variations in AustLII and NZLII. Each case was assessed at whether it fit Ressler criteria (Ressler, 1988).

Cases reaching Ressler criteria were added to the sample and coding was commenced. 300 variables were coded for each sexual homicide. Variables included; elements of the offense, demographic characteristics of the victim, activity of the victim in the occurrence of the crime, demographic characteristics of the offender, adoption of precautions, vehicle involvement, characteristics of the contact scene (approach), characteristics of the crime scene, characteristics of the scene where the body was found, general characteristics of the scene, type of relationship between the victim and the offender,

characteristics of the crime, presence or absence of a "trophy" (remembrance or bonus), types and means of using weapons in crime, criminal history of the offender, Ressler criteria, SeSaS criteria (Severe Sexual Sadism Scale), history of mental illness and developmental history. These items were inspired by studies published on this field (Beauregard & Martineau, 2013;. Darjee & Baron, 2018; Skot, Beauregard and Darjee, 2018).

The coding process encountered limitations, as the material open to the public varies between each Australian state and New Zealand. An attempt was made to account for this by matching cases by jurisdiction but this significantly reduced the number of cases. Thus, to ensure coding was as complete as possible, information was also derived from news publications and specialized crime websites, this assisted in acquiring information pertinent to coding, as well as further cases. In order to consider the information reliable, information derived from sources outside the published legal material was required to appear explicitly on at least two, but mostly in three or more different websites or reputable publications. If there was any disagreement or suspicion about the veracity of the information, it was discarded. Nonsexual homicides were identified using the following pairing strategy. The main words 'murder' and 'homicide' were used to find the cases in AustLII and NZLII database. The researchers then recorded the state that the crime occurred and both gender and age of the offender and the victim. Cases were checked to ensure they did not meet the criteria for sexual homicide. If all characteristics were confirmed then it was paired with a corresponding case in the Sexual Homicide group. The ages groups considered equivalent were 0-19 years old, 20-39 years old, 40-59 years old, over 60 years old. If the researchers did not find enough cases to fit all three characteristics, the remaining cases were controlled by age and gender of both offender and victim. If there were still some NSH cases without those characteristics, at least both gender and victim needed to be the same as the remaining cases from SH group. If more than one NSH case fits the characteristics described with an equivalent in SH group, the case which was included was selected by randomization. In cases involving multiple offenders or multiple victims, all the killers were included and the comparison with the victim which was included was done with any which fitted the gender and age pattern of the victim´s killer. Those cases were rare, with nine sexual killers with multiple victims and five of them had a pattern of killing victims with similar age and gender. Considering the other four sexual murderers, one of them had victims with same age, but different gender. The other three sexual killers had victims with mixed gender and age victims. In all these cases with multiple victims, the one which was included in the comparison was the first victim killed.

Statistical Analysis

Initially, continuous variables were assessed in relation to the assumptions of normality using the Kolmogorov Smirnov test. The normality of the data was rejected, and the Mann Whitney test was then performed to compare the continuous data. All independent variables were initially compared to the dependent variables using bivariate analysis with chi-square tests (Monte Carlo simulation or continuity correction were used when at least one cell had a frequency less than 5). The Monte Carlo simulation is a correction for tables larger than 2 x 2 to avoid scientific evidence in associations that could be random due to the small sample size in a category, hence the resampling by simulation. Variables with 3 or more categories or with a zero-frequency cell did not allow the calculation of the odds ratio.

The variables that proved to be statistically significant were later used as predictors in an analysis of logistic regression. This technique was chosen due to the variable response (Pallant, 2010; Tabachnick & Fidell, 2013). The variables were separated into four categories: 1-Offender demographic/lifestyle and other characteristics. 2-Victim demographic/lifestyle variables and relationship with the offender. 3-Offence Scene-related variables. 4-Body recovery scene related variables. Then, multiple regressions were performed with the subdivisions: with the intention to test models in 4 dimensions. The selected variables of each subdivision (forward stepwise) were then inserted into a single model that included all previous variables. All statistical analyses were conducted using SPSS version 26.

RESULTS

The entire sample was 284 individuals, being 142 SH and 142 NSH cases. In our first search we found 118 SH cases (Eichinger and Darjee, 2021). In the end, we had 142 SH cases. New cases were found when the researchers were looking for the NSH cases to include in the control group. Reading the details of those cases, 24 of them fit Ressler Criteria and were added to the sample. Basic information found in each group are described below.

In SH group, the offender´s profile showed: 30.9 years-old (average), mostly were male (92,2%) and 3 cases of multiple perpetrators. The victims were 34.3 years-old (average), mostly female (71.1%) and there were 9 cases of multiple victims. The most reported causes of death described were: asphyxiation/strangulation (35.6%), trauma (27.3%) and stabbing (25%). The states where the crimes more frequently occurred were: Victoria (39.4%), New South Wales (30.9%) and South Australia (7.7%). The offences happened between 1921 and 2019.

In NSH group (totally paired-controlled by gender and mostly controlled by age with SH group), the offenders were 35,5 years-old (average), mostly male (92,2%). The victims were 36,6 years-old (average), mostly female (71,2%). The most reported causes of dead described were: stabbing (36.2%), trauma (30.5%) and asphyxiation/strangulation (16.3%). The states where the crimes more frequently occurred were: Victoria (34.5%), New South Wales (23.2%) and Western Australia (14.1%). The offences happened between 1994 and 2018. In the matching process, all 142 NSH were matched by sex of the offender and the victim with corresponding 142 SH cases. We also tried to match the cases further: 118 SH and 118 NSH were matched for age and gender of offender and victim; 89 NSH were paired with 89 SH cases who shared the same sex and age of offender and victim and the same state in Australia or New Zealand where the crime occurred. However due to the reduction in sample size this analysis is based on the gender matching only with a resulting sample size of 284 cases.

Bivariate Analyses

The demographic / lifestyle variables and other characteristics of the offender are shown in table 1. Variables with an odds ratio higher than one show greater propensity in relation to sexual homicides. Those with a lower odds ratio than one shows a greater propensity for nonsexual crimes. The tables show just the significant differences due to the large number of variables.

Table 1. Offender demographic/lifestyle variables and other characteristics

		Sexual		Total	*P*	OR (CI 95%)
		No	Yes			
Offender race	Not indicated	5 (4.5)	0 (0.0)	5 (2.3)	0.001	-
	White	61 (55.5)	85 (77.3)	146 (66.4)		
	Non-white	34 (30.9)	17 (15.5)	51 (23.2)		
	Indigenous	10 (9.1)	8 (7.3)	18 (8.2)		
Offender occupation	Others	38 (29.0)	9 (9.7)	47 (21.0)	0.001	-

	Employed	50 (38.2)	53 (57.0)	103 (46.0)		
	Unemployed	43 (32.8)	28 (30.1)	71 (31.7)		
	Sex trade worker	0 (0.0)	3 (3.2)	3 (1.3)		
Offender marital status	Not indicated	12 (8.8)	6 (6.5)	18 (7.8)	0.021	-
	Single (includes child)	37 (27.0)	43 (46.2)	80 (34.8)		
	Married. common-law	73 (53.3)	34 (36.6)	107 (46.5)		
	Separated. divorced	15 (10.9)	10 (10.8)	25 (10.9)		
Offender living situation	Not indicated	21 (16.0)	7 (8.5)	28 (13.1)	0.001	-
	Parent(s)	16 (12.2)	17 (20.7)	33 (15.5)		
	Spouse. partner	24 (18.3)	23 (28.0)	47 (22.1)		
	Roommates	4 (3.1)	6 (7.3)	10 (4.7)		
	Minor child(ren)	2 (1.5)	3 (3.7)	5 (2.3)		
	Adult child(ren)	2 (1.5)	0 (0.0)	2 (0.9)		
	Group home. shelter	4 (3.1)	1 (1.2)	5 (2.3)		
	No one	14 (10.7)	14 (17.1)	28 (13.1)		
	Spouse and child(ren)	39 (29.8)	8 (9.8)	47 (22.1)		
	Spouse and other adults	3 (2.3)	0 (0.0)	3 (1.4)		
	Relatives (other than parents)	0 (0.0)	2 (2.4)	2 (0.9)		
	Other	2 (1.5)	1 (1.2)	3 (1.4)		
	Not indicated	19 (14.6)	2 (1.6)	21 (8.3)	<0.001	-

Offender sex orientation	Heterosexual	109 (83.8)	107 (87.0)	216 (85.4)		
	Bisexual	1 (0.8)	9 (7.3)	10 (4.0)		
	Homosexual	1 (0.8)	5 (4.1)	6 (2.4)		
Offender paraphilia type	No. not indicated	141 (100.0)	134 (94.4)	275 (97.2)	0.012	-
	Yes	0 (0.0)	8 (5.6)	8 (2.8)		
Sentence	Not guilty due to MH	10 (7.4)	2 (1.7)	12 (4.8)	0.035	4.560 (1.002 - 21.255)
	Guilty	125 (92.6)	114 (98.3)	239 (95.2)		
Mental health condition	No. not indicated	58 (42.0)	22 (34.4)	80 (39.6)	<0.001	-
	Intellectual disorder	1 (0.7)	8 (12.5)	9 (4.5)		
	Substance misuse disorder	22 (15.9)	5 (7.8)	27 (13.4)		
	Paraphilias	0 (0.0)	1 (1.6)	1 (0.5)		
	Personality disorder	7 (5.1)	4 (6.3)	11 (5.4)		
	Major mental illness	22 (15.9)	14 (21.9)	36 (17.8)		
	Psychotic disorder	1 (0.7)	6 (9.4)	7 (3.5)		
	Traumatic brain injury	0 (0.0)	1 (1.6)	1 (0.5)		
	More than one condition	27 (19.6)	3 (4.7)	30 (14.9)		
Childhood experience	None	108 (76.1)	104 (73.2)	212 (74.6)	0.005	-
	Physical abuse	7 (4.9)	14 (9.9)	21 (7.4)		
	Sexual abuse	5 (3.5)	12 (8.5)	17 (6.0)		
	Neglect	2 (1.4)	6 (4.2)	8 (2.8)		
	Domestic violence	5 (3.5)	3 (2.1)	8 (2.8)		
	More than one condition	15 (10.6)	3 (2.1)	18 (6.3)		

