Necrophilia and Lust Murder: Report of a Rare Occurrence

SELWYN M. SMITH, M.D., F.R.C.P.(C), M.R.C.Psych., D.P.M.* and CLAUDE BRAUN, M.A.**

Fixation upon "corpses" as the sole love object and enactment of compulsions toward them constitutes one of the rarer and more malignant perversions. Despite the fact that erotisation of death is frequent in the fantasies of sexual deviants, the literature on this topic is sparse. Of some 300 articles on sexual abnormalities, only a few in English appear to be on necrophilia.[1-4] Necrophiliacs are very rare; some are psychotic and inaccessible, and they infrequently consult the psychiatrist. In view of the shortage of clinical observations, we thought it of interest to report a case of necrophilia and lust murder that recently came to our attention.

Definition of Necrophilia

Necrophilia, or love of the dead, has generally been applied to two kinds of phenomena: (1) sexual necrophilia, a man's desire to have sexual intercourse or any other kind of sexual contact with a female corpse, and (2) nonsexual necrophilia, the desire to handle, to be near, and to gaze at corpses, and particularly, the desire to dismember them. Fromm has also postulated the less obvious "necrophilous character" to refer to a character-rooted passion that provides the soil in which the cruder and more overt manifestations germinate.[5]

Like all perversions, necrophilia is as old as mankind. Herodotus mentions that the ancient Egyptians took precautions against it. "The wives of men of rank . . . are not immediately on their decease delivered to the embalmers: they are usually kept for three or four days, which is done to prevent any indecency being offered to their persons."[6] Stekel[7] and Karpman[8] have drawn attention to the frequency of necrophilia and other sadistic acts. As examples, they describe individuals who become sexually aroused after a funeral; men who practice masturbation in graveyards; enhancement of sexual intercourse by the presence of a coffin; and the desire of certain necrophiles to have the woman lie motionless like a corpse or to appear asleep during intercourse. Certain Parisian brothels cater to this perversion; the prostitute is made up like a corpse with a pallid appearance, dressed in a shroud, and lies in a coffin.[9] By way of contrast, some people can eat no meat because it reminds them of "corpses." Others are unable to visit a

*Dr. Smith is Chief of Psychiatry and Director of Forensic Psychiatry, Royal Ottawa Hospital, Faculty of Medicine, University of Ottawa, Ottawa, Ontario, Canada K1Z 7K4.

**Mr. Braun is presently studying toward the Ph.D. in Psychology at the Faculty of Psychology, University of Ottawa, Ottawa, Ontario, Canada.

cemetery without being overtaken with nausea.

Our fairy tales reveal many necrophiliac and cannibalistic scenes, possibly as residues of primitive occurrences. Remnants of bloody sacrifice are found in various religions, and the narrative of the vampire has never disappeared from folk consciousness. Necrophiliac acts sometimes occur under the influence of a superstition. According to Stekel, Hellwig reports that a mother, in order to cure her hermaphroditic son, opened the grave of a virgin. The son had to follow the counsel of his mother and lie naked upon the corpse "in order to bring his sex in order."[7]

Psychopathology

Though a genetic basis of necrophilia has been assumed by several authors,[5,7] the present case report seems to be the only attempt to seek evidence for this belief. The psychopathology of necrophilia is highly variable among those few cases that have been clinically evaluated; it ranges from a relatively typical pattern of extreme conversion hysteria and fetishistic obsessive-compulsive neurosis[3,9-11] to psychopathy,[9] and, less frequently, schizophrenia[3] or severe intellectual deficiency.[7] Impotency or hypo-sexuality have been reported in association with necrophilia. In several instances alcohol abuse prior to necrophiliac rampages has been noted. Fugue states or severe headaches prior to or after the incident also have been reported. These observations take on new significance in light of the recent finding that alcohol-precipitated violence corresponds to alcohol-induced temporal lobe EEG abnormalities.[12]

