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Brief Reports

Homicide and LSD

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A 22-year-old student killed his girlfriend during a psychotic period which may have been precipitated by ingestion of lysergide. This closely followed another assaultive episode while he was under the influence of drugs. Prior to this, he had not had any untoward drug reaction.

REFERENCES in recent years have implied the possible association of homicide with the use of lysergide (LSD) and other drugs.[1,2] Many of these claims have been difficult to assess.

The history is frequently far from reliable. Legal considerations may obfuscate the evidence, multiple drug abuse often makes it difficult to blame any one drug, and underlying psychopathology may complicate the possible role of the suspected drug.

There appears to be some value, however, in compiling a record of cases of homicide where LSD (and other drugs) can be implicated in the absence of overt psychosis or assaultive behavior prior to the homicide. We believe the following to be one such case.

Report of a Case

A 22-year-old, single, undergraduate student was admitted to the psychiatric floor after attacking a former girlfriend with a knife. On the day of the attack he had smoked one cigarette of marihuana, taken two LSD tablets (of unknown strength), and had a glass of beer.

He met the girl on campus and she subsequently stated that he seemed preoccupied with world injustices, whereas in the past he used to "preach global love."

They parted and that evening he called at her dormitory, where initially he conversed with her and then suddenly attacked her with a knife. She fought him off and sustained superficial lacerations; he threatened to kill her and left. The next day university security guards found him hiding with a loaded shotgun in the shrubbery near the dormitory. He was transferred from the police station to the hospital.

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On admission, he denied any recall of the incidents and said he did not believe his intention was to kill the girl. He said his behavior was out of character for him and attributed it to a "bad trip" with LSD. His friends stated that he had always appeared gentle, even under the influence of drugs. He related his having used LSD more than 100 times, without any bad trips or flashbacks.

During examination he appeared to be a tall, gaunt, young man, initially apprehensive, but later able to relate warmly. He seemed moderately depressed and his speech was coherent and logical. There was no evidence of psychosis. He appeared to be of above average intelligence. The results of physical examination and laboratory studies were normal, except for (1) a mildly abnormal electroencephalogram with nonspecific changes possibly related to organic brain dysfunction; no focal activity was noted; and (2) psychological testing produced a WAIS (Wechsler adult intelligence scale) intelligence quotient of 123. There was no evidence of either organic or schizophrenic dysfunction.

While he was in the ward nothing striking was noted in his behavior, except that he initially kept aloof from the patients and staff. A noteworthy feature of his behavior was the lack of guilt or remorse in connection with the recent assault, which be blamed on LSD. Two days prior to discharge, he was observed to be under the influence of marihuana, which he admitted taking. His behavior was outgoing and gregarious, but otherwise unremarkable. His diagnoses on discharge were (1) a drug dependence and (2) an unspecified personality disorder; he was to be treated in the outpatient department.

Three days following his discharge he was arrested for the fatal shooting of another girlfriend. In court, he was found to be "unfit to stand trial for reasons of insanity" and he was sent to a state institution for the criminally insane. By his own admission, he had smoked a "lot of marihuana" and had taken LSD (an unknown amount) two days before he committed homicide.

Psychiatric testimony at the trial asserted that he was psychotic at that time and for at least the six previous months. He had allegedly told the examining psychiatrist of a complex delusional system wherein he felt he had to destroy the goddess Ashteroth, who was the reincarnation of Eve. The two assaults occurred in the context of this delusional system. He further revealed that he had concealed his thoughts from the hospital staff since he wanted to be discharged in order to purchase a gun in Vermont. He claimed that he killed the girl because she showed a sign that she was Ashteroth. Prior to her death, they had driven in his car for several hours, so the crime did not appear to be related to any reality factors, such as rejection or an argument.

He was born in Poland in 1949, migrated to Israel in 1957, then to Australia in 1960, and finally to Rochester in 1963. An only child, he was initially shy, but soon settled down in Rochester and appeared to cope well, both socially and academically, until the age of 19 years when he commenced drug usage. From this time on, he seemed alienated from his parents, and at age 21, he moved into a single apartment. He returned to his parent's house ten months later because he felt "lonely."

He began using marihuana in 1967 and LSD soon afterward. Recently, he supposedly took large amounts of morphine, cocain, and methamphetamine hydrochloride (Methedrine) while on an overseas journey. Three weeks prior to hospital admission, his drug supplies ran out, but he denied having any withdrawal effects, apart from a mild craving.

