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Posttraumatic Stress Disorder in Murderers

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ABSTRACT: Three case histories of men who suffered posttraumatic stress disorders after committing homicides are presented. These men were relatively young and had chaotic childhoods and minimal criminal histories. Each had killed a woman with whom he had a significant but intensely turbulent emotional relationship. The killings all occurred during altered mental states that were unrelated to the use of drugs or alcohol. The clinical significance and some of the medicolegal implications of this phenomenon are discussed.

KEYWORDS: psychiatry, posttraumatic reaction, homicide

Posttraumatic stress disorder is characterized by the onset of affective, autonomic, and cognitive symptoms following a psychologically traumatic event that is generally considered outside the range of usual human experience (DSM III). The disorder has been described among those who have survived natural, accidental, or deliberate assaults, and it is believed to be more severe and protracted when the trauma is of human design.

Those who commit murder may also suffer posttraumatic stress disorder if the killings occur in socially sanctioned settings [*1,2*]. This paper will focus on three cases in which men experienced posttraumatic stress disorders after murdering others. Some of the medicolegal implications and the clinical significance of this phenomenon will be discussed.

Case History No. 1

A 19-year-old white man was admitted to the maximum security unit of a state psychiatric hospital for a pretrial evaluation on a charge of murder. He had killed a young woman with a pocket knife during an apparent dissociative episode. He described the homicide as

> just like seeing a murder on TV and all of a sudden it stopped for a commercial. Time seemed to go very fast once I started stabbing her and could not stop. One minute I am stabbing my mother and the next minute I am standing there holding the knife and realizing that it's not my mom but a girl I've never seen before. She is all bloody and squirming in the seat. I start feeling horrible and panicked, thinking, 'Oh, my God, what have I done?'

He subsequently fled the scene and surrendered within 48 h.

This man was born and reared in a midwestern state. He described his mother as being possessive, domineering, and intrusive. During her periods of "going off," she would do very

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bizarre and inappropriate things. When she became active in witchcraft during his early adolescence, she tried to involve him in her "sex orgies". Although he successfully resisted involvement in those practices, he was physically beaten and abused by his mother and stepfather. At age 14, he and his siblings were placed in foster care because of repeated abuse. He freely admitted his hatred and anger toward his mother because of the mistreatment he suffered. He became "radically religious" during high school, and later enrolled in a fundamentalist Bible college to study photography. He had been in college for approximately two weeks at the time of the killing. He denied ever using alcohol or drugs.

During his stay in the maximum security hospital, he experienced emotional withdrawal, recurrent and intrusive recollections and nightmares about the killing, and extreme guilt. He had trouble sleeping, lost weight, and was observed to be depressed and suicidal. These symptoms gradually resolved over the course of approximately one year. Six years after the killing, he reported that he still had recurrent, intrusive recollections of the events, and occasional "bad dreams" about the killing.

Case History No. 2

A 21-year-old white man was sentenced to the state maximum security prison after being convicted of second-degree murder in the beating death of his wife. He also admitted to fatally beating his mother-in-law and throwing her body in a large river. Since her body was never found, he was never charged with that offense. The killings occurred in the context of an emotionally stressful marital breakup. The subject's wife repeatedly frustrated his attempts to gain visitation rights with his children, and he felt she was extorting money from him. At his wife's home one afternoon, an argument over seeing the children brought him to an emotional breaking point. He described the internal arousal of "basic animal emotion," and vaguely remembered striking her. As she lay on the floor having a convulsion, he went into another room, fed his infant son, played with him, and put him to bed. He described himself as feeling detached from the killing and the body, which he identified not as his wife, but as "a mess which was dangerous to my child." His mother-in-law unexpectedly entered at this point, and he recalled having an ill-defined sense of her being there. He threw her over his shoulder, breaking her neck. He took his wife upstairs and put her in the bathtub. He put his mother-in-law into a large cardboard container that he then stored in the car and later dumped into the river. He recalled greeting his sister-in-law as he left the house with the cardboard container. He felt assured as his sister-in-law entered the house because he knew she would not harm the children. He subsequently recalled feeling like something was wrong, telephoning his brother, and telling him about the incident. After disposing of his mother-in-law's body, he drove approximately 190 km (120 miles) to a small city. During that drive, he suffered a migraine headache and pulled off the road for awhile. Upon arrival, he telephoned several business contacts before returning to his apartment to sleep.

He reported being shocked when he was arrested and noted, "It took me years to reconstruct what happened. I couldn't even tell my lawyer what happened during the trial. When I tried to recall the events, I would get the shakes, have sweats, and my mind would say 'no.' I felt like it would kill me." He stated, "The trial was a fiasco; there was no truth involved in it. I was incapable of telling what happened that day. I tried to get a new trial but was unsuccessful."

While he was never abused as a child, his relationship with his poverty-ridden family was both difficult and extremely close. His mother's chronic illness made it necessary for him to work to support the family. At age 16, he married the victim because she was pregnant. After putting her through nursing school, he completed two years of college, majoring in chemistry. He had hoped to attend medical school, but quit college because of marital and financial difficulties. He felt close to his oldest son, whom he had reared while his wife worked. Marital problems escalated after his wife became pregnant with their second child, and they de-

cided to get a divorce after the baby was born. He quit school, worked to pay debts, and stopped sleeping with his wife. While she began to date other men, he attempted to continue the family activities.

He experienced repeated flashbacks and nightmares about the killings and felt "emotionally numb" for a long time afterward. As a result of his feelings of guilt and estrangement, he attempted suicide. These symptoms persisted in varying degrees for approximately two years.

