Murderers Who Are Not Guilty Due to Insanity: Demographic, Criminal and Psychiatric Characteristics

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ABSTRACT

Background: While various studies have revealed a correlation between major psychiatric disorders and violent behavior, studies focusing on the demographic, criminal, and psychiatric characteristics of murderers and their behavior at the scene of the crime are relatively scarce. The aim of this study is therefore to examine these characteristics of murderers who committed murder due to insanity and to analyze their behavior at the scene of crime.

Method: The study was conducted at the maximum secure unit of Sha'ar Menashe Mental Health Center and reviewed all files of the 69 inpatients who have committed murder and been admitted to the unit since its opening in 1997.

Results: 93% of the participants were diagnosed with schizophrenia, 70% had at least one psychiatric hospitalization before committing the crime, 57% did not adhere to medications between hospitalizations, 33% took medications sporadically, and 42% of those diagnosed with a psychotic disorder prior to the murder did not regularly attend their psychiatric follow-up. Regarding the crime, in 91% of the cases, the victim was known to the murderer, 69% of the murders were brutal, 47% of the murderers remained at the scene after committing the murder and only 30% left.

Conclusion: The findings offer a better understanding of the factors and motivations leading individuals with psychotic disorder to commit violent crimes and murder and their behavior at the scene of the crime. This may assist in identifying at-risk populations and developing and implementing relevant prevention programs.

INTRODUCTION

In the last three decades, various studies have indicated a significant correlation between mental disorders, mainly schizophrenia and other psychotic disorders, and violent behavior (1-4); it should, however, be stated that most individuals with mental disorders are not violent (5). According to these studies and others (6, 7), most individuals with mental disorders who were involved in violent offenses suffer from schizophrenia and a significant portion of their violent acts occurred during a psychotic episode under the influence of delusions and/or hallucinations (8, 9).

A close examination of the studies that focused on murderers who committed murder due to insanity reveals that most of them focused on the psychiatric characteristics of the offenders and their relationships with the victims (10, 11). Relatively few studies have addressed this topic with regards to the possible link between the murderers' psychiatric characteristics and their behavior at the scene of the crime (6, 12, 13). The aim of this exploratory study is to fill this lacuna by exploring the demographic and psychiatric characteristics of individuals who committed murder by reason of insanity and examining their criminal history and behavior at the scene of the crime.

ISRAELI LEGISLATION ON CRIMES COMMITTED DUE TO MENTAL ILLNESS

Israeli law recognizes situations in which a crime is committed owing to mental illness and determines that in such cases individual are not responsible for their deeds and cannot therefore be punished. Israeli Penal Law (1977) Article 34H Insanity (Amendment 57) states:

No persons shall bear criminal responsibility for an act committed by them, if – at the time the act was committed, because of a disease that adversely affected their

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spirit or because of a mental impediment – they lacked any real ability – (1) to understand what they did or the wrongful nature of their act; or (2) to abstain from committing the act.

In addition, Section 15(b) of the Mental Health Care Act 1991 states:

Defendants who were charged with criminal prosecution and the court found that they had committed the offense of which they were charged, but decided, on the basis of evidence presented by one of the litigants or evidence brought at its own initiative, that the defendants were ill at the time of the act and therefore not punishable and that they are still ill, the court will order that the defendants be hospitalized or receive medical treatment.

EMPIRICAL BACKGROUND

Many studies have examined the association between schizophrenia and other psychotic disorders and violent behavior, suggesting a 2.5 to 7 times greater risk of violence perpetration by those with active symptoms of schizophrenia than the general population (1-3, 14). Prevalence of schizophrenia among murder offenders ranges from 4% to 11% (7, 15-17), significantly higher than its prevalence among the general population (approximately 1%) (18). Peled et al. (6) referred to the link between delusions and hallucinations and violent behavior and argued that violent behavior of psychotic patients is a logical response to unrealistic thoughts (delusions) and false perceptions (hallucinations).