Off lifestyle party	No. not indicated	129 (90.8)	111 (78.7)	240 (84.8)	0.005	2.682 (1.334 - 5.393)
	Yes	13 (9.2)	30 (21.3)	43 (15.2)		
Off lifestyle homosexual	No. not indicated	139 (97.9)	128 (90.8)	267 (94.3)	0.010	4.706 (1.311 - 16.893)
	Yes	3 (2.1)	13 (9.2)	16 (5.7)		
Offender paraphilic	No. not indicated	141 (100.0)	134 (94.4)	275 (97.2)	0.012	-
	Yes	0 (0.0)	8 (5.6)	8 (2.8)		
Offender approach con	No	129 (90.8)	115 (81.0)	244 (85.9)	0.017	2.330 (1.148 - 4.728)
	Yes	13 (9.2)	27 (19.0)	40 (14.10		
Offender approach surprise	No	127 (89.4)	101 (71.1)	228 (80.3)	<0.001	3.437 (1.800 - 6.561)
	Yes	15 (10.6)	41 (28.9)	56 (19.7)		
Offender approach blitz	No	126 (88.7)	90 (63.4)	216 (76.1)	<0.001	4.550 (2.442 - 8.477)
	Yes	16 (11.3)	52 (36.6)	68 (23.9)		
Acts unusual	No. not indicated	136 (95.8)	105 (74.5)	241 (85.2)	<0.001	7.771 (3.157 - 19.134)
	Yes	6 (4.2)	36 (25.5)	42 (14.8)		
Acts ritualistic	No. not indicated	142 (100.0)	130 (91.5)	272 (95.8)	<0.001	-
	Yes	0 (0.0)	12 (8.5)	12 (4.2)		
Acts overkill	No. not indicated	98 (69.0)	56 (39.4)	154 (54.2)	<0.001	3.420 (2.096 - 5.581)

	Yes	44 (31.0)	86 (60.6)	130 (45.8)		
Use restraints	No. not indicated	134 (94.4)	120 (84.5)	254 (89.4)	0.007	3.071 (1.318 - 7.155)
	Yes	8 (5.6)	22 (15.5)	30 (10.6)		
Victim redressed	No	142 (100.0)	130 (91.5)	272 (95.8)	<0.001	-
	Yes	0 (0.0)	11 (7.7)	11 (3.9)		
	Unable to determine	0 (0.0)	1 (0.7)	1 (0.4)		
Sesas1	No evidence subject was sexually aroused during offense	142 (100.0)	72 (50.7)	214 (75.4)	<0.001	-
	Evidence of sexual arousal	0 (0.0)	70 (49.3)	70 (24.6)		
Sesas2	No more power than was deemed necessary	97 (68.3)	65 (45.8)	162 (57.0)	<0.001	2.554 (1.574 - 4.142)
	Used more power control. dominance than was necessary to carry out act	45 (31.7)	77 (54.2)	122 (43.0)		
Sesas4	No indication of acts meant to cause shame. disgust	125 (88.7)	111 (78.7)	236 (83.7)	0.024	2.111 (1.093 - 4.079)
	Indication of acts meant to cause shame. disgust	16 (11.3)	30 (21.3)	46 (16.3)		
Sesas5	No mutilation of sexual parts	142 (100.0)	116 (81.7)	258 (90.8)	<0.001	-
	Mutilation of sexual parts	0 (0.0)	26 (18.3)	26 (9.2)		
Sesas6	No mutilation of other body parts	104 (73.2)	119 (83.8)	223 (78.5)	0.03	0.529 (0.296 - 0.946)

	Mutilation of other body parts	38 (26.8)	23 (16.2)	61 (21.5)		
Sesas7	Level of violence not excessive of degree needed to control victim	80 (56.3)	23 (16.2)	103 (36.3)	<0.001	6.676 (3.828 - 11.642)
	Level of violence excessive of degree needed to control victim	62 (43.7)	119 (83.8)	181 (63.7)		
Sesas8	No insertion of objects evidenced	142 (100.0)	130 (91.5)	272 (95.8)	<0.001	-
	Insertion of objects evidenced	0 (0.0)	12 (8.5)	12 (4.2)		
Sesas9	No evidence of ritualistic behaviour	142 (100.0)	131 (92.3)	273 (96.1)	0.001	-
	Evidence of ritualistic behaviour	0 (0.0)	11 (7.7)	11 (3.9)		
Sesas11	No trophies	142 (100.0)	131 (92.3)	273 (96.1)	0.001	-
	Trophies	0 (0.0)	11 (7.7)	11 (3.9)		
Sesas12	No in-depth offence preparation	142 (100.0)	88 (62.0)	230 (81.0)	<0.001	-
	In-depth offence preparation	0 (0.0)	54 (38.0)	54 (19.0)		
Sesas13	No evidence of cruel conduct to humans or animals in past	142 (100.0)	101 (71.6)	243 (85.9)	<0.001	-
	Evidence of cruel conduct to humans or animals in past	0 (0.0)	40 (28.4)	40 (14.1)		

Sesas14	No evidence of being aroused by acts of torture. humiliation	142 (100.0)	131 (92.9)	273 (96.5)	0.001	-
	Evidence of being aroused by acts of torture. humiliation	0 (0.0)	10 (7.1)	10 (3.5)		
Personal items taken	No. not indicated	131 (92.3)	117 (82.4)	248 (87.3)	0.013	2.545 (1.200 - 5.396)
	Yes	11 (7.7)	25 (17.6)	36 (12.7)		
Precautions	No	71 (50.4)	88 (62.0)	159 (56.2)	0.049	0.622 (0.388 - 0.999)
	Yes	70 (49.6)	54 (38.0)	124 (43.8)		
Weapon removal	No	110 (78.0)	130 (91.5)	240 (84.8)	0.002	0.328 (0.161 - 0.668)
	Yes	31 (22.0)	12 (8.5)	43 (15.2)		
Weapon multiple	No. not indicated	126 (88.7)	112 (78.9)	238 (83.8)	0.024	2.109 (1.092 - 4.073)
	Yes	16 (11.3)	30 (21.1)	46 (16.2)		
Weapon different types	No. not indicated	129 (90.8)	113 (79.6)	242 (85.2)	0.007	2.547 (1.263 - 5.135)
	Yes	13 (9.2)	29 (20.4)	42 (14.8)		
Criminal history any prior	No. not indicated	65 (45.8)	87 (61.3)	152 (53.5)	0.009	0.534 (0.333 - 0.856)
	Yes	76 (53.5)	55 (38.7)	131 (46.1)		

Criminal history any sex	No. not indicated	139 (97.9)	125 (88.0)	264 (93.0)	0.001	6.301 (1.804 - 22.014)
	Yes	3 (2.1)	17 (12.0)	20 (7.0)		
Criminal history any property	No. not indicated	122 (85.9)	135 (95.1)	257 (90.5)	0.009	0.316 (0.129 - 0.774)
	Yes	20 (14.1)	7 (4.9)	27 (9.5)		
Criminal history burglary	No. not indicated	114 (80.3)	138 (97.2)	252 (88.7)	<0.001	0.118 (0.040 - 0.346)
	Yes	28 (19.7)	4 (2.8)	32 (11.3)		
Criminal history domestic	No. not indicated	117(82.4)	140 (98.6)	257 (90.5)	<0.001	0.067 (0.016 - 0.288)
	Yes	25 (17.6)	2 (1.4)	27 (9.5)		
Motive vengeance	No	102 (71.8)	121 (85.2)	223 (78.5)	0.006	0.443 (0.245 - 0.799)
	Yes	40 (28.2)	21 (14.8)	61 (21.5)		
Emotional setback	No. not indicated	81 (57.0)	117 (82.4)	198 (69.7)	<0.001	0.284 (0.165 - 0.489)
	Yes	61 (43.0)	25 (17.6)	86 (30.3)		
Offender suicide attempt	No. not indicated	125 (88.0)	138 (97.2)	263 (92.6)	0.003	0.213 (0.070 - 0.650)
	Yes	17 (12.0)	4 (2.8)	21 (7.4)		
Offender gave self up	Not at all	97 (68.3)	131 (92.3)	228 (80.3)	<0.001	0.181 (0.089 - 0.368)

	Within 24h of death1.0	45 (31.7)	11 (7.7)	56 (19.7)		
Mental health treatment	No. not indicated	103 (72.5)	125 (88.0)	228 (80.3)	0.001	0.359 (0.192 - 0.672)
	Yes	39 (27.5)	17 (12.0)	56 (19.7)		
Mental health diagnosis	No. not indicated	75 (52.8)	105 (73.9)	180 (63.4)	<0.001	0.394 (0.239 - 0.650)
	Yes	67 (47.2)	37 (26.1)	104 (36.6)		
Childhood antisocial	No. not indicated	140 (98.6)	122 (85.9)	262 (92.3))	<0.001	11.475 (2.629 - 50.093)
	Yes	2 (1.4)	20 (14.1)	22 (7.7)		
Any antissocial history	No. not indicated	135 (95.1)	122 (85.9)	257 (90.5)	0.009	3.162 (1.292 - 7.736))
	Yes	7 (4.9)	20 (14.1)	27 (9.5)		
Total		142 (100.0)	142 (100.0)	284 (100.0)		

The variables which significantly differentiated between the two groups are shown in table 1. The factors which differentiated the SH offender from NSH offenders were: white race, employed, single and heterosexual. The NSH offenders were also mostly white, employed and heterosexual (although less so than SH offenders), but most were also married. The SH offender group were more likely to be sex trade workers, bisexual and homosexual. Paraphilia was described in 8 SH and none of the NSH cases, although this is likely an underestimate in the SH group as reports rarely explicitly considered this. We also found differences in the offender living situation, for example SH offenders rarely live with children, even the ones who have a spouse. Living with no one or with their parents was more common in the SH group. In the NSH group, living with spouse and children was the 'rule'. Sentence finding of not guilty due to mental disorder was significant more frequent in NSH than SH.

In relation to mental health conditions and childhood experiences, substance abuse disorders were more prevalent in NSH and also more than one mental health condition was more common in NSH. Psychotic disorders were infrequent in the 2 groups (6 cases in SH and 1 in NSH) and showed coding difficulties with this variabale. It wasn´t often cited in all data, but there was difference between them, according to the tests. Those committing NSH were more likely to have experienced multiple types of adverse childhood experience. Sexual abuse (12 cases) and neglect (6 cases) appear to be more frequent in SH, but we are not sure of this difference, because lots of NSH suffered more than one kind of adverse childhood experience and it may include such experiences.

The offender lifestyle was not often described in the records. However, 30 of SH offenders were identified as having a ‘party’ lifestyle, compared to just 13 of NSH. This may relate to the contexts where offenders picked up victims.

In both groups, homossexual offenders were poorly indicated. But, according to the tests, a difference was found, with 9.2% in SH and 2.1% in NSH.

