

# PERI-HOMICIDAL REACTIONS TO HOMICIDAL BEHAVIOURS

Jodi A. Glading

Submitted in partial fulfilment of the requirements  
for the degree of  
Master of Psychology (Clinical)  
University of Tasmania  
October, 2001

I, Jodi Ann Glading, certify that this thesis contains no material which has been accepted for the award for any other higher degree at any university and to the best of my knowledge this thesis contains no materials previously published or written by another person, except where references are noted in the body of the text.

Jodi Ann Glading

This thesis is not to be made available for loan or copying for two years following the date this statement was signed. After this time the thesis may be made available for loan and limited copying can be made if in accordance with the 1968 Copyright Act.

Jodi Ann Glading

For

The Glading Family: Florence, Robert, Dawn, Erin, and Mandy  
who let me spread my wings and fly 10,000 miles from home to study  
and to  
Lester, who would have had he been alive.

## **Abstract**

Homicide is a crime that has received much attention and research yet little is known about the psychophysiological underpinnings that accompany an act of homicide. Current research has tried to categorise different types of homicide such as filicide or mass murder and explain why people who commit these crimes act in such a way. However, the research has failed to find one common mechanism that can be used with all different types of homicide and can also differentiate between aggressive acts and the homicidal act. In this paper, four case studies will be presented, each highlighting a different type of homicide: sexually motivated, escalation of conflict, psychopathic, chronic abusive relationship, and fearful problem-solving. By using guided imagery to obtaining psychophysiological reactions to the event, and visual analogue scales to measure psychological functioning, this study shows that the perpetrators' homicidal behaviour was different from their aggressive behaviours and that each type of homicide had different psychophysiological and peri-homicidal psychological patterns. Implications for further research and suggestions for the application of the methodology in a forensic setting are considered.

## **Acknowledgements**

Thank you dear Lord for bringing me to Tasmania, twice. Without Your divine mission I never would have come to this beautiful island to study, to make friends or to marry. Without Your guiding hand and heavenly wisdom none of this would have been possible.

I am indebted to both Dr. Chris Williams and Dr. Janet Haines for the help over the past few years. Without them this project would never have taken root and most certainly would not have been completed in just two years. The guidance and support I received, not only with this thesis but in studying in general, was unparalleled. Chris and Janet, thank you for all your hard work and for listening to me.

To my wonderful husband, Cameron. Thank you for your encouragement. You are my biggest fan and you remind me daily why I wanted to do all of this. When I was weary you were my rock. Thank you for all the rides back and forth to university, putting up with my late nights and my endless chatter about this project.

To my American family I thank you for letting me come so far away from all of you. Thank you for pushing me on the plane each time I wanted to stay in the USA. I'm glad I did this project and I'm glad I did it in Tasmania and now I'm ready to return to you.

To my Australian family, Lyn, Ian and Christian, I thank you for giving me a roof to live under, for the meals you cooked, the laundry you did, for the lifts you gave me and for your son and brother. I never could have done this without you. You urged me to do the best that I could.

To Pastor John Heidenrich, Shannon Lees, and Kate Archer I thank you for making me take a deeper look at myself. Thank you for not letting me give up when I really, really wanted to. Thank you for reminding me to pray and that life isn't about grades or theses or internships, but about people and our relationships with them.

To Em in the South and Maria in the North, friendship is the best medicine. Thank you telling me I could do this if I put my mind to it. You gave me strength when I had none left.

Finally, thank you to the participants. My only hope is that this research helped you understand yourselves a little better and that it may go on to help others in similar situations. I am praying for you all.