One group of studies focused on the time of the murder in relation to the course of the mental disorder. Hafner and Boker (19) found that 84% of all people in West Germany who committed murder and suffered from schizophrenia had been diagnosed for over a year prior to the crime and that 55% of them had been ill for over five years. Similar findings were found in other countries such as Turkey (20), China (21), Greece (22) and Sweden (23). However, a study taking place in New South Wales, Australia found that for 52% of offenders who committed murder and were found not guilty on the grounds of mental disorder, this was their first episode of psychosis (24).

Another group of studies focused on the risk factors of individuals who committed violent crimes by reason of insanity (5, 7). They found that the majority of people who committed violent attacks and suffered from severe mental disorder had not complied with treatment and tended to use drugs. Another study examined 47 cases of murder that were committed by individuals who had been discharged from psychiatric hospitals within the six months prior to the offense and compared them to 105 control cases of individuals that were discharged but did not commit any violent offense (22). Clinical factors that were exclusive to members of the first group included poor self-care, drug or alcohol abuse, and prior hospitalization due to violent behavior. In addition, the researchers found that all members of the first group suffered from a severe mental disorder a year prior to their conviction and that post-treatment factors related to the murder included a lack of compliance with the psychiatric treatment and drug abuse. Similarly, a correlation was found elsewhere between criminal violent behavior and alcoholism, drug use, noncompliance with treatment, anti-social personality disorder, and subtype of paranoid schizophrenia (25).

Drug and alcohol abuse have also been found significant risk factors among individuals with schizophrenia, with alcohol poisoning reported in 45% of the murder cases committed by people with schizophrenia (26). Another study demonstrated that more murderers diagnosed with schizophrenia and anti-social personality disorders suffered from alcohol abuse (27) than not (see also: 10, 22, 25).

Finally, a third group of studies focused on the relationship between offenders suffering from mental disorders and their victims. Two studies found that murder assaults due to psychotic disorders are more likely to involve a victim close to the offender, usually from the family circle (11-13, 28). Similarly, it was shown that in all serious attacks committed by men with psychotic disorders, in contrast to men without psychosis, the offenders knew their victims (29). Similar findings were found in further studies (20, 27, 30, 31). It should be noted that most assaults committed by psychotic as opposed to non-psychotic offenders were found to be carried out with no provocation by the victim (32).

The current study, the first of its kind in Israel, explores the demographic and psychiatric characteristics of individuals who committed murder due to insanity and examines their criminal history and behavior at the scene of the crime. As aforementioned, most studies in this area have focused on the examination of the socio-demographic and psychiatric characteristics of insane murderers, and relatively few studies have addressed criminological aspects. The present study intends to fill this lacuna by exploring and analyzing the criminal backgrounds of these individuals in addition to their

demographics, psychiatric features and conduct in the scene of crime.

METHODS

SAMPLE

We examined the medical files of all patients (n=69) who committed murder by reason of insanity and were admitted by a court order to the maximum-security unit at Sha'ar Menashe Mental Health Center between 1997 (the opening of the maximum-security unit) and 2019. It should be noted that this number represents more than 60% of the overall study population; according to information from the Israel Police, 111 murder cases were closed between 1989 and 2019 on the grounds that the defendant was not punishable due to insanity. Since this is the only maximum-security unit in Israel, there is a high proportion of people from all over Israel who have committed murder and been found not guilty due to insanity.

Table 1. *Psychiatric History Characteristics*

Prior hospitalizations	Yes	70% (48)
	No	30% (21)
Number of prior hospitalizations (n=48)	1	21%
	2-5	25%
	6-9	31%
	10+	23%
Number of involuntary hospitalizations (n=48)	None	13%
	1	33%
	2-5	42%
	6-9	10%
	10+	2%
Diagnosis	Schizophrenia	93%
	Other	7%
Drug use*	Yes	48%
	No	42%
	Unknown	10%
Alcohol use*	Yes	41%
	No	52%
	Unknown	7%
Prior violence (n=48)	Yes	73%
	No	23%
	Unknown	4%
Compliance with psychiatric follow-up between hospitalizations (n=48)	No follow-up	42%
	Infrequent follow-up	33%
	Frequent follow-up	17%
	No information	8%
Compliance with psychiatric treatment between hospitalizations (n=48)	Noncompliance	57%
	Partial compliance	33%
	Compliance	2%
	No information	8%

