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The Grief Process in Those Admitted to Regional Secure Units Following Homicide

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ABSTRACT: Although there is considerable literature on grief and grief work, there have been few studies of the grief process in those who have killed someone. This paper reviews the scope of this problem in England and Wales and examines a number of issues in connection with the grieving process in those who have killed but, because they were found to be suffering from an "abnormality of mind" at the time of the offence, were found not guilty of murder. Increasingly, these patients are referred for treatment to Regional Secure Units, under hospital orders of the Mental Health Act of 1983.

KEYWORDS: psychiatry, homicide, mental illness, grief

Under English law (the Homicide Act, 1957, Section 2[i]), if a person kills or is a party to the killing of another, and is found to have been suffering at the material time from "such abnormality of mind (whether arising from a condition of arrested or retarded development of mind or any inherent causes or induced by disease or injury) as substantially impaired his mental responsibility for his acts or omissions," then that person will *not* be convicted of murder. In such cases, it is common for the person to be found guilty of manslaughter on the grounds of diminished responsibility and to be made the subject of a hospital order, under the Mental Health Act of 1983.

Traditionally, the maximum security Special Hospitals took these patients. However, since the recommendations of the Butler Report [*1*], there has been a slow growth of "Regional Secure Units" [*2*], which aim to assess and treat mentally disordered offenders in conditions of "medium security." This growth in the provision of medium security, combined with changes in the admission policy in Special Hospitals [*3*], has meant that only those individuals who are perceived as posing a grave and immediate danger to the public, should they abscond, are now admitted to the Special Hospitals. Increasingly, therefore, the Regional Secure Units are admitting patients who have been convicted of manslaughter.

This article reviews descriptive studies of both the offenders and the offences and draws upon the literature of normal and abnormal grief to suggest why these individuals may experience complicated grief reactions.

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The Offenders

Epidemiological work by Coid [4], drawing on a wide range of sources, indicates that in England and Wales more than 25% of homicides are committed by mentally abnormal offenders. This contrasts with countries with a high frequency of homicide (for example, the United States) in which the proportion of homicides committed by mentally abnormal offenders is small [4].

Although there is considerable annual variation in homicide figures, the overall trend is upward. In 1986 there were 610 recorded homicides in England and Wales [5]. In 1985, of 449 individuals convicted of homicide, 74 (16.5%) were found guilty of Section 2 manslaughter. Of these 74 cases, 36 received a hospital order and 10 were placed on probation supervision. These figures give some indication of the number of new patients convicted of manslaughter coming into contact with the psychiatric services each year. Between 1964 and 1979, Dell [3] reports that 15 to 23% of those males convicted of homicide were found guilty of Section 2 manslaughter. The percentage for females is much higher.

At an individual unit-based level, recent publications by Fraser [6] and Earp, [7] give figures for manslaughter ranging from 2.9 to 8.2% of all admissions to their respective Regional Secure Units. The author's own experience on one 22-bed ward of the Regional Secure Unit in the northwest of England indicates that, in a three-year period, 12.3% (ten) of the admissions were of patients who had committed a homicide.

Although it is difficult to obtain reliable diagnostic categories, patients convicted of manslaughter and admitted to Regional Secure Units have usually been diagnosed as suffering from a depressive or psychotic illness. Those diagnosed as suffering from "psychopathic disorder" more commonly go to prison or Special Hospitals. In Dell's study [3] the diagnoses of those convicted of manslaughter were as follows: 20% suffered from schizophrenia, 37% from depression, and 27% from personality disorder.

Many had received previous psychiatric treatment or had shown marked disturbance prior to the offence. Dell's examination of male offenders [3] indicated that 34% had received psychiatric inpatient treatment prior to the offence, and 9% had received psychiatric outpatient treatment prior to the offence. She also found that 34% had made suicide attempts *before* the offence.

The Offences

In contrast with homicides in the United States, few homicides in England and Wales are perpetrated with guns. In 1986 in England and Wales, sharp and blunt instruments were used in 50% of homicides, and hitting or strangulation were used in 32% [5]. Although figures are not available on the method of killing for those in Regional Secure Units, the author's experience suggests that these methods would also be common in the manslaughter group, with arson also common.