Regarding the acts involving the planning and commission of a crime, we found significant differences. It was clear that the 'blitz attack', surprise or 'con attack' were more prevalent in SH than NSH. Since in most NSH cases the victim and the offender knew each other, these kind of approaches weren´t usually described in the records.

Acts described as unusual, ritualistic or involving ‘overkill’ are expressive and more common in SH. Specific acts as the use of restraints to avoid the victim from escape and redressing the victim, appeared to be specific to SH offenders.

When analysing those crimes with Sexual Sadism Scale (SeSaS), it´s very clear that sadism was far more common in the SH cohort. When we just consider the comparison between items not specific of sexual crimes, as SeSaS 2, 3, 4, 6 and 7, they are still more frequent in SH. The exception is the item 6, which is mutilation of other body parts that are not sexual parts which is more common in NSH. Torture (item 3) looks to be similar in both groups. We found that personal items from victims are more often taken during SH compared to NSH.

The use of multiple weapons and different types of weapons were also more common in SH. On the other hand, taking precautions and removing the weapon from the crime scene were more frequent in NSH.

A history of criminal convictions, including; property offences, burglary and domestic violence were all more frequent in NSH. SH cases had a higher rate of past convictions of sexual crimes. Homicides motivated by vengeance or after an emotional setback were much more frequent in NSH. The SH had less attempts of suicide by the offender and did not tend to hand themselves to the police. The NSH had a higher prevalence of mental health diagnosis and treatment. The SH had much higher rates of childhood antisocial behaviour and any antisocial behaviour, consistent with previous research. The victim demographic / lifestyle variables are shown in table 2.

Table 2. Victim demographic/lifestyle variables in relation with the offender

		Sexual		Total	*P*	OR (CI 95%)
		No	Yes			
Victim race	Not indicated	9 (8.0)	0 (0.0)	9 (4.1)	0.002	-
	White	70 (61.9)	84 (80.0)	154 (70.6)		
	Non-white	28 (24.8)	14 (13.3)	42 (19.3)		
	Indigenous	6 (5.3)	7 (6.7)	13 (6.0)		
Victim main occupation	Others	34 (33.3)	23 (26.7)	57 (30.3)	<0.001	-
	Employed	37 (36.3)	43 (50.0)	80 (42.6)		
	Unemployed	21 (20.6)	9 (10.5)	30 (16.0)		
	Sex trade worker	0 (0.0)	11 (12.8)	11 (5.9)		
	Drug dealer	1 (1.0)	0 (0.0)	1 (0.5)		
	Student	9 (8.8)	0 (0.0)	9 (4.8)		
Victim living situation	Not indicated	12 (8.8)	4 (4.6)	16 (7.2)	<0.001	-
	Adult	53 (39.0)	48 (55.2)	101 (45.3)		
	Child(ren)	8 (5.9)	7 (8.0)	15 (6.7)		

	Adult(s) and Child(ren)	45 (33.1)	8 (9.2)	53 (23.8)		
	Living alone	18 (13.2)	20 (23.0)	38 (17.0)		
Victim lifestyle drugs	No. not indicated	114 (80.3)	126 (88.7)	240 (84.5)	0.049	0.517 (0.266 - 1.005)
	Yes	28 (19.7)	16 (11.3)	44 (15.5)		
Victim lifestyle prostitute	No. not indicated	142 (100.0)	126 (88.7)	267 (94.0)	<0.001	-
	Yes	0 (0.0)	17 (12)	17 (6.0)		
Victim activity visiting	No	137 (96.5)	125 (88.7)	262 (92.6)	0.012	3.507 (1.248 - 9.854)
	Yes	5 (3.5)	16 (11.3)	21 (7.4)		
Victim activity date	No	137 (96.5)	124 (87.9)	261 (92.2)	0.007	3.756 (1.346 - 10.843)
	Yes	5 (3.5)	17 (12.1)	22 (7.8)		
Victim activity working	No	140 (98.6)	127 (89.4)	267 (94.0)	0.001	8.268 (1.854 - 36.862)
	Yes	2 (1.4)	15 (10.6)	17 (6.0)		
Victim activity prostitution	No	142 (100.0)	125 (88.0)	268 (94.4)	<0.001	-
	Yes	0 (0.0)	16 (11.3)	16 (5.6)		
Victim and offender relationship: strangers	No	113 (79.6)	89 (62.7)	202 (71.1)	0.002	2.320 (1.364 - 3.947)
	Yes	29 (20.4)	53 (37.3)	82 (28.9)		

Victim and offender relationship: acquaintance	No	58 (40.8)	100 (70.4)	158 (55.6)	<0.001	0.290 (0.177 - 0.474)
	Yes	84 (59.2)	42 (29.6)	126 (44.4)		
Victim and offender relationship: familial	No	109 (76.8)	128 (90.1)	237 (83.5)	0.002	0.361 (0.184 - 0.710)
	Yes	33 (23.2)	14 (9.9)	47 (16.5)		
Victim and offender relationship: intimate	No	83 (58.5)	110 (77.5)	193 (68.0)	0.001	0.409 (0.244 - 0.686)
	Yes	59 (41.5)	32 (22.5)	91 (32.0)		
Victim targeted	No	39 (27.5)	58 (42.3)	97 (34.8)	0.009	0.516 (0.313 - 0.851)
	Yes	103 (72.5)	79 (57.7)	182 (65.2)		
Elements indicate domestic relationship victim/offender	No. not indicated	67 (47.2)	109 (76.8)	176 (62.0)	<0.001	0.270 (0.162 - 0.450)
	Yes	75 (52.8)	33 (23.2)	108 (38.0)		
Total		142 (100.0)	142 (100.0)	284 (100.0)		

Caucasian ethnicity was more prevalent amongst victims and especially so in the SH group. The SH victims were usually employed (50%), just 10% are unemployed and there were 11 victims who were 'sex trade workers'. No victims of NSH were sex workers. Victims who also worked as prostitute (including alongside other occupations) were 12% of all SH victims confirming the high risk associated with this occupation.

SH victims tend to live with another adult or alone. NSH victims tended to live with one adult or with another adult and children. Just 17% of the SH victims lived with children, compared to 39% of NSH victims. We also found less use of psychoactive substances in SH victims than NSH victims.

The activities SH victims were involved at the time of the offence were significantly different to NSH. Victims were more likely to be visiting friends or family, dating, working, or in a prostitution activity. In comparison, no specific activity was found in association with NSH.

Considering the relationship between the victim and the offender, we found that in the 2 groups it was more common that they also knew each other. Despite that, being completely strangers is more common in SH victims. Being an acquaintance, familial, intimate and in any domestic relationship were more frequent in NSH. We also found that victims were 'targeted' (the offender has also decided before the crime to kill specifically that victim) in the 2 groups (57.7% in SH, 72.5% in NSH), but it was much more frequent in NSH. The offence scene-related variables are shown in table 3.

Table 3. Offence scene-related variables

		Sexual		Total	*P*	OR (CI 95%)
		No	Yes			
Offence scene neighbourhood	Not indicated	6 (4.3)	3 (2.6)	9 (3.5)	0.009	-
	Industrial	0 (0.0)	1 (0.9)	1 (0.4)		
	Retail. business	9 (6.4)	5 (4.3)	14 (5.4)		
	Residential	114 (80.9)	81 (69.8)	195 (75.9)		
	Uninhabited	7 (5.0)	11 (9.5)	18 (7.0)		
	Farm. agricultural	1 (0.7)	0 (0.0)	1 (0.4)		
	Park. recreational	4 (2.8)	15 (12.9)	19 (7.4)		
Offence scene gained entry	Building open	14 (12.1)	2 (2.4)	16 (8.0)	0.010	-
	Let in by third person	4 (3.4)	4 (4.8)	8 (4.0)		
	Forced entry	8 (6.9)	12 (14.5)	20 (10.1)		
	Offender lived. worked in building	52 (44.8)	31 (37.3)	83 (41.7)		
	Let in by victim	17 (14.7)	24 (28.9)	41 (20.6)		
	Insecure door. window	8 (6.9)	6 (7.2)	14 (7.0)		

	Key	13 (11.2)	4 (4.8)	17 (8.5)		
Number scenes	1	111 (81.0)	66 (56.4)	177 (69.7)	<0.001	-
	2	24 (17.5)	37 (31.6)	61 (24.0)		
	3	2 (1.5)	14 (12.0)	16 (6.3)		
Weapon type	Unknow	41 (29.1)	12 (12.6)	53 (22.5)	<0.001	-
	Knife	45 (31.9)	37 (38.9)	82 (34.7)		
	Firearm	15 (10.6)	4 (4.2)	19 (8.1)		
	Axe. hatchet	3 (2.1)	3 (3.2)	6 (2.5)		
	Bludgeoning tool	10 (7.1)	15 (15.8)	25 (10.6)		
	Ligature	2 (1.4)	15 (15.8)	17 (7.2)		
	Electric weapon	1 (0.7)	0 (0.0)	1 (0.4)		
	Other	19 (13.5)	7 (7.4)	26 (11.0)		
	Multiple	5 (3.5)	2 (2.1)	7 (3.0)		
Weapon multiple	No. not indicated	125 (88.7)	64 (68.1)	189 (80.4)	<0.001	3.662 (1.860 - 7.210)
	Yes	16 (11.3)	30 (31.9)	46 (19.6)		
Victim Cause of Death	Unknow	6 (4.3)	0 (0.0)	6 (2.2)	<0.001	
	Gunshot	14 (9.9)	5 (3.8)	19 (7.0)		

	Stabbing	51 (36.2)	33 (25.0)	84 (30.8)		
	Bf trauma	43 (30.5)	36 (27.3)	79 (28.9)		
	Asphyxiation. strangulation	23 (16.3)	47 (35.6)	70 (25.6)		
	Other	4 (2.8)	11 (8.3)	15 (5.5)		
Duration of the offence	Less than 1 hour	111 (83.5)	15 (11.5)	126 (47.9)	<0.001	-
	1-3 hours	9 (6.8)	99 (76.2)	108 (41.1)		
	3-24 hours	9 (6.8)	7 (5.4)	16 (6.1)		
	More than 24 hours	4 (3.0)	9 (6.9)	13 (4.9)		
Offence scene deserted	No	130 (95.6)	66 (54.5)	196 (76.3)	<0.001	18.056 (7.391 - 44.109)
	Yes	6 (4.4)	55 (45.5)	61 (23.7)		
Offence scene visible	No	59 (43.4)	98 (82.4)	157 (61.6)	<0.001	0.164 (0.092 - 0.293)
	Yes	77 (56.6)	21 (17.6)	98 (38.4)		

Offence scene audible	No	10 (7.4)	91 (76.5)	101 (39.6)	<0.001	0.024 (0.011 - 0.053)
	Yes	126 (92.6)	28 (23.5)	154 (60.4)		
Offence scene living quarters	No	104 (76.5)	47 (39.8)	151 (59.4)	<0.001	4.910 (2.858 - 8.434)
	Yes	32 (23.5)	71 (60.2)	103 (40.6)		
Offence scene residence	No	40 (29.4)	58 (49.2)	98 (38.6)	0.001	0.431 (0.257 - 0.722)
	Yes	96 (70.6)	60 (50.8)	156 (61.4)		
Offence scene public building	No	124 (91.2)	115 (97.5)	239 (94.1)	0.034	0.270 (0.074 - 0.980)
	Yes	12 (8.8)	3 (2.5)	15 (5.9)		
Total		142 (100.0)	142 (100.0)	284 (100.0)		

Offence scene-related variables

The comparisons for the offence scene variables showed that a residential area was the most common scene across both types of homicide, particularly NSH. (69.8% in SH, 80.9% in NSH). Despite that, there were differences noted, specially involving parks and uninhabited places, which were more common in SH. Deserted places (45.5% in SH, 4.4 in NSH), not audible and not visible places were also more common in SH. A public scene was not very frequent, but also more common in NSH. NSH were usually committed in just one crime scene (81.0%). SH had a significantly greater incidence of more than one crime scene (43.6%).