INSTRUMENTS

Data were collected from both paper and electronic medical files including prior hospitalization summaries, indictments, departmental admission summaries, expert opinions, and reports that include all hospitalizations and diagnoses for each patient. The data included sociodemographic variables (prior to the murder), criminal history, psychiatric history, variables concerning the relationship between the murderer and the victim and the murder motives, and murderer's behavior at the scene of crime and forensic variables (for a detailed description of the variables, see Table 1).

PROCEDURE

Data were collected from the patients' medical files by the principle investigator (PI) and three research assistants (RA). The RAs were carefully and thoroughly trained by the PI. The data were collected using a uniform pre-prepared data collection form. All forms were reviewed by the principle investigator, and she coded them into the SPSS software. The study was approved by the Internal Review Board (IRB) of Sha'ar Menashe Mental Health Center. As this is a retrospective chart study, the review board waived the requirement for participants' informed signed consent.

RESULTS

DEMOGRAPHIC CHARACTERISTICS

The files reviewed were for 69 males aged between 18 and 85 at the time of the murder (M=36.08, SD=12.08), with a median age of 35. Of these, 55% (n=38) were born in Israel, while 25% (n=17) immigrated from the Former Soviet Union, 7% (n=5) from Ethiopia, and 13% (n=9) from other countries. The majority (83%; n=57) were Jewish, with approximately 10% (n=7) Muslims, 4% (n=3) Christians, 1.5% (n=1) Druze, and 1.5% (n=1) whose religion was unknown. Most (86%; n=59) lived in urban centers, while 9% (n=6) lived in villages and 5% (n=4) lived in other settlements or were tourists. Most (84%; n=55) were not married at the time of the murder: single (61%; n=42), divorced (23%; n=16), and married (16%; n=11). According to the reports, many were of low (42%; n=29) or medium to low (23%; n=16) socioeconomic status; only a minority (9%; n=6) had a

medium to high socioeconomic status. There was no information for 26% (n=18) of the participants.

CRIMINAL HISTORY

According to the patients' medical files, approximately half of the research participants (51%) were previously arrested for various types of crimes (mainly due to drugs and violent crimes); at least 22% were known to have a criminal history before the age of 18.

PSYCHIATRIC HISTORY

Most of the participants (93%) were diagnosed with schizophrenia before or after committing the murder and 70% of the whole research population had at least one psychiatric hospitalization prior to the offense. Among the latter, 73% had three admissions or more, 86% had at least one involuntary hospitalization and 50% had at least one court-ordered hospitalization; 73% had previous violent behavior due to their mental disorder. This information is based on computerized hospitalization registration. The information includes the hospitalization status of the patient at the time of admission to the hospital. Hence, data regarding changes of hospitalization status from voluntary to involuntary during hospitalization are missing. Moreover, the listed data are minimum and it is possible that the numbers (here and in the table) are higher.

With regards to substance abuse, in accordance with the patients' self-reports and reports written by the psychiatrists following interviews with their family members, 41% of the participants reported using alcohol and 48% using illegal drugs. In most cases, there were no details regarding the extent and frequency of consuming alcohol or drugs.

Only one of the 48 participants who were psychiatrically diagnosed prior to the murder was described as being fully compliant with treatment, and only 17% of them (n=8) were described as complying with the psychiatric follow-up. In most cases (74%), a deterioration of the patients' mental state (i.e., a change in behavior and the appearance of psychotic symptoms such as delusions or hallucinations) prior to committing the murder was recorded (as reported by the patient, a family member, or a doctor). All the psychiatric characteristics are shown in Table 2.