God bless you all,

Jodi Glading

## Table of Contents

<b>Abstract</b>	<b>Page</b> i
<b>Acknowledgments</b>	ii
<b>Table of Contents</b>	iv
<b>List of Tables</b>	vi
<b>List of Figures</b>	viii
<b>List of Appendices</b>	x
<b>Chapter 1                      Introduction</b>	<b>1</b>
1.1    Definition of problem.....	2
1.2    Overview of thesis.....	3
<b>Chapter 2      Factors associated with Homicidal Behaviour</b>	<b>5</b>
2.1    Precursors of homicidal behaviour.....	6
2.1.1    Biological factors.....	6
2.1.2    Psychological adjustment.....	7
2.1.3    Demographic and epidemiological factors.....	10
2.2    Instrumental versus reactive homicide.....	12
2.3    Summary.....	13
<b>Chapter 3      Assessment issues: Recreating Past Events</b>	<b>14</b>
3.1    Assessment difficulties.....	15
3.2    Uses of Guided Imagery.....	15
<b>Chapter 4      Case 1 - Escalation of Conflict</b>	<b>18</b>
4.1    Case.....	19
4.2    Method.....	20
4.2.1    Participants.....	20
4.2.2    Design.....	21
4.2.3    Materials.....	21
4.2.3.1    Psychological tests.....	21
4.2.3.2    Subjective peri-homicidal measures.....	22
4.2.3.3    Imagery scripts.....	23
4.2.4    Apparatus.....	24
4.2.5    Procedure.....	25

4.2.6	Data transformation and scoring.....	25
4.2.7	Data Analysis.....	26
4.3	Results.....	26
4.3.1	Psychological measures.....	26
4.3.2	Psychophysiological response to imagery.....	29
4.3.3	Psychological response to imagery.....	
4.4	Discussion.....	38
<b>Chapter 5</b>	<b>Case 2 - Battered woman</b>	<b>43</b>
5.1	Case.....	43
5.2	Method.....	46
5.3	Results.....	48
5.3.1	Psychological measures.....	48
5.3.2	Psychophysiological response to imagery.....	51
5.3.3	Psychological response to imagery.....	
5.4	Discussion.....	60
<b>Chapter 6</b>	<b>Case 3 - Homicide and Psychopathy</b>	<b>65</b>
6.1	Case.....	65
6.2	Method.....	68
6.3	Results.....	70
6.3.1	Psychological measures.....	70
6.3.2	Psychophysiological response to imagery.....	74
6.3.3	Psychological response to imagery.....	
6.4	Discussion.....	87
<b>Chapter 7</b>	<b>Case 4 - Sexual Offence</b>	<b>91</b>
7.1	Case.....	91
7.2	Method.....	94
7.3	Results.....	96
7.3.1	Psychological functioning.....	96
7.3.2	Psychophysiological response to imagery.....	99
7.3.3	Psychological response to imagery.....	102
7.4	Discussion.....	110
<b>Chapter 8</b>	<b>Conclusions</b>	<b>113</b>
<b>References</b>		<b>116</b>
<b>Appendix A</b>		<b>138</b>
<b>Appendix B</b>		<b>143</b>



## List of Tables

		Page
Table 1	The content of each stage of each script for Case One (Amanda).	24
Table 2	The scores obtained on each of the subscales of the CAQ for Case One (Amanda).	27
Table 3	The percentile scores obtained for the scales and subscales of the STAXI for Case One (Amanda).	28
Table 4	The scores for the subscales of the Ways of Coping scale for Case One (Amanda).	28
Table 5	The level of endorsement for each irrational belief for Case One (Amanda).	29
Table 6	The content of each stage of each script for Case Two (Alice).	47
Table 7	The scores obtained on each of the subscales of the CAQ for Case Two (Alice).	48
Table 8	The percentile scores obtained for the scales and subscales of the STAXI for Case Two (Alice).	49
Table 9	The scores for the subscales of the Ways of Coping scale for Case Two (Alice).	50
Table 10	The level of endorsement for each irrational belief for Case Two (Alice).	51
Table 11	The content of each stage of each script for Case Three (Toby).	69
Table 12	The scores obtained on each of the subscales of the CAQ for Case Three (Toby).	71
Table 13	The percentile scores obtained for the scales and subscales of the STAXI for Case Three (Toby).	72
Table 14	The scores for the subscales of the Ways of Coping scale for Case Three (Toby).	73
Table 15	The level of endorsement for each irrational belief for Case Three (Toby).	74
Table 16	The content of each stage of each script for Case Four (Derek).	95