Cases of necrophilia have been interpreted as demonstrating a number of specific dynamic patterns. Our case report will show that they are all applicable to, but insufficient to explain the facts of the case. These dynamics include the following: (1) unconscious ambivalence toward sexual partners aggravated by a deep-seated thirst for revenge displaced from the dominating mother onto the dominating spouse, resulting in a compulsive and ecstatic association between love or admiration, and pain or humiliation,[5,9] (2) castration anxiety, feelings of male inadequacy, interpersonal passivity, and fear of women, resulting in the need to prove one's strength by inflicting pain, and to satisfy compensatory cravings for omnipotence by abusing a totally subservient victim,[13] (3) unconscious internalisation of the parental attitude that sex is dirty and unnatural leading to a compulsion to punish or suppress it through symbolic murder,[14] (4) compensation for inherent physical weakness and insignificance and for lack of sexual drive and virility derived through the brutal show of power,[15] and (5) a libidinal association between first orgasms and a depressed, morbid state due to family disruption, as well as "primal scene" trauma.[16]

Case Report

D.P., aged 36, was first seen by the authors at the culmination of a series of partial strangulations of 20 different women, the last of whom he finally murdered as he desecrated her body. He copulated with the body several times after her death.

Police records, previous psychiatric files, witnesses, relatives, and personal interviews with D.P. revealed that he had been a sickly and emaciated baby

and remained physically and emotionally immature throughout his lifetime. During infancy he had been insecure and phobic of darkness, loud noises, strands of hair or feathers, and being alone. His mother had died when he was one year old, and his father then immediately embarked upon a loveless marriage with the housemaid. D.P.'s new stepmother had initially spoiled him, but had rejected him when she bore her first child six years later. The father had always demonstrated an obvious preference for the other siblings, particularly a diabetic brother. Both parents had provided a strict upbringing.

D.P. had been enuretic until age seven. He had been truant from school and had run away from home on at least ten occasions. He had been sadistic toward small animals and had attacked his stepsisters with knives and heavy pans. At age eleven he had nearly succeeded in cutting off his sister's finger.

He had frequently witnessed his alcoholic father beating and strangling his stepmother. His father had also performed adulterous intercourse in full view of the children, yet in hiding from his wife. On several occasions his father had also brutally beaten the children, particularly D.P. His father stole money from the children to pay for his liquor, frequently threatened suicide, and once carried out one of these threats to a nearly successful conclusion.

When D.P. was 15 he was slapped on his penis and chastized by his stepmother when he had an erection. He was unaware of the facts of life until he was 18. Sex was a "dirty word" in their household. He discovered masturbation alone and felt confused and guilty about it, regarding an erection as some kind of malicious, cancerous growth. He would masturbate when he was angry and depressed about his father's "affairs," and was preoccupied with sadistic masturbatory fantasies. He developed a deep-seated hatred toward his father and stepmother and profound jealousy toward his siblings.

He completed his schooling during grade ten. He then experienced some homosexual play and married the first woman with whom he had sexual intercourse. His family considered his wife a "slut" and rejected her. Primarily because of mutual sexual inadequacy his marriage dissolved. His life then became characterized by a pattern of alcoholism, petty crime, promiscuity, transient work history, and chronic sexual assault of women – always when under the effects of alcohol. When apprehended and during incarceration he constantly maintained a grubby and dirty appearance. At the time of evaluation he weighed 90 lbs. (40.5 kg.) and measured 5'6" (167.6 cm.).

Symptomatology

This case demonstrates a combination of hysterical and psychopathic personality traits somewhat reminiscent of the famous Christie case of necrophilia.[10] Symptoms observed include histrionic anxiety attacks, insomnia, anorexia, suicidal behavior, severe depression, pathological meekness, phobic behavior, and a morbid view of the world. Family members confirmed his own reports of fugue states, which he called blackouts, followed by amnesia. One psychiatrist had previously diagnosed him as a case of "triple personality."

He also manifested a variety of psychopathic symptoms. These included

absence of feelings of remorse, lack of inhibition, lack of judgment and insight into his problems, an unstable and completely impersonal sex life, complete lack of concern and callousness toward his parents, wife, children, and relatives, and an imperviousness to punishment or negative consequences of his actions. His family members confirmed a history of numerous childhood behavior problems, including truancy, poor socialization, pathological lying, impulsive acting-out, and verbal manipulation and abuse. During adolescence, he began to impersonate people and would hustle for jobs, money, and sex. He later became a confirmed alcoholic and for a period of time used excessive amounts of tranquilizers. He also experimented with LSD, cocaine, and marijuana, but was not a regular user. Though he had a lengthy criminal record (See Table 1), he was quite agile at evading police apprehension.