The way the offender accessed the offence scene was usually where he or she also lived or worked in both groups. Despite that, in SH, we found a greater incidence of the offender being let in by the victim (28.9%) and also forced entry (14.5%) when compared to NSH (14.7% and 6.9% respectively).

When we analyse weapon use, we found knife use was common in both groups (31.9 in NSH, 38.9 in SH). However, SH offenders were more likely to use multiple weapons (31.9% against 11.3% in NSH). The use of bludgeoning tool and ligature were very much more frequent in SH. In NSH, the use of firearm was more frequent.

The duration of offence was different between the groups. In 83.5% of NSH it was described as during less than 1 hour. In most of the SH cases the duration of the offence was between 1-3 hours (76.2%). The offence which lasted more than 2 hours were also more frequent in SH (9 cases) than NSH (4 cases). The body recovery scene-related variables are shown in table 4.

Table 4. Body recovery scene-related variables

		//		Total	*P*	OR (CI 95%)
		No	Yes			
Victim disrobe	not indicated	134 (95.0)	18 (16.1)	152 (60.1)	<0.001	-
	Victim disrobed self	2 (1.4)	83 (74.1)	85 (33.6)		
	Offender disrobed victim	1 (0.7)	6 (5.4)	7 (2.8)		
	Clothing not removed	2 (1.4)	0 (0.0)	2 (0.8)		
	Offender moved clothing up or down	1 (0.7)	3 (2.7)	4 (1.6)		
	Unknown how removed	1 (0.7)	2 (1.8)	3 (1.2)		
Body recovery neighbourhood	Not indicated	5 (4.0)	2 (1.6)	7 (2.8)	<0.001	-
	Industrial	1 (0.8)	2 (1.6)	3 (1.2)		
	Retail. business	9 (7.3)	9 (7.3)	18 (7.3)		
	Residential	91 (73.4)	64 (51.6)	155 (62.5)		
	Uninhabited	11 (8.9)	33 (26.6)	44 (17.7)		

	Farm. agricultural	2 (1.6)	0 (0.0)	2 (0.8)		
	Park. recreational	5 (4.0)	14 (11.3)	19 (7.7)		
Body recovery gained entry	Building open	20 (20.0)	1 (1.4)	21 (12.3)	<0.001	-
	Let in by third person	2 (2.0)	3 (4.2)	5 (2.9)		
	Forced entry	7 (7.0)	11 (15.5)	18 (10.5)		
	Offender lived. worked in building	41 (41.0)	22 (31.0)	63 (36.8)		
	Let in by victim	13 (13.0)	23 (32.4)	36 (21.1)		
	Insecure door. window	7 (7.0)	5 (7.0)	12 (7.0)		
	Key	10 (10.0)	6 (8.5)	16 (9.4)		
Body recovery deserted	No	106 (89.1)	58 (45.7)	164 (66.7)	<0.001	9.700 (4.946 - 19.024)
	Yes	13 (10.9)	69 (54.3)	82 (33.3)		
Body recovery visible	No	51 (42.9)	103 (81.7)	154 (62.9)	<0.001	0.167 (0.094 - 0.299)
	Yes	68 (57.1)	23 (18.3)	91 (37.1)		
Body recovery audible	No	13 (10.9)	99 (78.6)	112 (45.7)	<0.001	0.033 (0.016 - 0.068)
	Yes	106 (89.1)	27 (21.4)	133 (54.3)		
Body recovery living quarters	No	98 (82.4)	69 (54.8)	167 (68.2)	<0.001	3.885 (2.142 - 6.937)
	Yes	21 (17.6)	57 (45.2)	78 (31.8)		

Body recovery residence	No	43 (36.1)	71 (56.8)	114 (46.7)	0.001	0.430 (0.257 - 0.720)
	Yes	76 (63.9)	54 (43.2)	130 (53.3)		
Body recovery public building	No	101 (84.9)	124 (97.6)	225 (91.5)	<0.001	0.136 (0.039 - 0.474)
	Yes	18 (15.1)	3 (2.4)	21 (8.5)		
Clothes hidden	No. not indicated	141 (99.3)	134 (94.4)	275 (96.8)	0.042	8.418 (1.039 - 68.212)
	Yes	1 (0.7)	8 (5.6)	9 (3.2)		
Body disposal	Unknow	26 (18.4)	17 (13.5)	43 (16.1)	0.015	-
	Openly displayed to ensure discovery	37 (26.2)	15 (11.9)	52 (19.5)		
	Concealed to prevent discovery	26 (18.4)	36 (28.6)	62 (23.2)		
	Lack of concern	43 (30.5)	52 (41.3)	95 (35.6)		
	Displayed to offend public	4 (2.8)	2 (1.6)	6 (2.2)		
	Staged to suggest other motive	5 (3.5)	4 (3.2)	9 (3.4)		
Victim state dress	Unknow	32 (22.7)	4 (3.9)	36 (14.8)	<0.001	-
	Completely removed	3 (2.1)	48 (47.1)	51 (21.0)		
	Partially removed	3 (2.1)	40 (39.2)	43 (17.7)		
	Moved up or down	0 (0.0)	5 (4.9)	5 (2.1)		

	Fully clothed	103 (73.0)	5 (4.9)	108 (44.4)		
Body placement	Unknow	18 (12.8)	6 (5.5)	24 (9.6)	<0.001	-
	Buried	6 (4.3)	6 (5.5)	12 (4.8)		
	Partially buried	0 (0.0)	2 (1.8)	2 (0.8)		
	In water	4 (2.8)	10 (9.1)	14 (5.6)		
	Completely exposed	64 (45.4)	51 (46.4)	115 (45.8)		
	In a vehicle	5 (3.5)	4 (3.6)	9 (3.6)		
	Concealed (includes a container)	5 (3.5)	17 (15.5)	22 (8.8)		
	Skeletal remains	2 (1.4)	0 (0.0)	2 (0.8)		
	Burned	11 (7.8)	10 (9.1)	21 (8.4)		
	Undisturbed	21 (14.9)	1 (0.9)	22 (8.8)		
	Partially concealed	5 (3.5)	3 (2.7)	8 (3.2)		
Body displayed	No. not indicated	80 (56.3)	126 (88.7)	206 (72.5)	<0.001	0.164 (0.088 - 0.304)
	Yes	62 (43.7)	16 (11.3)	78 (27.5)		
Body dismemberment	No. not indicated	139 (97.9)	123 (86.6)	262 (92.3)	<0.001	7.157 (2.068 - 24.772)
	Yes	3 (2.1)	19 (13.4)	22		
Body parts moved	No. not indicated	140 (98.6)	130 (91.5)	270 (95.1)	0.006	6.462 (1.419 - 29.422)
	Yes	2 (1.4)	12 (8.5)	14 (4.9)		
Total		142 (100.0)	142 (100.0)	284 (100.0)		

Body recovery scene-related variables

The body disposal method was different between the groups. The SH group tended to either leave the body without any concern or conceal to prevent the discovery of the body. In NSH, we found more frequency of letting the body openly displayed and also with lack of concern, which facilitated the body recovery comparing to SH.

The victim state of dress when the body was discovered was different between the crimes. In 73% of NSH the victim was fully clothed, compared to 4.9% in SH. In SH, the clothes were completely or partial removed in 86.3% of cases, in comparison to 4.2% of NSH. Moving up the clothes of the victims happened in 5 murders in the SH group and none of the NSH. In most of the cases the victim was the one who disrobed him/herself (74.1% of SH) and the offender disrobing the victim happened in fewer cases (5.4% of SH). The clothes of the victim were usually not hidden in both cases, but was more frequent in SH, as they´re often removed in these crimes. The body was usually displayed in NSH, but hidden in SH. The dismemberment and parts of the body moved were noted in 13.4% and 8.5% of SH. In NSH it was less frequent at 2.1% and 1.4% respectively.

The cause of death was different between the two groups, with asphyxiation/strangulation more prevalent in SH (35.6% versus 16.3% in NSH) and gunshot in NSH (9.9% versus 3.8% in SH).

There was a paucity of information about the exactly body position after the death in both crimes. Considering body placement we have a little bit more information and the most common was the body being completely exposed (45.4% in NSH, 46.4% in SH). The main differences in SH group were: in the water (10 cases) and concealed (17 cases). The NSH group left the body undisturbed in 21 cases. In SH it only happened in 1 case.

The neighbourhood where victims were found were more commonly residential (73.4% in SH, 51.6% in NSH). In SH the body was much more frequently found in parks and uninhabited places than NSH. The method of entry to the body recovery scene was similar to the crime scene, open building places were more frequent in NSH and less frequent in SH. In NSH, offence scene and body recovery scene usualy are the same. The other characteristics of body recovery scene were similar to the crime scene with more deserted, non-visible and non-audible places than in SH. In NSH, the victim was more likely to be recovered from a private residence or public place.

Continuous variables

There were few continuous variables and the differences found between the two groups were the total items in SeSaS scale and the total history of prior sexual offences, which were significantly more common in SH (see table 5). Variables with an odds ratio higher than one show greater propensity in relation to sexual homicides. Those with a lower odds ratio than one show a greater propensity for non-sexual crimes.