Comment

We have described the case of a young man who committed a serious assault and then a homicide in the setting of drug use. As in other reported cases, the picture is complicated by multiple drug use, the credibility of the subject's own story in the context of a murder charge, and the uncertainty of whether drugs exacerbated an underlying psychosis or bore a more direct causal relationship to the homicide.

A possible temporal connection exists between this man's assaultive behavior and his use of LSD or marihuana or both, as these were the main drugs used in the weeks preceding the attack. The exact quantity, purity of preparation, and setting in which he took the drugs are unknown.

We wonder why he had experienced more than 100 LSD trips and smoked large quantities of marihuana in the

past without apparent untoward effect, before committing homicide possibly under their influence.[3] It is said that an experienced drug user is less likely to be overwhelmed by the effects of a drug.[4] However, even experienced users, with a past record of good trips, can suffer unexpected psychotic reactions.

In spite of the rather favorable psychological report and the lack of evidence of psychosis on the ward, his past erratic behavior is suggestive of possible psychiatric problems. Was this the result of his considerable drug abuse over the past three years? He had no history of psychiatric contact or of assaultive behavior.

It is, perhaps, more significant that psychiatric observation and testing at our university inpatient service failed to reveal any evidence of psychosis or of schizophrenia.

The psychiatric testimony at the trial, however, suggested that while in the hospital, he was deliberately evasive and planned the murder to follow. There is some dispute in the literature about whether such organized goal-oriented action is feasible in the state of ego disruption seen in drug psychosis.[5] Another point of interest is that he claimed complete amnesia for the first assault; again there is some dispute regarding whether such amnesia occurs at all with LSD.[5]

Although violent behavior is often experienced during bad trips,[6,7] homicide in association with LSD use has only been reported four times in the medical literature. Homicide has never been reported in association with marihuana. Some reports indicate that violent behavior may indeed be discouraged by use of marihuana (as stated in *Psychiatric News*, vol 7, April 15, 1972).

The following are four reported homicides committed by persons under the influence of LSD:

A 25-year-old woman with a psychopathic personality murdered her boyfriend two days after the last of her five therapeutic LSD sessions.[8] As with our case, the homicide, if it was related to LSD at all, did not occur during the drug's acute effects.

In 1966, a 32-year-old man stabbed his mother-in-law to death several hours after LSD ingestion. Examining psychiatrists said he was a chronic paranoid schizophrenic and that LSD worsened his condition. Expert testimony indicated that his amnesia for the homicide was not unusual and that, while in an amnesic state, he could still appear rational.[1]

A 24-year-old man murdered a stranger following an argument. He was intoxicated with alcohol when he took LSD. As it was his first use of a hallucinogenic drug, he had no experience to draw from and, therefore, its results were probably more disruptive and frightening.

A 22-year-old borderline character, with prominent paranoid and homosexual tendencies, had about 20 benign LSD trips, and then two bad ones; one of the latter trips supposedly led to the homicide.[2]

Thus, reviewing our case and the literature, a number of questions remain:

1. How do we detect the person at risk? Who will have an adverse reaction to LSD, and if so, why does one adverse reaction lead to homicide and another not? An individual with premorbid psychopathologic tendencies presumably is more likely to develop an adverse reaction.

2. Having admitted a patient following a drug-associated assault, how do we decide when it is safe to discharge him? In the case reported here, psychological testing and ward observation proved poor predictors of dangerous behavior.

3. What are the roles of LSD and marihuana singly or in combination regarding homicide?

4. Lastly, what should be the legal responsibility of an individual following his commission of homicide under the influence of drugs?

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Polyethylene Mesh

A New Treatment for Decubital Dermatitis

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A new, disposable polyethylene foam mesh was found helpful in the care of decubital dermatitis. The unique design and structure of this sheeting reduces maceration and provides a suitable cushion-support for individuals confined to bed for long periods.

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PERHAPS no dermatitis is more common than that which ensues from confinement to bed or to chair. Such a dermatitis results from a variety of causes. Without question, moisture, pressure, friction, irritation, sensitization, and, indeed, infection each play a contributory role in varying degrees. This type of dermatitis seen in the clinical setting is often not readily classifiable as a simple folliculitis, or a miliaria, or a contact dermatitis, but rather, it is a dermatologic potpourri. Accordingly, we would like to propose that "decubital dermatitis" be used as an operational term to delineate this band of dermatitides.

Decubital dermatitis has been treated in more ways than anyone could list. Perhaps the most successful treatment is prevention. Here, most important are (1) frequent examina-