Case History No. 3

A 21-year-old unmarried white man was interviewed for a pretrial psychiatric evaluation after he killed his grandmother. He fatally stabbed her during a psychotic episode that had gradually evolved over several weeks. He had been having ideas of reference, visual hallucinations, persecutory delusions, and auditory command hallucinations allegedly from the devil telling him to kill her or be killed.

During his childhood, his parents frequently separated and ultimately divorced. When he was eleven years old, his mother died of cancer, and he began living with her parents. His grandfather died four years later. His relationship with his grandmother, the victim, varied because she was upset over his drinking and bad grades. Although he became withdrawn and isolated after his mother's death, he became more sociable during high school and dated regularly. Despite above average grades in high school, he was "kicked out" of college because of bad grades. He then lived with his grandmother for four months, until she put him out of the house for drinking and not attending school. After spending nine months with his godfather, he returned to live with his grandmother and attended a local business college, until he again "flunked out" for not doing the work. During his subsequent unemployment, he relied on his grandmother's financial support until the killing.

He first began experimenting with marijuana at age 15, and began drinking alcohol at age 17. He also used LSD, amphetamines, hashish, and sedatives infrequently. He had not used drugs for two months and had stopped drinking several days before the stabbing.

Afterwards, he had recurrent and intrusive recollections of the killing. He had nightmares of the devil, but not specifically of the killing. He demonstrated decreased interest in his activities, estrangement from others, and a constricted affect. He described hyperalertness, sleep disturbance, and difficulty concentrating. He avoided activities that aroused recollections of the killing, such as reading murder mysteries. His symptoms were intensified by seeing murder stories on television.

Discussion

It has long been recognized that those who kill or seriously injure others in socially approved ways may develop posttraumatic stress disorder. Bartemeier et al [*1*] found that the killing of enemy soldiers was one of several factors leading to "combat exhaustion," a condition characterized by various symptoms, including increasing irritability, sleep disturbance, psychomotor retardation, withdrawal, "affective flattening," increased apprehension, fear, and confusion. Danto [*2*] observed nightmares, sleep disturbance, daytime flashbacks, emotional detachment, isolation, depression, helplessness, suicidal thoughts, and other symptoms among police officers who killed suspects. Both these symptom constellations are similar to those of posttraumatic stress disorder.

The subjects described in the preceding case histories suffered posttraumatic stress disorder following the murders they had committed. Several common factors are apparent in their histories, such as relative youth, minimal if any criminal history, chaotic childhood, and the real or symbolic killing of a woman with whom the subject had a significant but intensely turbulent emotional relationship. Two of these men killed during dissociative epi-

sodes and one during an acute psychotic episode. None of the men was under the influence of drugs or alcohol, but all experienced extreme emotional distress. The fact that all of these men had troublesome developmental histories is significant in light of Andreasen's [*3*] findings that preexisting psychopathology may increase the impact of certain stressors.

Although the stress undergone by combat soldiers and police officers who kill in the line of duty is considerable, murderers must cope with additional problems. Soldiers and police officers have the approval of their peers and superiors. While Vietnam veterans did not receive wholehearted support on the home front, they could at least turn to veteran support groups for help. In contrast, the murderer receives clear messages of social disapproval; criminal conviction represents the highest level of official stigmatization and societal rejection.

The killer is unlikely to receive support from peers in prison because of the "hang tough" milieu and his attorney's advice not to discuss the case.

Although combat killings may never be brought to the public's attention, the acts of police officers and murderers are likely to receive a great deal of publicity. Whereas the combat soldier and police officer are likely to kill strangers, the murderer suffering from posttraumatic stress disorder is likely to have killed a loved one. Because he is incarcerated, he has to mourn the loss of the victim without the ordinary support of family and friends.

The evaluating psychiatrist's failure to diagnose and treat posttraumatic stress disorder promptly in murderers may lead to injustices before and after the trial. The need to avoid discussing the crime to prevent self-incrimination reduces the likelihood that the disorder will be correctly diagnosed. The symptom of diminished concentration may interfere with competence to stand trial. There has been one reported case of a Vietnam veteran whose symptoms of posttraumatic stress disorder interfered with his ability to cooperate with counsel to such an extent that he was not considered competent to stand trial [*4*]. The defendant with this disorder may be more inclined to plea bargain rather than undergo the marked upset of reliving the experience at trial.

Confusion of posttraumatic stress disorder symptoms with those of other psychiatric diagnoses may lead to an incorrect assessment of criminal responsibility. Improper decisions regarding the release of insanity acquittees may also result from undiagnosed symptoms. Most states require that an insanity acquittee who continues to be dangerous because of mental disease be kept in the hospital. If the mental disease that led to the killing is in remission, such patients may be safely released. Persistent symptoms of posttraumatic stress disorder are clearly irrelevant to the commission of the original dangerous act because the disorder was induced by the homicide itself.

Unfortunately, these brief reports do not allow us to discern the influence of arrest, interrogation, criminal detention, or incarceration upon the course of the disorder. It is quite possible that some of these additional stressors could be sufficiently outside the range of usual human experience to actually cause a posttraumatic stress disorder. But, each of these killers experienced varying admixtures of their symptoms that were directly linked to their respective killings—for example, recurrent and intrusive recollections, nightmares, flashbacks, guilt; thoughts triggered by external stimuli; and avoidance of activities that aroused recollection of the killing. We therefore believe that the killing itself constituted the traumatic event.

We believe that identification of posttraumatic stress disorder among murderers will enable more appropriate evaluation and disposition of defendants. It may also facilitate appropriate treatment, reduce the presumably increased risk of suicide, and allow these prisoners to begin rehabilitation more quickly.

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