Homicidal Ideation in Youth With Attention-Deficit/Hyperactivity Disorder

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Large-scale homicides and mass shootings are increasingly prevalent in the United States. While a complex interplay of personal and social motivations drives perpetrators, public attention often turns to the role of psychiatric illnesses. Child psychiatrists are often called to assess, predict, and mitigate the risk of violence among youth. We present the case of a 14-year-old patient with attention-deficit/hyperactivity disorder (ADHD) and major depressive disorder (MDD), admitted for homicidal ideations with plans to murder 26 people. We will discuss the approach to adolescent violence assessment, along with management strategies that address both psychosocial factors and comorbid mental illnesses.

Case Report

Ms A, a 14-year-old girl with a history of *DSM-5*–defined ADHD and MDD, was admitted to the psychiatric ward of the hospital in February 2021 for escalating homicidal ideation, culminating with thoughts to stab family members and murder 26 strangers. On a few occasions, the patient had to physically remove herself from family due to the intensity of thoughts to harm them. Between November 2020 and February 2021, the patient had 3 hospitalizations for homicidality. Ms A reported an extensive history of depressed mood, anxiety, inattention, and aggression since elementary school. This contributed to poor peer relationships (due to physical fights) and learning difficulties, as well as active suicidality and self-harm behaviors starting at age 10 years. The patient's early life was notable for disturbed attachment due to alleged physical abuse by her mother and her mother's boyfriends, as well as alcoholism in her father.

During hospitalization, Ms A was started on methylphenidate 36 mg for ADHD. Escitalopram 10 mg was initiated for mood symptoms. Trazodone 50 mg was added to improve sleep. Home medication of aripiprazole 15 mg was continued for mood augmentation. The patient participated in group therapy (cognitive-behavioral therapy, dialectical behavior therapy) with a focus on emotion regulation. Family sessions were held to discuss communication and psychosocial stressors. After 2 weeks of hospitalization, the patient reported resolution of homicidality and was discharged back to current outpatient providers for therapy and medication management.

Discussion

Over the past few decades, violence among children and adolescents has become an increasing concern.[1] Although rates of juvenile violence have declined, mass shootings are now more common.[1] Child psychiatrists are often asked to evaluate youth expressing homicidality, with the goal of assessing their acute risk for violence and treating any comorbid psychiatric diagnoses that could contribute to aggression and impulsivity. This is a daunting task. The Structured Assessment for Violence Risk in Youth[2] is a 25-item questionnaire evaluating key risk factors for violence and aggression in youth. The case presented here highlights many such features, including disturbed attachment, trauma, and psychiatric illness. During hospitalization, our team worked to address multiple risk factors. Individual sessions provided support and education regarding trauma. Family sessions focused on improving communication and rebuilding relationships. Pharmacotherapy addressed comorbid psychiatric illness.

Several studies[3–5] highlight that treating comorbid psychiatric illness can reduce impulsivity and aggression. Stimulants can reduce aggression in youth with ADHD plus oppositional defiant disorder/conduct disorder[3] or ADHD plus proactive aggression and callous unemotional traits.[4] Stimulants improve mood and behavioral issues in chronically irritable youth with ADHD.[5] Once stimulant medication is optimized, adding an antipsychotic or α agonist can further reduce ADHD symptoms, oppositional behavior, and aggression.[6] Benefits of polypharmacy should be weighed against increased risks of adverse events, including metabolic syndrome with antipsychotics.[6] Family-based concordant treatment is also important.

Psychiatrists can never predict homicide. Yet, by systematically addressing psychosocial risk factors for aggression and treating comorbid psychiatric illness, we can hopefully mitigate a youth's risk of future violence.

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