Table 5. Quantitative variables

	Sexual				
	No		Yes		
	Median	Interquartile range	Median	Interquartile range	*P*
Ch prior total	1.00	3.00	2.00	7.00	0.021
Ch sex total	0.00	0.00	0.00	0.00	< 0.001
Sesas total	1.00	2.00	3.00	3.00	< 0.001

Logistic regression models

Logistic regression can help in 'predicting' the grouping (dependent variable). In our study the goal is to predict whether a homicide is a SH or NSH, based on various independent variables (regarding the offender, the victim, the offence scene and the body recovery scene). We decided to separate the independent variables into 4 relevant domains and then perform the regressions: 1-Offender demographic/ lifestyle and other characteristics. 2-Victim demographic/ lifestyle variables and relationship with the offender. 3-Offence Scene-related variables. 4-Body recovery scene-related variables.

Logistic regression models grouping variables by offender, victim, offence scene and body recovery scene

The first model included the variables in Table 6 that presented up to 50 missing data, generating a model with n = 229. This model was significant ($p < 0.001$) and has a Cox and Snell R2 of 0.579 and a Nagelkerke R^2 of 0.774. The second model included variables in Table 7 with up to 50 absent cases, whose number was 278 aggressors. This model was also significant ($p < 0.001$), with an R^2 of Cox and Snell of 0.250 and an R2 of Nagelkerke of 0.334. The third model included the variables in Table 8 with up to 50 missing data (n = 166). The model was also significant ($p < 0.001$) with a Cox and Snell R^2 of 0.519 and a Nagelkerke R^2 of 0.729. The fourth model included variables in Table 9 with up to 50 missing data, whose number was 221 aggressors. This model was also significant ($p < 0.001$), with an R^2 of Cox and Snell of 0.545 and an R^2 of Nagelkerke of 0.728. The last model included the selected variables from the 4 subdivisions (n = 177) and it´s in table 10. The fifth model was significant ($p < 0.001$) with a Cox and Snell R^2 of 0.666 and a Nagelkerke R^2 of 0.896, explaining between 66.6% and 89.6% of the variance of the results for the type of homicide. In the first regression, the variables analysed were the one´s related to the offender profile. When the murderer has a party lifestyle, approaches the victim in a blitz attack, surprise attack or 'con attack', commits unusual acts, takes items from victim, has history of antisocial behaviour and demonstrates item 7 from SeSaS (Level of violence excessive of degree needed to control victim) these predict SH rather than NSH. This probability also increases if the offender does not: have a history of burglary, domestic violence, mental health diagnosis and item 6 from SeSaS (Mutilation of other body parts).

The second regression considered the characteristics of the victim profile to predict sexual homicide. The results showed that, if a homicide victim, at the moment of the crime was engaging in: dating, visiting friends/family or working, those predict sexual homicide. On the other hand, if the victim lifestyle includes frequent use of drugs and the relationship between the victim and the murderer is classified as a domestic relationship or an acquaintance the probability of sexual homicide decreases.

The third regression used crime scene variables potentially useful in investigations. There appears to be a greater chance of sexual homicide in the following circumstances: when the homicide happens in any living quarters, and at the same time, there is more than one crime scene, when the duration of offence is more than one hour, when the cause of death includes asphyxiation or strangulation, if the victim wasn´t dressed, if the scene wasn´t audible and it wasn´t the offender's residence.

The fourth regression showed a model which considered the body recovery scene. A deserted and inaudible scene where a victim was found disrobed (partially or totally) suggested a higher chance of a sexual homicide. On the other hand, if the body of the victim is displayed it reduces the chances of a sexual homicide.

Our last model is a 'mix' of the 4 domains. It showed that if the victim and offender are strangers and the victim is working, if the offense duration is more than one hour, if the victim was disrobed, the crime scene was any living quarters and the body recovery scene is non-audible it suggested a sexual homicide crime. Burglary was not associated with this crime.

The multiple regression analysis is shown separately for each model in tables 6, 7, 8, 9 and 10.

Table 6. Logistic Regression – Model I.

	β	S.E.	Wald	df	*P*	Exp(β)	CI 95%	
							Inferior	Superior
Offender lifestyle party	1.975	0.742	7.091	1	0.008	7.208	1.684	30.845
Offender approach con	3.423	0.876	15.283	1	<0.001	30.676	5.513	170.687
Offender approach surprise	2.789	0.682	16.745	1	<0.001	16.270	4.277	61.889
Offender approach blitz	2.629	0.640	16.849	1	<0.001	13.861	3.950	48.640
Acts unusual	4.080	1.270	10.328	1	0.001	59.167	4.913	712.569
Sesas6	-3.264	0.941	12.036	1	0.001	0.038	0.006	0.242
Sesas7	2.280	0.558	16.671	1	<0.001	9.779	3.273	29.218
Items taken	2.168	0.932	5.416	1	0.020	8.743	1.408	54.290
Criminal history of burglary	-2.694	0.895	9.073	1	0.003	0.068	0.012	0.390
Criminal history of domestic	-3.315	1.573	4.442	1	0.035	0.036	0.002	0.793
Mental health diagnosis	-1.218	0.541	5.072	1	0.024	0.296	0.103	0.854

Any antissocial behaviour	2.603	1.099	5.615	1	0.018	13.508	1.568	116.335
Constant	-5.159	0.952	29.391	1	0.000	0.006		

Note: Exp(β) = Exponentiation of the Beta coefficient; S.E. = Standard error; df = degrees of freedom; CI = confidence interval.

Table 7. Logistic Regression – Model II.

	β	S.E.	Wald	df	*P*	Exp(β)	CI 95%	
							Inferior	Superior
Victim lifestyle drugs	-0.820	0.399	4.232	1	0.040	0.440	0.202	0.962
Victim activity visiting	1.876	0.585	10.274	1	0.001	6.525	2.072	20.545
Victim activity date	1.813	0.604	9.012	1	0.003	6.129	1.876	20.022
Victim activity working	2.268	0.821	7.621	1	0.006	9.656	1.930	48.304
Victim and offender strangers	-0.946	0.434	4.751	1	0.029	0.388	0.166	0.909
Victim and ofender acquaintance	-1.617	0.371	18.972	1	<0.001	0.198	0.096	0.411
Elements involving domestic relationship	-1.680	0.357	22.184	1	<0.001	0.186	0.093	0.375
Constant	1.331	0.367	13.112	1	0.000	3.783		

Note: Exp(β) = Exponentiation of the Beta coefficient; S.E. = Standard error; df = degrees of freedom; CI = confidence interval.

Table 8. Logistic Regression – Model III.

	β	S.E.	Wald	df	*P*	Exp(β)	CI 95%	
							Inferior	Superior
Number scenes	1.270	0.501	6.430	1	0.011	3.562	1.334	9.507
Victim state dress	-0.407	0.174	5.464	1	0.019	0.666	0.473	0.936
Victim Cause of death	0.667	0.287	5.410	1	0.020	1.948	1.111	3.417
Duration of the offence	0.895	0.322	7.753	1	0.005	2.448	1.304	4.597
Offence scene audible	-2.814	0.667	17.793	1	<0.001	0.060	0.016	0.222
Offence scene living quarters	2.204	0.777	8.050	1	0.005	9.065	1.977	41.559
Offence scene residence	-1.892	0.781	5.872	1	0.015	0.151	0.033	0.696
Constant	-1.891	1.133	2.788	1	0.095	0.151		

Note: Exp(β) = Exponentiation of the Beta coefficient; S.E. = Standard error; df = degrees of freedom; CI = confidence interval.

Table 9. Logistic Regression – Model IV.

	β	S.E.	Wald	df	*P*	Exp(β)	CI 95%	
							Inferior	Superior
Victim disrobe	1.706	0.333	26.293	1	<0.001	5.508	2.869	10.574
Body recovery	1.263	0.493	6.572	1	0.010	3.536	1.346	9.286

scene deserted								
Body recovery scene audible	-2.476	0.460	28.948	1	<0.001	0.084	0.034	0.207
Body recovery displayed	-1.553	0.540	8.274	1	0.004	0.212	0.073	0.610
Constant	0.407	0.438	0.862	1	0.353	1.502		

Note: Exp(β) = Exponentiation of the Beta coefficient; S.E. = Standard error; df = degrees of freedom; CI = confidence interval.

Table 10. Logistic Regression – Model V.

	β	S.E.	Wald	df	*P*	Exp(β)	CI 95%	
							Inferior	Superior
Criminal History burglary	-5.875	1.694	12.032	1	0.001	0.003	0.000	0.078
Victim activity working	4.222	1.867	5.113	1	0.024	68.157	1.755	2646.968
Victim and ofender are strangers	4.190	1.238	11.449	1	0.001	66.017	5.829	747.621
Victim state dress	-0.817	0.274	8.911	1	0.003	0.442	0.259	0.755
Duration of the offence	1.689	0.554	9.299	1	0.002	5.417	1.829	16.044
Offence scene living quarters	1.855	0.896	4.290	1	0.038	6.391	1.105	36.968
Victim disrobe	1.234	0.382	10.441	1	0.001	3.434	1.625	7.259

Body recovery audible	-5.371	1.278	17.670	1	<0.001	0.005	0.000	0.057
Constant	1.822	1.276	2.041	1	0.153	6.186		

Note: Exp(β) = Exponentiation of the Beta coefficient; S.E. = Standard error; df = degrees of freedom; CI = confidence interval.

DISCUSSION

The current study investigated the differences between SH and NSH, considering aspects of offender, victimology, crime scene and body recovery scene characteristics. The two groups were totally matched by gender, mostly matched by age and state in Australia or New Zealand where the crime occurred in order to homogenise the sample.

The bivariate analyses showed very relevant information with differences in offender and victim lifestyle in each group, offender approach and victim activity before the crime. The cause of death (strangulation/asphyxiation), overkilling, presence of sadistic behaviour, the use of multiple weapons and history of any sexual offence were significantly more frequent in SH.

The logistic regressions were performed within the 4 dimensions described and then a fifth regression was performed to unify the previous four in order to find a general model. All regressions were significant and the last of them, as an example, showed that in the event of a homicide in which, concomitantly: victim and aggressor do not know each other, if the duration of the offense was longer than one hour, if the victim was working moments before the crime, whether the crime scene was a room or accommodation (environment used to sleep) and whether the victim was found naked, in a place where it would not be possible to hear the victim, it´s probably a sexual homicide.