D.P. reported an impressive variety of sexual deviations. He had indulged in homosexual prostitution, sadism, masochism (erotic self-hanging), promiscuity, exhibitionism (made blue movies of himself), incestual fantasy and sexual molesting of one of his sisters, voyeurism, and necrophilia. He was frequently impotent with women and preferred either copulating with unconscious or "frozen" women, or masturbating to the accompaniment of sadistic fantasies. During a period of conflict with his first wife, he expressed his revenge by completely abstaining from sexual activity with her for six months. Shortly thereafter he developed prostatitis which required medical treatment.

D.P. appeared never to have been short of friends and recalled having had highly satisfactory "romances." Indeed, he had no difficulty securing a certain type of sexual partner. He recalled partially strangling at least twenty different women, many of whom tolerated his abuse and even pleaded to live with him after he had assaulted them. Most of his sexual contacts, however, were peculiarly pathetic and may well have served as fetishistic substitutes for meaningful sexual relations: one was a thirteen-year-old child and another was sixty years of age. Others were psychotic, retarded, or alcoholic. Some were sexual and emotional masochists, prostitutes, or past victims of incestuous and non-incestuous rape. One was frigid, others exhibited promiscuity or self-destructive tendencies. Remarkably, three different women asked D.P. to kill them. Of the twenty women D.P. assaulted, he claimed that only eight were assaulted against their will and without forewarning.

The patient's necrophiliac activities began in earnest with his first wife when he choked her with his legs during oral-genital intercourse and fantasized that she was under his complete control and that he was free to perform lecherous acts upon her body without resistance or awareness on her part. Eventually, he demanded that his wife "play dead" during intercourse. If she refused, he would forcibly strangle her until she lost consciousness. He would then, according to his wife's account, perform sexual deeds upon her body like a furious animal. Interestingly, he never forced himself upon any woman unless intoxicated with alcohol.

He began studying newspaper obituary columns and was often tempted to frequent graveyards, but was too afraid of them to do so. He became a hospital orderly because he was fascinated by death and dying. Eventually,

he began assaulting and strangling women directly in the streets. He also began stealing in front of male friends. He developed a morbid view of the world, claimed incidents in which he was clairvoyant about deaths or catastrophies, made mysterious predictions, had morbid "foresightful" dreams, and was able to "understand" and "communicate" with the dead. Several of his dreams contained bizarre scenes of omnipotence such as hypnotizing crowds and controlling people with drugs so he could beat and rob them. He experienced morbid fetishistic perceptual distortions during hysterical anxiety attacks, such as lights dimming, rats gnawing, his own skin turning grey, etc. In his capacity as an orderly he cleansed and prepared a young female corpse for disposition. He then performed genital intercourse on this corpse on the marble slab in the hospital morgue. He claimed that the body responded to his caresses appreciatively, came to life, and talked with him. He reported that he received two "spiritual" visits from her after the incident in the morgue; polygraphic and voice analysis suggested that this was an authentic delusion and not a lie. The profundity of his necrophilia is also illustrated in some of his reported dreams:

> I dreamed somebody strangled me. I died. I was on a white surface and everything around me was black. There was nothing but me, . . . floating. I was completely away from everything. There was total emptiness. I felt like a king of where-ever I was. I felt really good.

> I was killed in a car crash. I was alone in the car and killed instantly. My body was thrown into bits and pieces and I never felt a thing. Everything went black everywhere on top, and I was on a white space. I felt good. I was no longer around here. I was free.

> I fell asleep dreaming about killing my wife (I had choked her and beaten her up a few days before). I dreamed she had black slacks on and a pink sweater. I knocked her over the head, then I strangled her and I carried her to the bathtub, which had water in it. I took all her clothing off except panties and brassiere. That excited me sexually. Then I put her in the water . . . .

D.P.'s case is further characterized by a series of mild neurological impairments and complaints, namely, blurring of vision, loss of vision in the right eye, strabismus, dizziness, "blackouts," unprovoked rage, mild pronunciation defect, maturational lag, minor facial tics, and a limp, dating back to his first attempts to walk at age two. His intermittent right-sided headaches were a prominent feature and their onset preceded by approximately two weeks a series of incidents involving assaults and strangulations. He also had a history of numerous head injuries and severe head-banging in prepubescent years.