In 1986 the victim and the perpetrator were known to each other in 70% of homicide cases, which is in keeping with figures for previous years. Although there are no detailed figures readily available for manslaughter cases, Dell [3] reported that one half of the killings in her manslaughter sample took place in a home shared by the offender and victim. Manslaughter therefore appears to remain a predominantly family affair.

Grief and Homicide

Although there have been a large number of studies examining grief processes arising from a variety of contexts (for example, Parkes [8]) and some studies concerning specific grief reactions connected with homicide (Black and Kaplan [9] and Rynearson [10]), the author is aware of only one study (Fraser [6]) which has attempted to examine bereave-

ment in those who have killed. In view of this, research which has investigated normal and abnormal grief will be drawn upon to suggest why those who have killed when suffering from an "abnormality of mind" may suffer difficulties in their grief reactions.

Parkes [8], in a comprehensive review of the field, suggests that there are a number of factors which contribute to complicated grief reactions. Parkes [8] groups these factors under four general headings, and the factors are ranked under each heading in their approximate order of importance. These are detailed in Table 1 and should be considered with reference to the above data on offenders and offences. Each heading is briefly discussed here.

Type of Death

Clearly the very nature of homicide means that most of the cases dealt with in Regional Secure Units are heavily loaded with these factors. Even though the patients have been judged by a court to have been of "diminished responsibility," they usually hold themselves accountable and therefore blame themselves for their actions.

Characteristics of the Relationship

In the author's experience, both male and female patients have, almost without exception, killed either their own children or a spouse/partner, parent, or close relative. This suggests that these cases are likely to be heavily loaded with some of these factors.

TABLE 1—*Parkes's* [8] *summary of risk factors for complicated grief reactions.*

Type of death
a cause for blame on the survivor
sudden, or unexpected and untimely
painful, horrifying, or mismanaged
Characteristics of relationship
relationship "dependent" or "symbiotic"
relationship ambivalent
spouse dies
child under 20 dies
parent dies (especially mother) leaving child or children 0 to 5 or 10 to 15 years old
parent dies leaving older, unmarried adult
Characteristics of survivor
grief-prone personality
insecure, overanxious (with low self-esteem)
previous mental illness
excessively angry
excessively self-reproachful
physically ill/disabled
previous unresolved losses
inability to express feelings
Social circumstances
family absent or seen as unsupportive (lack of intimate other)
detached from traditional cultural and religious support systems
unemployed
with dependent children at home
low socioeconomic status
other losses (Kastenbaum [11] calls this "bereavement overload")

Characteristics of the Survivor

Again, the very nature of the offence means that many patient cases will be highly loaded with these factors. Most patients admitted have made a serious attempt at suicide following the offence, which may be an indication that some of these factors are operating. In addition, some patients seem to have learned not to express their feelings while held on remand, since this often leads to prison authorities considering them to be a suicide risk and placing them in an unpleasant strip cell. For men, expressions of negative emotion are also perhaps seen as signs of weakness in the prison culture and may therefore be suppressed.

Social Circumstances

The social circumstances of those who have killed change dramatically. They are removed from their families and other support networks by their incarceration. In a Regional Secure Unit it is likely that they will be a considerable distance from their former home. This, of course, presupposes that their families are still able to offer support to them in view of their offence, which frequently involves a member of the family. Even if the family remains supportive, they will almost certainly have difficulty finding ways to show this support, other than in practical ways, since they are likely to be grieving and coming to terms with the death themselves.

Other Factors Which May Complicate the Grieving Process

Clearly those who have killed score highly on many of the factors which are associated with complicated grief reactions. The losses which the patient experiences are sudden, multiple, and simultaneous, and such is the nature of the offence that he or she is unlikely to receive much support from traditional sources. Even the staff working on Regional Secure Units may at times have difficulty giving support to a patient who has killed a particular type of victim or used a particular method of killing.

The patient also has little access to the normal social expressions of grief found in mourning. He or she will usually be unable to attend the funeral, or make arrangements for it (including any plaque or headstone), and in most cases will not see the body after the homicide. Family members may not know whether to discuss the deceased, and if they do discuss the deceased, may not know in what terms to do so. The patient may also feel unable to talk about the deceased.

"Linking objects" (Volkan [*11*]) may not be available because they have been used as evidence, so the patient may have little at hand with which to focus the grieving process.

If the patient is suffering from a psychotic illness, the illness may interfere with the grieving process. If one accepts the importance of identifying and expressing feelings in grief work [*12*], then this interference could take place through the flattening or inappropriateness of affect associated with the illness. Neuroleptic medication may also have a flattening effect on the emotions and in a similar way interfere with the grief process.