Consideration of findings in light of previous research

a) Offender characteristics

The SH offender´s profile was clearly differentiated in relation to the NSH offender. The profile of SH showed predominant characteristics of: caucasian ethnicity, employed, single and heterosexual (although more likely homosexual than NSH. The NSH were caucasian, employed, heterosexual but often married. This is corroborated in other studies (Chan, Myers, & Heide, 2010; Milsom, Beech, & Webster, 2003; Proulx et al., 2007) where there was a higher prevalence of sex trade workers, bisexuality and homosexuality in the SH offender´s group. Paraphilia was described in only 8 SH, which is

underestimated, because that information wasn´t often available in our databases. But unsurprisingly, none of the cases in the NSH group had any paraphilia described. Chan and Beauregard, 2015, found significantly more deviant sexual fantasies in SH when compared to NSH. Another difference noted in our data is the offender living situation: SH offenders rarely lived with children, even those with a spouse. Living alone or with parents was more common, too. In the NSH group, living with spouse and children is the 'rule', clearly. This fits with previous research showing that social isolation is more common in SH (Grubin, 1994; Proulx et al, 2007; Oliver et al, 2007).

Considering mental health conditions, we found substance abuse disorders more prevalent in NSH then SH. More than one mental health condition was also more common in NSH. Psychotic disorders were infrequent in the 2 groups (6 cases in SH and 1 in NSH). Major Mental Illness, found in 21.9% in SH and 15.9% of NSH, was similar in prevalence. We´ve considered as Major Mental Illness the most relevant disorders in Psychiatry, such as Schizophrenia and Bipolar Disorder, which usually manifest psychotic symptoms. The Psychotic Disorders group included some other illnesses, such as those with psychotic symptoms induced by drugs or alcohol. The not guilty sentence due to mental impairment was significantly more frequent in NSH (7.4%) than SH (1.7%). As explained in the beginning of our study, we experienced difficulties in the coding process with significant variability in the information available in reports, but even considering this, the results contradicted the common sense concept, in the lay imagination, that sex offenders are generally mentally ill. There are some studies, specific to sexual offences as well as general violence that show that criminals are not usually mentally ill (Alden et al, 2007; Valença et al, 2015; Oliveira et al, 2017). The findings of not guilty sentence due to mental impairment indicate, in NSH cases, that illness more often drove NSH offending than SH. The findings of substance misuse are consistent with NSH cases being more generally criminal.

The information of childhood experience showed important findings. Adverse childhood experience was not highly prevalent in either group, but under reported in our databases. Analysis demonstrated that NSH offenders usually suffer more than one condition of adverse childhood experience, compared to SH. Considering the related specific adverse childhood experiences analysed separately, we found some specifics in SH:: Sexual abuse on its own (12 cases) and neglect on its own (6 cases) were more frequent than in NSH. However, we cannot confirm any relevant association because collecting data coded in this way and with a low incidence may prejudice results. Milsom et al., 2003; Briken, Habermann, Brewer, & Hill, 2005; Nicole & Proulx, 2007; cited a higher incidence of violence in childhood, but lower incidence of sexual abuse.

The offender lifestyle wasn´t often described. But we found a big difference in "party lifestyle". 30 SH offenders were described this way, whereas only 13 of the NSH group. Chopin & Beauregard, 2019, describe SH as either more engaged in social activities or lonelier persons compared to NSH. This paradox in behaviour types possibly demonstrate that within the SH group there are specific subgroups of profiles.

When we studied acts involving the crime and planning, we saw lots of differences involving the 'approach'. It is clear that 'blitz attack', surprise attack or convincing the victim as a 'con attack' are much more common in SH than NSH. Beauregard and Martineau, 2012, found that ‘con attack’ was most frequent in SH, which differs from our research. We do not agree with a general ‘prototype’ of a sexual murderer as an introverted socially inept offender as described by Grubin, 1994. For example, our research showed more frequent blitz and surprise attacks in the SH group, but con attack was also more specific to SH then NSH when comparing each other. We possibly have different SH profile subtypes. Perhaps, con, blitz and surprise attacks aren´t the usual modus operandi from NSH, especially because they´re usually an intimate partner or familiar and may have other descriptions of approach.

Acts described as unusual, ritualistic, overkill or expressive were more common in SH. Specific acts such as the use of restrains and redressing the victim despite not being frequent, looked specific to SH offenders. Unsurprisingly though given the nature of sexual murder. This pattern would suggest that SH try to use some kind of intimate method of killing that requires close contact with the victim. Overkill in this group is described in many studies (Beauregard & Martineau, 2012; Chan & Heide, 2009; Stefanskal, Higgs, Bishopp, & Beech, 2015).

When analysing those crimes with the Sexual Sadism Scale (SeSaS), it is very clear that sadism is much more prevalent in SH. When we consider the comparison between items not specific to sexual crimes (SeSaS items 2, 3, 4, 6 and 7), most of these are still more frequent in SH. The exception is item 6, (mutilation of non-sexual body parts) which is more common in NSH. Torture (item 3) was similar in the two groups. Other researchers have described sadism in sexual homicide. Darjee (2019) studied the associates of sadism and psychopathy in SH and found that those characteristics were linked to aspects of SH. The sadistic characteristics in SH are well established in many studies (Reale, Beauregard, and Martineau 2017; Darjee and Baron, 2018; Chopin K. & Beauregard E., 2019) and confirmed in our research.

We found that personal items from victims were more often taken in SH than NSH. We could not specify the items taken as a 'trophy', like classically explained by some authors where offenders develop ‘unique collections of artefacts that link them to their victims’ (Warren et al, 2013). But, considering taking personal items, generally, even including robbery, this was still more frequent in SH. As the descriptions of the crime and its dynamic in the source material accessed were not often done by specialists, we lack this specific information. As such, taking personal items is more common in SH. The use of multiple and different types of weapons was also more common in SH. On the other hand, taking precautions to not be caught and removing the weapon from the crime scene were more frequent in NSH. Beauregard & Martineau, 2013, found high incidence of precautions in SH (more than half), in our research we found 38%, and significantly less than in NSH. These authors used specific police data which probably had more detailed information on these specific characteristics than ours.

In terms of history of criminal convictions, no specific crime, property offences, burglary and domestic violence were all more frequent in NSH. The SH had more past convictions for any sexual crime. Briken, Habermann, Kafka and Berner (2006) and Oliver et al. (2007) found that at least one third to one half of SH had a history of convictions for sexual offences, especially rape. These results are consistent with the literature which show us that SH are closer to sexual offences than to other homicides (Chopin and Beauregard, 2019; Skott, Bauregard and Darjee, 2018). The homicides motivated by vengeance and in the context of an emotional setback were much more frequent in NSH. The SH group had less suicide attempts by the offender and less often turned themselves in to police. Attempts at suicide are very rare in SH offenders and, Skott, Bauregard and Darjee (2018) also found a big difference when compared to the NSH group.

SH offenders have higher rates of childhood antisocial behaviour and any antisocial behaviour in their lives than NSH. All of the SH described as antisocial in this research had a past history of antisocial behaviour in their childhood. This information is consistent with other research (Häkkänen-Nyholm et al, 2009; Chopin and Beauregard, 2019).

Victim characteristics and relationship with the offender

While studying the victim characteristics and their relationship with the offender we found that the more common race in both groups of victims was caucasian, with a higher proportion of caucasian victims in the SH group. There are differences between the groups regarding occupation. The SH victims were usually employed (50% of victims). Only 10% were unemployed. Eleven victims were 'sex trade

workers', which seems to be a risk factor for sexual homicide. None of the victims of NSH were sex workers. Victims who also work as sex workers, even secondary to other occupations, were at least 12% of all SH victims, thus confirming the risk of this occupation. Brewer et al, 2006, showed the increased risk of being a victim of a SH when engaged in a prostitution activity, also showed by Quinet, 2011; Salfati, James and Ferguson, 2008.

The SH victims lived with another adult or alone. The NSH victims also lived with an adult or with an adult and children. Just 17% of the SH victims lived with children, but 39% of the NSH victims lived with children. Chopin & Beauregard, 2019, described that SH victims usually live with a partner or with parents. The same authors also found lower rates of use of psychoactive substances in SH victims. In our research, we found similar results, with fewer SH victims using drugs than NSH victims.

The activities that the SH victims were involved in at the time of the crime were significantly different from NSH. The SH victims were visiting friends or family, dating, working, or involved in prostitution. No specific activity was found as more common in NSH victims. Beauregard and Martineau, 2012, found domestic activities as the most frequent by the SH victims. According to Chopin & Beauregard, 2019, SH victims are more likely to be attacked while playing or jogging/walking. Our research findings contradicted this. We found specific victim's activities in SH, which could help in analysing homicides. As police or researchers understand those activities as a SH pattern, they could take these elements into consideration and point investigations in that direction.

When the relationship between the victim and the offender was studied across both groups, victims and offenders tended to know each other. Despite this, being complete strangers was more common in the SH victims. Being in acquaintanted, familial, intimate or in any domestic relationship was more frequent in NSH. Meloy (2000); Roberts & Grossman (1993) described SH victims as strangers or casual acquaintances of the offenders. According to Beauregard & Proulx, 2007, some male victims were a 'target'. In our research we did not do a comparison between the gender in each group and cannot corroborate this. What we found was that victims were 'targeted' (the offender had decided before the crime to kill the specific victim) in the 2 groups (57.7% in SH, 72.5% in NSH), but significantly more frequently in NSH.

Offence scene-related variables

The study of offence scene variables produced findings that may be relevant to criminal investigations. The neighbourhood where the two groups of homicides happened were more frequently

residential (69.8% in SH, 80.9% in NSH). Despite this, there were differences, specially involving parks and uninhabited places, which were more common in SH. Deserted places (45.5% in SH, 4.4 in NSH), not audible and not visible places were also more common in SH. The offence scene being a residence was the most common in both groups, but much more frequent in NSH. A public scene was not very frequent, but more common in NSH. NSH were usually committed in just one crime scene (81.0%). SH more often had more than one crime scene (43.6%) compared to the NSH group (19%). Previous research supports this (Chopin et al, 2019; Darjee & Baron, 2018). However, Abrahams et al, 2017, did not find differences between SH and NSH in this aspect. Possibly, the increase in crime scenes and outside and desert locations to SH should show that these offenders are more often staying for a long time with their victims and may kidnap them and stay in an inaccessible place. This was also described in sadistic offenders (Hazelwood, Dietz and Warren, 2001).

The way the offender accessed the offence scene was usually related to where they also lived or worked, but we found greater incidence of the victim allowing entry (28.9%) and also forced entry (14.5%) in SH when compared to NSH (14.7% and 6.9%). This makes sense when we look at the profiles of the offenders who utilised the surprise or con attack. Beauregard & Martineau, 2013; Grubin, 1994 described forced entry as very frequent, contrary to our research.