Many members of D.P.'s family had experienced sudden overwhelming and controlling influences that produced death or disease (See Figure 1). There is, of course, no evidence in this or other case descriptions for linking necrophilia per se to hereditary factors. Nonetheless, the extent of morbidity and mortality in the family background and the effect that this may possibly

have had on his development is particularly striking and warrants further exploration.

Psychiatric and Psychometric Evaluation

The Wechsler Adult Intelligence Scales yielded a verbal I.Q. of 114 and a performance I.Q. of 99. Another measure of non-verbal intelligence (Raven's Matrices) yielded a score that corresponded to the 30th percentile of the normal population. Personality tests – Rorschach, Sentence Completion Test, Eysenck Personality Inventory, House-Tree-Person Test, Thematic Apperception Test, Fould's Hostility Scales, Minnesota Multiphasic Personality Inventory, and Zuckerman's Sensation Seeking Scale – revealed an extremely uninhibited, yet not overtly extroverted character structure. Cognitive valence of sadistic, destructive, murderous impulses was shown to be very high. D.P. demonstrated neither the capacity for empathy, nor basic self-esteem. Veiled desires and oblique self-destructive urges were interpreted.

A passive-dependent and aggressive interpersonal style associated with a poor sexual differentiation characterized his productions. A rich and multiply perverse fantasy life was uncovered. Diagnostic measures were contaminated by a "faking bad" attitude. Nevertheless, his choice of symptom reporting reached highly pathological levels in hypochondriacal, schizophrenic, hysterical, depressive, psychasthenic, and psychopathic categories, in that order. He reported few complaints in areas such as social isolation, mania, or paranoia.

A full battery of neuropsychological tests, including the Halstead-Reitan series, revealed mild to moderate diffuse brain damage as indicated by impairment of sensory, motor, and reasoning abilities dependent upon integrity of the brain. However, detailed medical and neurological investigations including hematological, biochemical, and urine analysis, an EKG, and karyotyping revealed no abnormalities. Skull x-rays, EEG's with pharyngeal leads, and a brain scan were also normal.

Behavioral inventories revealed an extreme disposition for dangerous assaultive behavior of various types and self-injuriousness. Police reports describing his underwear as saturated with black dirt, blood, and numerous hairs attested to his lack of personal hygiene.

Legal Outcome

D.P. was competent to stand trial for murder. On the basis of the neurological and psychiatric examinations, the possibility that a significant neurological defect was causally related to his abnormal behavior seemed unlikely. It was also clear that D.P.'s mental processes were abnormal and that he had a "mental disorder" in the medical sense of that term. His symptoms and signs of ego weakness, impulsivity, somatic complaints, drug dependence, recurrent depressive episodes, and particularly the questionable episodes of thought disorder raised the important issue of whether his failure of reality testing placed him, at the time of the killing, within the category of a diseased mind. It was the author's opinion that although he had a "disease of the mind" (in a medical and legal sense), this would not bring him within the ambit of Section 16 of the Criminal Code of Canada.

(Insanity in the Criminal Code is based upon a modified McNaughton Rule with the onus on the defense to establish at the time of the offense that the accused had a disease of the mind that rendered him unable to fully appreciate the nature and quality of his act.) From the account of the offense it was also clear that D.P. was able to appreciate the nature and quality of his act and knew that what he was doing was wrong.

At trial the author (S.S.) presented his opinion that D.P. did not appear to have had any conscious intent to kill or physically hurt or injure his victim. His many previous involvements in similar forms of sexual activity with willing or consenting partners and the fact that none had died were highlighted.

D.P. appeared to have been motivated toward having the woman helpless and unresisting, rather than in pain. He showed no evidence of the more usual forms of sadistic behavior in which the infliction of pain on the partner for the purpose of sexual excitation was the end sought. His behavior rather was characterized by a search for a passive partner, accompanied by tender feelings toward his uncomplaining and unresponsive mate. His particular sexual propensity was that he was satisfied by a mimicking of loss of consciousness by his partners. This argument that he had not consciously sought the death of his partners seemed to be supported by his hoping and believing in the fact that they were in reality alive, and was confirmed by both his behavior with the corpse in the hospital morgue several years previously and with the victim of the killing for which he had been charged. This opinion was also supported by police evidence that he left the door to the room open, exposing the corpse in the belief "that she was sleeping." Interestingly, the results of the polygraph and psychological stress evaluation separately validated this point of view.

