Brit. J. Psychiat. (1979), **134,** 125–8

Correspondence

NECROPHILIA, MURDER AND HIGH INTELLIGENCE

DEAR SIR,

Dr Fullerton (*Journal*, October 1978, **133,** 382) is quite right in saying that the case described by Dr Lancaster (*Journal*, June 1978, **132,** 605) raises a number of issues of forensic interest.

I also examined Dr Lancaster's patient and gave evidence at the Crown Court. I gave the opinion:

1. That he was not suffering from McNaughton insanity.
2. That there was nothing to suggest that he suffered from such an abnormality of mind . . . as to substantially impair his mental responsibility for his acts.
3. There was no evidence whatsoever that at the time of the crime he was suffering from a confusional state or any state of non-insane automatism associated with impaired consciousness.

Both his EEG and psychological tests gave normal results.

It is true that he had consumed over half a bottle of whisky over a period of between 9 and 5 hours before the crime—yet he was an habitual drinker presumably with a considerable tolerance to alcohol —and he showed no signs of intoxication. It is by no means certain that he had consumed any clonidine. My own search of the literature suggested that the main evidence for the association between clonidine and aggressive behaviour is to be found in a paper which showed that certain strains—but not other strains—of laboratory rats developed group aggressive behaviour after relatively massive doses of clonidine over prolonged administration.

The accused had worked at the hospital in the grounds of which the victim's house was situated. He managed to cycle up a rough lane to arrive at the house very shortly after her husband had left to go on early duty. He was seen by a man on his way to work, pedalling quite normally. It seemed to me an extraordinary coincidence that he happened on the one house of many hundreds in the area where a woman was asleep in bed shortly after her husband had left for work on an early shift. This was another reason why I was unable to accept Dr Lancaster's postulate of behavioural automatism.

Dr Lancaster mentions the Appeal findings in the case of *DPP vs Majewski* (*1976 2 WLR 623*)—see *Criminal Law Review, 1976*, p. 374–8—in relation to self-induced intoxication and murder. In fact, the crucial case in this respect was *DPP vs Beard* (*1920 AC 479*). Beard had been convicted of murder when so drunk that he did not know what he was doing and could not remember after. Murder (unlawful killing with malice aforethought—i.e. intent) is a crime of specific intent where intent is implied in the definition of the offence. It is incumbent, therefore, in a case of murder, for the prosecution to show that at the time of the crime the accused had the *mens rea* (the wrongful mind—the intent) to commit the crime. Manslaughter (unlawful killing without malice) is not a crime of specific intent. It is therefore only necessary for the prosecution to show that the accused did the wrongful act—the *actus reus*, and proof of intent is largely irrelevant.

Thus the Beard appeal was successful on the ground that it was held that Beard did not possess the *mens rea*—the ability to form an intent to murder. A conviction for manslaughter was substituted as intent is irrelevant to that offence.

In the Majewski case the situation was different. Majewski was no doubt equally drunk from self-induced intoxication. However, he had been charged with a series of assault offences—actual bodily harm and assault on a police constable in the execution of his duty (*Police Act* 1964, s. 51). None of these are offences of specific intent liability—so that intent—*mens rea*—was not an issue.

Dr Lancaster in his article points out that, as a result of the Majewski case self-induced intoxication is no defence in assault cases—and asks for clarification in murder cases. The answer is in the Beard case—and the Majewski finding reinforced this, quoting it at some length.

It may be of some interest that this issue was raised not many months later in the same Crown Court as Dr Lancaster's case. A 37-year-old man was charged with the murder of an elderly widow in her flat late one night. Strangely, he also committed an act of necrophilia. There was abundant evidence that he had consumed at least two bottles of rum and was so drunk that he did not know what he had done and could not remember afterwards. He was charged

with murder. At Court, the defence made submissions based on the Beard findings supported by the Majewski opinion. The Court accepted a plea of not guilty to murder—but guilty to manslaughter.