RELATIONSHIP BETWEEN MURDERER AND VICTIM AND THE MOTIVES FOR THE MURDER

In the great majority of cases (91.5%) the victim was known to the offender. Of these, 54% of the victims were family members: 18.5% were spouses, 18.5% were mothers, 10% were fathers, and 7% were brothers or sisters. Only in 8.5% of the cases were the victims complete strangers. The distribution of murders according to the relationship between the murderer and the victim is shown in Figure 1.

In most cases (62%), the motive for the murder was described as paranoid delusions; in 6% of the cases, there were also hallucinations. Imperative hallucinations led to murder in 5% of the cases. Delusions of unfaithfulness or betrayal motivated 9% of the murders (in one case there were also matching hallucinations) and grandiosity delusions combined with hallucinations motivated 3%. Other factors were responsible for 12% of the murders, and there was no detailed information for 3%.

Reports showed that 49% of the participants did not plan the murder, most (68%) took place in their home or

Table 2. *Description of the Variables*

General Category of Variables	Specific Variables per Category
Socio-demographic Variables	Age; country of birth; year of immigration; marital status; religion; place of residence, and area of residence
Criminal History	Criminal offenses; age of onset of crime; violent behavior prior to the age of 18; types of crime; number of arrests and number of imprisonments
Psychiatric History	Number of previous psychiatric hospitalizations; age at first hospitalization; psychiatric diagnoses; number of involuntary hospitalizations; number of hospitalizations in maximum-security unit; previous acts of violence under the influence of the disorder; drugs and alcohol use [type, age, violent behavior and/or hospitalization after use, use on the day of the murder]; response to outpatient medication; response to outpatient psychiatric follow-up; time between hospitalization and murder; time between the psychiatric follow-up and the murder, and psychiatric follow-up/ psychiatric medication/ involuntary ambulatory treatment at the time of the murder
Relationship between the Murderer and the Victim and the Murder Motives	Number of victims; previous acquaintance with the victim; type of acquaintance with the victim; previous confrontations with the victim; motives to commit the murder, and planning of the murder
Murderer's Behavior at the Scene of Crime and Forensic Variables	Weapon used in order to commit the murder; the method of the murder, and the behavior after the murder

the home of the victim, and in the large majority (91%) of the cases there was one victim.

BEHAVIOR AT THE SCENE OF THE CRIME AND FORENSIC FINDINGS

In about half of the cases (48%) the murder was committed via stabbing, in 7% beatings, and in 19% a combination of means (stabbing, beatings and hitting with an axe or stick). Firearms were used in only 10% of the cases. With regard to the pattern of murder, in 69% of the cases the murder was conducted brutally with multiple stabbings or beatings and in 21% of the cases the body was dissected.

Interestingly, 47% of the participants remained at the scene of the crime after committing the murder and only 30% left immediately after carrying out the crime. No relevant data were available for the remaining 23% (see Fig. 2). Lastly and equally surprisingly, at least 12% of the total population (both those who remained at the scene and those who left) called for help after committing the murder (there is missing data in about 22% of cases).