D.P. was found guilty of manslaughter. The judge at sentencing clearly recognized that if eventually he were to be returned to society, his dangerousness would have to be ameliorated and he would have to remain under prolonged therapeutic supervision for a number of years thereafter. D.P. had a genuine awareness of these requirements and was prepared to participate willingly in a treatment program.

The judge in this case followed the procedure adopted by the trial judge in *Regina v. Boombower.*[16] In that case the trial judge sentenced the accused to a fixed term of imprisonment and recommended that he be taken to a secure hospital facility to commence his sentence. It was clear from the sentence of life imprisonment that the intention of the judge in this case rested on the assumption that if D.P. responded to treatment he could be released from the Mental Health Centre on parole under the 1970 Parole Act when safe and appropriate. It also allowed for the possibility that he could be transferred to a penitentiary to serve the balance of his sentence if changed circumstances and the opinion of the hospital and correctional authorities warranted such a transfer. Section 26 of the 1970 Ontario Mental Health Act clearly establishes that "a patient shall be discharged from a psychiatric facility when he is no longer in need of observation, care and treatment provided therein." The secure psychiatric hospital facility readily accepted his admission but for a variety of reasons returned him to the penitentiary several months later. D.P. then appealed his discharge from the

hospital on the issue that he had been refused treatment. The appeal was dismissed.

Such incidents are not uncommon and highlight some of the problems in ensuring that a mentally ill convicted prisoner be allowed to go directly to a psychiatric hospital that is prepared to accept him for treatment.

Conclusion

Lust murder generally involves a complication of motives. The confessed motive or the one that lies nearest the surface may have behavioral significance only because of some deeper and less clearly recognized motivational determinant. It is possible that D.P.'s actions served as a symbolic revenge for real or imaginary wrongs and provided an outlet for his humiliated ego. D.P. was able to engage in the most laborious and affective intimacies with one whom he could never approach if she were alive. The victim, once brought under complete control, was required to remain outside the capacity to resist.

It is also of interest to speculate on the role of the victim and the pleasure she and others experienced from hypoxia. Dietz has reviewed the development of our knowledge of the sexual induction of cerebral hypoxia and has named the phenomenon Kotzwarraism, after Kotzwarra, a prominent musician who died in 1791 at the hands of a prostitute whom he had had hang him.[17] The best known examples of Kotzwarraism are the use of amyl nitrate near the moment of orgasm and repetitive erotic self-hangings. Dietz describes a variety of other examples, but notes that the only previous hard evidence of an association with lust murder comes from Brittain's comment that he has known of two practitioners of autoerotic sexual asphyxia who committed sadistic murders and another who fantasized about lust murder,[18] and from Usher's case report of a man who repeatedly choked his sexual partners and eventually killed one.[19]

A number of cautious but interesting conclusions can be drawn from this case.

1. There is evidence that victims of necrophiliacs harbor conscious as well as unconscious death wishes, supporting Reinhardt's[11] and Stoller's[12] views that the ego aberrations of severe sadists drive them toward the most pathetic of possible victims who are used solely as fetishistic substitutes.

2. Necrophiliacs clearly are not necessarily social isolates or unintelligent, confirming Stekel's view that persons of high intellect and repute may perform necrophiliac acts.[7] In this connection it is interesting that Maupassant, whose house always smelled of ether, reported from personal experience that human flesh "was absolutely tasteless."

3. The importance of modeling and identification is demonstrated in this case but is at variance with Stekel's[7] and Ehrenreich's[3] contentions that necrophilia is an atavistic petrification or is purely genetically determined. The role of hereditary factors in this case is impossible to determine.

4. Necrophilia may appear as the culmination of a pattern of multiple and increasingly perverse practices rather than as an isolated, abrupt, deviation.

5. There appears to be a psychodynamic interaction between erotic self-hanging (lust-suicide) and necrophilia (lust murder). Self-hanging, the erotisation of a feeling of helplessness, has been interpreted as a narcissistic

and masochistic reminiscence fantasy of the triumph of survival in the face

FIGURE 1
D.P.'s PARTIAL HEREDITARY BACKGROUND