I. Pierce James

Glenside Hospital,
Bristol BS16 1DD

GONADAL LESIONS IN TRANSSEXUALISM

Dear Sir,

It is almost unanimously admitted that transsexuals have functionally and structurally normal gonads. The few exceptions reported are probably fortuitous associations. However, we do not know of any systematic research on the gonads of these patients. We suggested as early as 1971 that gonadal lesions might occur quite frequently, and a study of 10 cases—6 female and 4 male—has confirmed this supposition.

In all 6 cases of female transsexuals the ovaries were polysystic with granulo-thecal hypertrophy and sometimes with stromal luteinization. One had primary amenorrhoea, 2 had secondary amenorrhoea (at the age of 25 and 28 respectively) and 3 had disorders of the menstrual cycle. One of the female patients had a male type of facial and genital hair distribution (in the absence of any hormonal treatment). There were also some small hormonal anomalies: constant decrease of urinary oestrogens (under 10 μg/24 h), and in one case the value of testosterone glucuronide was increased (32.0 μg/24 h).

In the males there were also gonadal lesions. The testes had a polymorphous aspect: low cellularity, some tubules with spermatogenesis arrested in initial stages. This was noticed in three out of four males. In one case the tubes were completely hyalinized. Secondary sexual characters were deficient: facial hair was sparse or absent. The level of total oestrogens was high: over 10 μg/24 h and the level of testosterne glucuronide was low—under 70 μg/24 h. In all 10 cases the karyotype was normal.

In our opinion gonadal lesions, obviously nonspecific, accompanied by small hormonal anomalies are frequently present in transsexualism. Their significance is uncertain, but the possibility that they are secondary to a disorder of the hypothalamo-hypohyseal area cannot be excluded.

B. Ionescu
C. Dumitrache
C. Maximilian

Institutul de Endocrinologie,
71279 Bd. Aviatorilor 34-36,
R-76.134 Bucuresti,
Romania

THREE DIFFERENT FORMS OF DEPRESSION IN ONE FAMILY

Dear Sir,

The grandfather used to drink socially. His wife's death at the age of 32 marked the onset of heavy drinking. His drinking was episodic, and, according to his son, associated with depression, he was never seen by a psychiatrist. The possible occurrence of alcoholism as a part of depressive illness is well known. He had few relatives and no friends.

His son, aged 54, had an impulse to drive his car into a wall, following the loss of his week's wages in gambling, and came to hospital. The death of the son's only daughter in 1964 had pushed him into heavy gambling, and he sold his car and house to pay for his debts, while his wife had to go out to work again. Still he could not stop gambling every now and again. Heavy losses occurred twice, each time after losing his job. At hospital he showed evidence of depressive illness, and was treated with tricyclic antidepressants and family therapy from May 1977. He and his wife are now able to enjoy a better family and social life than they ever had even before their daughter's death, and as his depression lifts his gambling stops. He describes himself as a loner. The relationship between pathological gambling and depression has been studied by various authors, including Moran (1970: *British Journal of Addiction*, **64,** 419).

Their daughter had a case record in three general hospitals, each time after taking an overdose. The first was precipitated by her father going out with a woman not his wife, and the last by her own separation from her boy friend. On the first occasion the psychiatrist's opinion was hysteria, and on the second reactive depression. She was not seen by a psychiatrist during the third and fatal admission because she was too ill, yet the notes strongly support the possibility of genuine suicidal attempt and depression. She had no emotional support from her parents, who expressed guilt feelings for that.

Paykel has offered a model for the modifying factors between events and illness. The nature of the event, a loss, its undesirability and significance, were similar in the three patients, and the lack of emotional and social supports probably played a role in the precipitation of illness in all of them. The father's ability to stop gambling for over a year now is probably related to the better emotional family life. This case supports Paykel's model through three generations of one family.

N. R. Bishay

John Conolly Hospital,
Rednal,
Birmingham B45 9BD