Figure 1. *Relationship with victim*

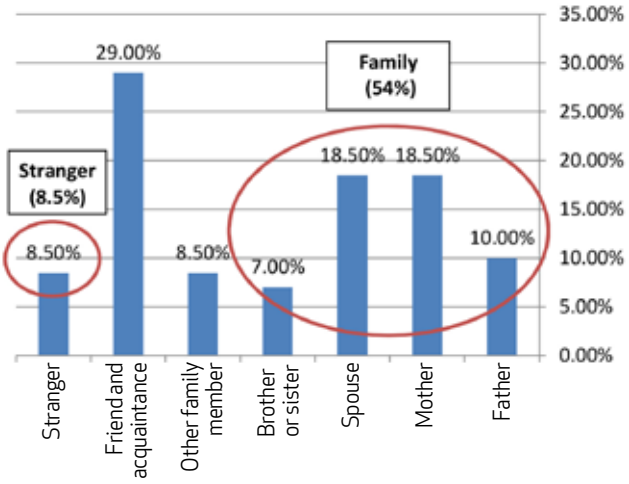
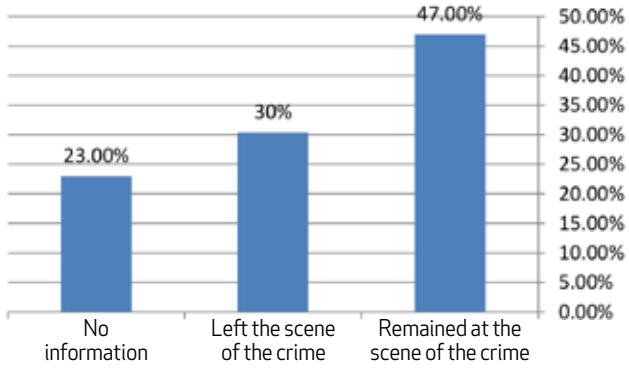


Figure 2. *Behavior after committing the murder*



DISCUSSION

The aim of this research was to examine the demographic, criminal and psychiatric characteristics of individuals who committed murder by reason of insanity and to analyze their behavior at the scene of the crime.

This study's first major finding, which stands in contrast to most research findings about criminal murderers (namely, defendants who committed murder, were tried, and are seen as having criminal responsibility and not suffering from insanity), relates to the participants' behavior at the scene of the crime. Most studies have indicated that criminal murderers flee the scene immediately on executing the murder and try to conceal the evidence (33, 34). In contrast, we found that a high percentage of those who committed murder due to insanity remained at the scene of the crime and occasionally even called for help. A possible explanation for this type of behavior concerns the complete, absolute and irrefutable belief of psychotic offenders in the authenticity of their delusions. Delusions are defined as false fixed ideas that are not shared by others and are not amenable to change in light of conflicting evidence (18). Persecutory or paranoid delusions are the belief that one is going to be harmed or harassed by an individual, an organization or another group (18). Whereas most criminal murderers perceive reality in a reasonable way (non-delusional) without damaging their reality testing and thus commit murder from choice, acknowledging that their act is illegal (35), the majority of psychotic murderers are motivated by paranoid delusions, perceive reality in a psychotic and dangerous way (delusional reality), and, consequently, act in a deterministic and unavoidable way. In other words, some psychotic murderers cannot distinguish between the prohibited and the permitted, while others understand that the act is prohibited but cannot avoid doing it. According to this line of reasoning, Peled et al. (6) maintained that the violent behavior of psychotic patients is a logical response to unrealistic thoughts (delusions) and false perceptions (hallucinations). Given the fact that most participants were diagnosed as suffering from persecutory delusions, it is reasonable to assume that their absolute belief that they would be harmed by the victim led them to act violently against him/her, knowing subjectively that they had done the right and unavoidable thing and that there was no reason for them

to hide or conceal it. Therefore, in the participants' subjective perception, there was no need to flee the murder scene and conceal evidence, and there was often even an internal demand to call the police and report the murder.

This absolute belief in delusional reality also serves as an explanation for the extreme violence performed during the act of murder (i.e., multiple stabbings or beatings and dissection and abuse of the corpse). Such violence reflects powerful emotions (i.e., fear, anger and jealousy) which often characterize delusions (6, 12). These findings are consistent with findings from Holland and Germany that offenses committed by individuals with psychotic disorders were physically harsher than those committed by individuals without such disorders (29).

The second main finding of this study relates to the demographic aspect of the participants, particularly the overrepresentation of immigrants. Specifically, 45% of all participants are non-Israeli in origin, which is significantly higher than their distribution (35%) (36) in the general population. These data supports and strengthens other research findings indicating the high prevalence of immigrant populations among people with mental disorder who committed murder (24). Common explanations are associated with various unique social, cultural, and subcultural characteristics of immigrant populations (37) or, alternatively, with numerous assimilation challenges such as socialization processes, economic difficulties and harsh living conditions (38). An additional explanation relates, in our opinion, to immigrants' lack of knowledge regarding access to mental health services and the laws dealing with forced ambulatory care and hospitalization. We posit that this unfamiliarity prevented many mentally ill immigrants and their families from seeking psychiatric and legal assistance, which resulted in a deterioration in their mental state and, tragically, the execution of their violent criminal act.