When we analysed weapon use, we found a similarity, in that knives were used in about a third of both groups (31.9% in NSH, 38.9% in SH). But there were some specific differences. SH involved multiple weapons more often (31.9% against 11.3% in NSH). The use of bludgeoning tool and ligature were much more frequent in SH. In NSH, the use of firearm was more frequent than SH. These findings accord with the concept of SH offenders using more ‘personal and close contact arms’ (Chan HC &, Heide KM, 2008). The use of firearms occurred more often in NSH according to Beauregard and Martineau, 2012; Chopin & Beauregard, 2019, which was confirmed in our study.

The duration of the offence was very different between the groups. In 83.5% of NSH it was described as during less than 1 hour. In most of all SH the duration of the offence was between 1-3 hours (76.2%). Offences that lasted more than 2 hours were also more frequent in SH (9 cases) than NSH (4 cases). We didn´t find this information in other comparative studies. We can hypothesize that sadistic murderers (as most SH offenders) would stay more time with their victims.

Body recovery scene-related variables

The body disposal method was another thing which differed between the groups. SH cases showed a tendency to leave the body without any concern or concealed to prevent its discovery. In NSH, the body was more often openly displayed and also with lack of concern, which facilitated body recovery compared to SH. Body disposal and even trying to modify the crime scene were more frequent in SH in the research of Häkkänen-Nyholm, 2009, Abrahms et al, 2017.

The victim state of dress when the body was found was unsurprisingly completely different between the crimes. In 73% of NSH the victim was fully clothed, which just happened in 4.9% of the SH cases. In this group, the clothes were completely or partially removed in 86.3% of all SH. This just happened in 4.2% of NSH. Moving up the clothes of the victims happened in 5 murders in the SH group and none of the NSH cases. Häkkänen-Nyholm, 2009; Chopin et al, 2019 described similar findings in their research.

Studying how the victim was disrobed we found that in most cases the victim disrobed him/herself (74.1% of SH) and the offender disrobed the victim less often (5.4% of SH). This finding was scarce in NSH, as expected as NSH doesn't involve undressing. There was one case where the victim disrobed herself in a NSH, in which the offender wanted to be sure that the victim hadn't had his money (the offender was a drug dealer).

The clothes of the victim were usually not hidden in both cases, but it was more frequent in SH as pointed out above. The body was usually displayed in NSH, but hidden in SH. The dismemberment and parts of the body moved were noted in 13.4% and 8.5% of SH. In NSH it happened in 2.1% and 1.4% respectively. That is an important difference that tends to confirm a potentially sadistic profile in SH, such as not giving themselves up and hiding the victim´s body. Chopin and Beauregard, 2020, described dismemberment and moving body parts maybe an aggressive and instrumental murderer.

The cause of death was significantly different between the two groups, particularly for asphyxiation/strangulation in SH (35.6% versus 16.3% in NSH) and gunshot in NSH (9.9% versus 3.8% in SH). Carter & Hollin, 2010, Beauregard and Martineau, 2012, had similar findings, because upclose and intimate method of killing.

We lacked information about the exact body position after the death in both types of crimes. Considering body placement, we had some information and the most common was the body being completely exposed (45.4% in NSH, 46.4% in SH). The main differences shown in the SH group were:

in the water (10 cases) and concealed (17 cases). The NSH group had the body undisturbed in 21 cases. In SH it only happened in 1 case. Those differences may confirm the pattern of more commonly sadism and anger in some cases with instrumental murder described in the profile of SH.

The neighbourhood where victims were found was most commonly residential (73.4% in SH, 51.6% in NSH). In SH the body was much more frequently found in parks and uninhabited places than NSH. The way used by the offender to go into the body recovery place was very similar to the crime scene, just with an increase of difference regarding open building places, more frequent in NSH and less frequent in SH. The other characteristics of body recovery scenes were similar to general crime scenes: more deserted, non-visible and non-audible places in SH. On the other hand, more residences and public buildings in NSH. Beauregard & Martineau, 2013, had similar findings.

Multivariate models

Multivariate models using logistic regression can help develop models that differentiate the types of homicide, which can potentially inform crime prediction and perhaps prevention. Considering the theme of our research, those models can help in understanding Sexual Homicide, particularly if they are studied and validated by other researchers. In our research we decided to separate all the variables in 4 domains and perform logistic regressions with the aim of understanding those domains in SH as compared to other homicides, as showed in the results.

In our research we didn't find much information about the crime scene or body recovery scene. Despite that, there are several relevant information about those. If future studies focus on this specific data information and have access, for example, to complete police records, they could possibly present more relevant models.

Our fifth model tried to predict a sexual homicide taking into consideration all the dimensions. We may intend to give more value to that model, but when we think about having more information in 'segmented' crime dynamics, to look at specific models, such as the four models described, could be very useful as a 'starting point' from where investigators or even a prevention programme would begin.

The concept of constructing models is relevant because it is an attempt to take research further and try to predict or even prevent SH, if we have more stable models from larger research, specially including many countries around the world.

Hill et al, 2012, conducted an organized study to validate the prediction of relevant instruments to predict the risk of recidivism in violence as Historical-Clinical-Risk Management-20 (HCR-20;

Webster et al., 1997), the Sexual Violence Risk-20 (SVR-20; Boer et al., 1997), and the Psychopathy Checklist-Revised (PCL-R; Hare, 2003) in a sample of 90 male sexual murderers in Germany. For the surprise of those researchers, the results were poor and were just significant enough to predict recidivism in isolated items and most of them related to NSH.

Possible explanations for these unexpected results were described in this paper: retrospective study design with missing information about influences during the long duration of detention and time after release, small sample size as well as the possibility that the risk assessment instruments investigated were valid only for general offenders and not to sexual murderers (Hill, et al, 2012).

Considering the idea to compare samples in different places and countries, Chopin & Beauregard, 2019, did an interesting comparison between SH in Canada and France. They´ve found differences in the two groups but the conclusion was that there are more similarities than differences. Sea et al., 2019, compared samples in Canada and Korea. Those groups also had similarities and differences, and most of the difference was explained due to cultural specificities. Another study conducted by James, Proulx, and Lussier (2018) compared samples of SH in Canada and France. As Chopin & Beauregard, 2019, some differences in the groups were also explained by different legislation, which facilitates the access to drugs for e.g., in Canada, SH offenders were more addicted than French SH. They´ve also found a more pathological sexually deviant profile in the French sample, which could explain other differences. The local culture was also considered.

Eric Beauregard, Matt DeLisi and Ashley Hewitt, 2017, performed regression models comparing non homicide sexual offenders (NHSO) and homicide sexual offenders (HSO) to try to predict differences between these groups. In conclusion, they found different criminal careers. NHSOs are more specialized in their criminal career, meaning that they present a higher number of prior convictions for sexual crimes when compared to all other crimes, whereas most SHOs start their criminal career early and commit a variety of crimes, with very few sexual crimes. This was different from other research in the topic, which found no differences in the previous criminal careers between the groups (Nicole & Proulx, 2007).

Häkkänen-Nyholm et al, 2009, conducted a study to understand homicides in Finland and the possible prevalence of SH. They´ve found that 2.8% of all homicide were SH. Studying offenders and victims' characteristics was the first study to perform a logistic regression comparing SH and NSH. The

history of sexual crimes and mental health treatment/care contact before age of 18 were the two significant variables found by those authors.

Chopin and Beauregard, 2019, conducted a comparative study between sexual homicide, nonsexual homicide and violent sexual assault using a French national police database. They also performed logistic regression, which showed SH are more likely to target a female victim, single or living with a partner. The SH occurred frequently when the victim was playing prior to the crime, and they were less likely to occur if victims are performing domestics activities if compared to NSH. The SH offenders are male, stocky and presents evidence of some paraphilic disorders, sexual collections, and sexual dysfunctions. They´re also less likely to be engaged in social activities, use psychoactive substances, and engage in criminal activities when compared to NSH. Considering the modus operandi, SH offenders are usually strangers to the victim and more likely to use con or surprise approaches when compared to NSH. SH offenders commit their crime in a residence or at an entertainment location when compared to NSH. The SH victims have a higher risk to be beaten, stabbed, or asphyxiated. SH offenders are less likely to use their weapon intentionally, to destroy or remove evidence. They are also less likely remove the weapon from the crime scene when compared to NSH offenders.

Skot, Beauregard and Darjee, 2018, conducted an analysis with a large comparison between male sexual homicide offenders and nonsexual homicide offenders in Scotland. The first regression showed offender characteristics and found that: being employed, aged between 16-30 years and non-white skin were more frequent in SH. The second model included victim characteristics and the third model included both characteristics from offenders and victims and it showed, contrary to the previous model, that: age and employment were no longer significant predictors. Non victim characteristics were significantly different between the groups. Offenders who targeted strangers and destroyed evidence at the crime scene and were not white were tipically sexual homicide

Conclusion

The current study compared two groups of offenders: sexual homicide and nonsexual homicide. Our findings have revealed that there are important differences between these groups. As found in recent research, ours also suggests that the sexual homicide offender is a distinct type of offender, different from homicide offenders and non-homicide sexual offenders.

We believe that it is necessary to investigate sexual homicide further and gain a deeper understanding into existing subtypes. The models are an interesting and promising instrument to

understand sexual homicide and then improve our management, treatment and possibly development measures, which could prevent it. Including by the development of adequate risk assessment instruments and security placements, helping police investigation of sexual homicide and offering specific treatment programmes to this population.

Limitation of the study

Our research has some limitation, which include lack of information, not having full access to records, not interviewing the offenders directly and not having consistent data available (for example for different jurisdictions). Our data only considered offenders in Australia and New Zealand so they may not generalise to other populations around the world. We could not consider the differences between the subtypes of sexual homicide, which certainly can influence the analyses. Constructing models is a promising strategy, but still quite new.

Implications for theory, practice and future research

The development of several models can be a strategy to extend the knowledge and deepen the study of sexual homicide offenders. We need to clarify that models are not applicable yet, but they may help investigations and new researchers on this topic. Our research found some new information and we could describe at least 5 models that try to predict sexual homicide, considering 4 different aspects. The good news is that all of those models found more information than previous research in the theme that used this concept.