In Parkes' [*13*] study of normal and pathological grief, one symptom alone was found more frequently than others in those experiencing abnormal grief—namely, "ideas of guilt and self-reproach." In cases of homicide, these ideas are often realistic and very prominent, which may explain the high proportion of suicides following homicide (West [*14*] and Dell [*3*]). The potential for suicide following admission to a Regional Secure Unit is indeed a major concern for those who are trying to treat these individuals. Guilt is an issue which, in the circumstances of manslaughter, the patient may never be able to resolve.

In many ways, the experiences of a person who has killed may easily fulfil the diagnostic criteria for in *Diagnostic and Statistical Manual III-R* (DSM III-R) for posttraumatic

stress disorder. One could hypothesize that this would also have an inhibitory effect on mourning, thereby further complicating the grief process.

Case Illustrations

The following case vignettes illustrate some of the points the author has raised. *Case A* illustrates the lack of social support and isolation experienced by one who has killed within the family. *Case B* illustrates the determination of another to commit suicide. *Case C* illustrates a number of features which could fulfill the DSM III-R diagnostic criteria for posttraumatic stress disorder.

Case A

This 24-year-old woman was admitted for assessment after killing her 4-year-old son. Twenty-four hours prior to the offence she had attempted to take her own life by an overdose of temazepam but had discharged herself from the hospital. Subsequently, she smothered her son with a pillow and then attempted suicide with an overdose of paracetamol and alcohol. She woke up several hours after this attempt and tried to cut her wrists with some broken glass from a tumbler but was only able to inflict superficial wounds. She then placed bedding against the door and set fire to other bedding material in an effort to overcome herself with fumes. It was at this point that she was discovered.

She was not allowed to see her son's body or attend the funeral and could make no arrangements for the headstone, flowers, or other details. Her family immediately disowned her, and despite repeated attempts by her, refused to speak to her or communicate with her in any other way. She had only a small number of visitors, partly because of the large distance of her home from the unit. None of these visitors were able to talk to her about her son or the reasons she was in the unit. She was diagnosed as suffering from a major depressive episode.

Case B

This 56-year-old man was admitted following a serious suicide attempt while he was being held on remand. He had been suffering from depression for a number of years but, prior to this, had had an unremarkable history. He had killed his wife while she was in the bath by multiple blows to the head with a hammer. He had then taken an overdose, but was discovered by chance and subsequently recovered in the hospital. In the remand prison he had attempted to hang himself after timing the movements of the prison warders, and needed to be cut down after being discovered. A room search of the unit in connection with an unrelated matter revealed that he had obtained and hidden some glass. He freely admitted that this was in preparation for another suicide attempt. He was diagnosed as suffering from a major depressive episode.

Case C

This 28-year-old man was admitted for assessment following an arson offence. The offence took place 6 months after his release from prison, where he had served 18 months on a manslaughter charge. The manslaughter offence involved the strangulation of his wife when he was suffering from depression. At admission, he exhibited a range of symptoms typical of posttraumatic stress disorder. He experienced recurrent distressing dreams about the offence, and contact with his young son appeared to cause him extreme distress. He could not recall full details of the manslaughter offense (perhaps because of psychogenic amnesia) and reported feelings of detachment from others and blunted affect.

He made efforts to avoid thoughts and feelings about the offence, and his sleep was disturbed, primarily because he worried about falling asleep and dreaming about the offence. In addition, he reported difficulties concentrating and was prone to angry outbursts.

Conclusions

This review has indicated that there are a number of individuals who are coming into the Regional Secure Units after receiving convictions for manslaughter on the grounds of diminished responsibility. In view of the fact that they often spend more than two years as inpatients, the author suggests that they will come to form an increasing proportion of the population of the Regional Secure Units.

Research into normal and abnormal grief indicates that these people are likely to experience complicated grief reactions, which can be viewed as the direct and indirect results of their offences. In addition, the concept of posttraumatic stress disorder could also be applied to their experiences, further complicating the grief reactions. Case vignettes have been used here to illustrate some of these points.

No attempt has been made in this article to suggest ways of helping these patients with their grief work, but this is clearly an area of concern for those involved in their treatment, since these patients present such a high risk of suicide.

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