Israel, like many other western countries, is a multicultural and heterogenic country that has received and continues to receive hundreds of thousands of immigrants from various countries over the last three decades (36). We maintain that a more activist policy should be implemented by the various government ministries (Ministry of Health, Ministry of Labor, Social Affairs and Social Services, Ministry of Aliyah and Integration, and Ministry of Public Security) as well as by health maintenance organizations. Such policies should incorporate, among others, identifying at-risk populations, organizing outreach activities, raising awareness among immigrant families, and providing information about hospitalization options, clinic and hospital locations, essential phone numbers, etc. Such information should be easy to access and be published on different platforms (e.g., electronic media and social networks such as Facebook, online newspapers, etc.) and in all relevant languages.

A third finding of this study relates to the participants' criminal and violent history. Almost three-quarters (73%) of all the participants had a background of violent behavior and at least half (50.8%) had a criminal record prior to committing the murder (mainly in violent and drug-related crimes). From the high occurrence of these factors, they can be assumed to serve as predictive indicators of future violent behavior. Specifically, individuals with psychotic disorders and with a background of violence and delinquency should be cautiously defined as an "at-risk population" (similar to the at-risk population in general medicine) and their supervision and monitoring in the community should thus be more rigorous. Nonetheless, it should be noted that the combination of previous violent behavior, alcoholism and antisocial personality disorder markedly increase the risk of future violent behavior, not only among people with mental disorders but also among defendants who commit murder and are seen as having criminal responsibility (39).

Finally, as in many other studies (21, 40), our findings reveal that most of the participants were known to the Israeli mental health system prior to their hospitalization, and had experienced prior involuntary hospitalizations owing to their violent behavior. Furthermore, in line with findings from other studies (7, 22, 30), most of the participants expressed low compliance with their psychiatric treatment and suffered from problems associated with the use of psychoactive substances in addition to deterioration of their mental state prior to committing the murder. This state of affairs consequently raises questions as regards to the reduction of the number of murders by increasing compliance with treatment and follow-up and preventing loss of contact with mental health caregivers.

There is a clear need to reduce violent acts and murders committed by individuals with psychotic disorders and, at the same time, to refrain from relating to them, in general, as violent and thus stigmatizing them. This leads us to conclude that the definition of individuals with mental disorders who are at risk of violent behavior should be revised in accordance with the variables that have emerged in this and other studies and that this population should be better monitored. Additionally, legislation must enable intervention and prevention among those discharged from hospital following severe

aggression and the implementation of a prevention policy incorporating crisis intervention teams, increased awareness among caregivers and family members, and improved accessibility of community-based psychiatric services.

LIMITATIONS

The main limitation of this study concerns its reliance on missing information. Although the medical decisions were written in real time, they often lack significant details. There is, in addition, no uniformity in the reports. For example, some of the indictments and expert opinions do not include details about the offender's behavior immediately following the murder, and some of the data concerning their criminal history and drugs and alcohol use were lacking and inaccurate. A more thorough examination of the cases at the time or access to additional databases (official police records, criminal registers, history of follow-up in outpatient clinics, etc.) might have improved their accuracy. In addition to these recommendations for different methods of data collection, we also suggest that future studies focus on quantitative and qualitative variables that characterize murderers who commit murder due to insanity and differentiate between them and murderers who commit murder not due to insanity as well as non-violent people with mental disorders.

This limitation notwithstanding, the results of this exploratory study add to the existing knowledge base about murder due to insanity. These findings may provide professionals in the mental health system and scholars with a better understanding of the phenomenon and may help in the development and implementation of prevention programs for people with mental disorders who are at risk of violent behavior.

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