Cluster analyses for sexual homicide offenders

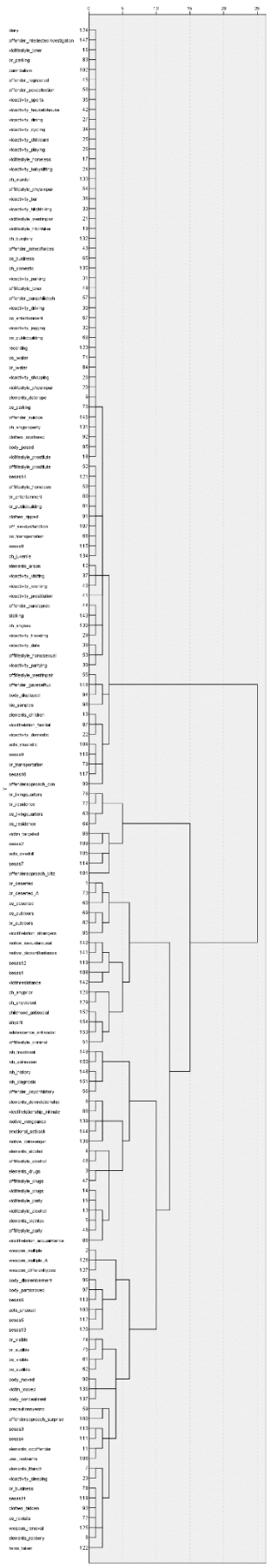
There are a few publications and models of different types of sexual offenders. A very well-known study empirically classified them as sadistic or non sadistic (Langevin et al., 1988; Proulx et al., 2007, Reale, Beauregard, & Martineau, 2017; Stefanska, Nitschke, Carter, & Mokros, 2019).

Sewall, Krupp and Lalumière, 2013, proposed a classification, based on some coded profile characteristics and tested using information from a website with SH information. They found different clusters and then proposed a model considering 3 different subtypes: competitively disadvantaged, psychopathic, and sadistic offenders. It is an interesting effort to try to test using different data sources if we are able to achieve more specific and not totally empiric classifications.

Considering the possibility to go further in our research, deepen the study of sexual homicides and apply models to explore them, we concluded the analysis in this research by presenting an initial

study of sexual homicides profile and found some specificities. A cluster analysis was performed with the 142 sex homicide offenders, using a dendrogram applying the Ward's method and measuring the quadratic Euclidean distance. In this analysis, only the binary variables were inserted.

Figure 1. Cluster analysis. Dendrogram using Ward's connection.



Studying specific characteristics of the sexual murderers' group as shown in the dendogram can provide valuable information about these offenders. By analysing and studying them, we can observe similarities and differences, which, with further exploration, would be able to reveal that there are probably specific profiles within the sexual murderers' group, considering; victimology, crime scene, body recovery scene and specificities in the offender´s profile. This point should be an important area of further research.

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7. CONCLUSÕES

Esta pesquisa, por meio de redação de artigos científicos, analisou relações entre a psiquiatria, o direito e a violência, produzindo conhecimento técnico e científico, permitindo-se, assim, reflexões nesse eixo temático.

A revisão de literatura sobre transtornos mentais, violência e institucionalização prolongada foi realizada e os trabalhos analisados, dividindo-os em dois grupos: "Estudos relacionando fatores ligados à predição/risco de violência e institucionalização" e "Estudos relacionando risco de violência e desassistência/desinstitucionalização". Verificou-se que a doença mental isoladamente não é fator diretamente associado ao maior risco de violência e que fatores relacionados à própria institucionalização e à assistência com privação de liberdade influenciam a predição de violência. Concluiu-se que abordagens humanizadas, multiprofissionais e com equipe treinada, aliadas ao gerenciamento dos reais fatores de risco de violência, contribuirão para uma melhor assistência e menor necessidade de institucionalização.

O estudo dos indivíduos institucionalizados na Casa de Passagem do Instituto de Saúde Mental revelou um perfil de indivíduos homens, com idade média de 47,6 anos, solteiros, com baixa escolaridade e pouca qualificação profissional, procedentes do sistema prisional ou de clínicas e hospitais psiquiátricos de longa permanência. Grande parte desses indivíduos estava em polimedicação, com histórico de comportamento violento e predominantemente tiveram diagnóstico psiquiátrico de psicose, sendo a Esquizofrenia o diagnóstico mais frequente. Dois itens se mostraram altamente relacionados a um maior tempo de institucionalização, com significância estatística: a polimedicação e o antecedente de internação por comportamento violento. A análise desse tipo de população se mostrou fundamental para agregar conhecimento sobre a mesma e, especialmente, fomentar políticas públicas visando melhorar a assistência em saúde, que deve ser ampla, humanizada, multiprofissional e de qualidade, com o objetivo de reduzir as internações prolongadas e, quando necessárias, torná-las adequadas e humanizadas.

O estudo dos casos de homicídios contra familiares que foram cometidos por pessoas com transtornos mentais revelou os seguintes diagnósticos nos agressores: Transtorno Afetivo Bipolar com sintomas psicóticos, Esquizofrenia Paranoide e Transtorno de Personalidade Borderline com comorbidade de uso de substâncias. Os dois primeiros foram considerados inimputáveis, enquanto o terceiro foi considerado semi-imputável, de acordo com a decisão judicial, embasada por laudos psiquiátricos forenses. A justiça determinou medida de segurança com tratamento psiquiátrico

obrigatório para os três casos. A discussão da imputabilidade penal de indivíduos com transtornos mentais é um desafio para o Direito, a Psiquiatria e a Sociedade. O tratamento adequado é obrigatório para a prevenção de crimes envolvendo transtornos mentais, conforme a literatura científica. A verificação da imputabilidade penal é essencial para o encaminhamento adequado das pessoas em qualquer sistema jurídico do mundo, protegendo assim os direitos humanos e garantindo-se o tratamento psiquiátrico para aquelas que necessitam.

A análise de laudos psiquiátrico-forenses de verificação de cessação de periculosidade no Instituto de Medicina Legal do Distrito Federal revelou que os itens mais considerados pelos peritos nessas avaliações forenses foram os referentes à PCL-R, START e às partes não estáticas da HCR-20 e da TTV. Para a não cessação de periculosidade, os itens com significância estatística foram: presença de autoestima inflada, mentiras patológicas, ausência de remorso, afeto superficial, insensibilidade, frágil controle comportamental, comportamento sexual promíscuo, problemas comportamentais precoces, faltas de metas realísticas a longo prazo, impulsividade, falha em assumir responsabilidades, delinquência juvenil. E para a cessação de periculosidade, tiveram significância estatística os itens: presença de habilidades sociais, presença de relacionamentos, estado emocional equilibrado, presença de controle dos impulsos, ausência de gatilhos externos, presença de suporte social, presença de recursos materiais, atitudes organizadas, aderência a regras, conduta não conflitante com a lei, boas estratégias de enfrentamento, tratabilidade do transtorno, envolvimento com o tratamento e adesão. A sistematização e a padronização das perícias psiquiátricas criminais necessitam ser bem estabelecidas e o uso de instrumentos organizados para a avaliação de risco são fundamentais para apoiar uma correta decisão do perito quanto à cessação ou não cessação da periculosidade.

A atualização de literatura realizada revelou que as consequências do isolamento social frente à pandemia e da violência sexual contra as mulheres mais descritas na literatura foram: redução dos seus direitos reprodutivos, crise econômica provocando exploração sexual, "encarceramento" forçado no domicílio por parte de parceiro violento e aumento da agressão sexual contra mulheres que já mantêm relações íntimas com parceiros violentos. Houve, ainda, um aumento do abuso cibernético em crianças, especialmente em meninas, devido ao aumento do uso da Internet sem a supervisão dos pais. Também foi descrito um enorme desmantelamento de vários centros especializados em atendimento a mulheres vítimas de violência em todo o mundo. O constrangimento e o medo de falar sobre a violência sofrida e denunciar aumentaram com o isolamento, visto que, no contexto pandêmico, há um menor contato com a família, amigos, rede

de proteção e o próprio sistema de saúde. É preciso sensibilizar governos, profissionais e a rede de proteção para proteger essas mulheres, oferecendo-se treinamento e capacitação de profissionais de saúde para identificação de casos suspeitos, para que se tente prevenir uma explosão de casos de traumas, violências, feminicídio e adoecimento psíquico nas mulheres.

O estudo comparativo de homicídios sexuais e não sexuais na Austrália e na Nova Zelândia encontrou informações relevantes como diferenças envolvendo esses crimes. 101 itens foram significativamente diferentes, conforme estudo estatístico detalhado. Itens marcadamente diferentes encontrados nesta pesquisa foram: o estilo de vida do agressor e da vítima em cada tipo de homicídio, diferenças em relação à abordagem do agressor à vítima; atividade da vítima antes do crime. A causa da morte (estrangulamento/asfixia), o assassinato brutal com excesso de violência ("*overkilling*"), a presença de comportamento sádico, o uso de múltiplas armas e o histórico de alguma ofensa sexual prévia foram significativamente mais frequentes nos homicídios sexuais. As regressões logísticas foram realizadas conforme as quatro dimensões descritas e, em seguida, uma quinta regressão foi realizada para unificar as quatro anteriores a fim de encontrar um modelo preditivo geral. Todas as regressões foram significativas e a última delas, que visou criar um modelo preditivo geral, mostrou que, no caso de um homicídio em que, concomitantemente: vítima e agressor não se conheciam previamente, a duração do crime foi superior a uma hora, a vítima estava trabalhando momentos antes do crime, a cena do crime foi um quarto ou alojamento (ambiente/cômodo utilizado para dormir) e a vítima foi encontrada nua, em um local onde não seria possível ouvir a vítima, provavelmente, trata-se de um homicídio sexual, segundo o modelo preditivo obtido. Uma análise específica dos homicídios sexuais, em que semelhanças entre os perfis de assassinos foram agrupadas graficamente através da figura chamada dendograma, sugeriu fortemente que há perfis específicos dentre os homicídios sexuais, reforçando a ideia de uma tipologia dentro do grupo. Acredita-se ser necessário aprofundar cada vez mais a análise dos homicídios sexuais, em especial a esses subtipos, de forma a promover a validação da sua tipologia, o que pode vir a contribuir para a sua identificação precoce e até possibilitar prevenção desses crimes, com o aperfeiçoamento desses modelos.

Esta pesquisa concluiu que a relação entre a psiquiatria, o direito e a violência pode ser explorada e interpretada sob diferentes vertentes, desde os processos de institucionalização e o estudo dos fatores associados ao risco de violência nos indivíduos com doença mental, às repercussões na saúde psíquica e na violência contra a mulher, seja no contexto de isolamento social, seja no estudo dos homicídios sexuais. Não é objetivo encerrar essa ampla temática ou

chegar a alguma conclusão definitiva sobre a mesma, mas sim fomentar conhecimento técnico-científico e promover reflexões em áreas intimamente relacionadas, mas, muitas vezes, analisadas e estudas de modo independente.

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