Table 17	The scores obtained on each of the subscales of the CAQ for Case Four (Derek).	96
Table 18	The Percentile Scores obtained for the scales and subscales of the STAXI for Case Four (Derek).	97
Table 19	The scores for the subscales of the Ways of Coping scale for Case Four (Derek).	98
Table 20	The level of endorsement for each irrational belief for Case Four (Derek).	99
Table 21	Ratings for Not close to real life – close to real life and Images not clear – images clear VASs for each stage of each script for Case One (Amanda).	144
Table 22	Ratings for Not close to real life – close to real life and Images not clear – images clear VASs for each stage of each script for Case Two (Alice).	145
Table 23	Ratings for Not close to real life – close to real life and Images not clear – images clear VASs for each stage of each script for Case Three (Toby).	146
Table 24	Ratings for Not close to real life – close to real life and Images not clear – images clear VAS for each stage of each script for Case Four (Derek).	147

## List of Figures

		Page
Figure 1	The mean heart rate for the baselines and each stage of each script for Case One (Amanda).	30
Figure 2	The ratings for the not anxious-anxious VAS for each stage of each script for Case One (Amanda).	32
Figure 3	The ratings for the not angry-angry VAS for each stage of each script for Case One (Amanda).	33
Figure 4	The ratings for the normal-unreal VAS for each stage of each script for Case One (Amanda).	34
Figure 5	The ratings for the not fearful-fearful VAS for each stage of each script for Case One (Amanda).	35
Figure 6	The ratings for the not agitated-agitated VAS for each stage of each script for Case One (Amanda).	37
Figure 7	The ratings for the not guilty-guilty VAS for each stage of each script for Case One (Amanda).	38
Figure 8	The mean heart rate for the baselines and each stage of each script for Case Two (Alice).	53
Figure 9	The ratings for the not anxious-anxious VAS for each stage of each script for Case Two (Alice).	54
Figure 10	The ratings for the not angry-angry VAS for each stage of each script for Case Two (Alice).	55
Figure 11	The ratings for the normal-unreal VAS for each stage of each script for Case Two (Alice).	57
Figure 12	The ratings for the not fearful-fearful VAS for each stage of each script for Case Two (Alice).	58
Figure 13	The ratings for the not agitated-agitated VAS for each stage of each script for Case Two (Alice).	59
Figure 14	The ratings for the not guilty-guilty VAS for each stage of each script for Case Two (Alice).	60
Figure 15	The mean heart rate for the baselines and each stage of each script for Case Three (Toby).	76

Figure 16	The ratings for the not anxious-anxious VAS for each stage of each script for Case Three (Toby).	78
Figure 17	The ratings for the not angry-angry VAS for each stage of each script for Case Three (Toby).	80
Figure 18	The ratings for the normal-unreal VAS for each stage of each script for Case Three (Toby).	82
Figure 19	The ratings for the not fearful-fearful VAS for each stage of each script for Case Three (Toby).	83
Figure 20	The ratings for the not agitated-agitated VAS for each stage of each script for Case Three (Toby).	85
Figure 21	The ratings for the not guilty-guilty VAS for each stage of each script for Case Three (Toby).	87
Figure 22	The mean heart rate for the baselines and each stage of each script for Case Four (Derek).	101
Figure 23	The ratings for the not anxious-anxious VAS for each stage of each script for Case Four (Derek).	103
Figure 24	The ratings for the not angry-angry VAS for each stage of each script for Case Four (Derek).	105
Figure 25	The ratings of the normal-unreal VAS for each stage of each script for Case Four (Derek).	106
Figure 26	The ratings for the not fearful-fearful VAS for each stage of each script for Case Four (Derek).	107
Figure 27	The ratings for the not agitated-agitated VAS for each stage of each script for Case Four (Derek).	108
Figure 28	The ratings for the not guilty-guilty VAS for each stage of each script for Case Four (Derek).	109

## **List of Appendices**

	<b>Page</b>
Appendix A      Consent forms and information sheet.	138
Appendix B      Ratings for the control VASs.	143

# **Chapter 1**

## **Introduction**

Homicide attracts a large amount of attention, from the legal system, the general public and from research. The common law definition of homicide can vary from state to state in the United States but is typically based on the Model Penal Code (Section 210.1) that says "A person is guilty of criminal homicide if he purposely, knowingly, recklessly, or negligently causes the death of another human being" (American Law Institute, 1980, p4.). The Australian Penal Code generally defines homicide as an act or omission that contributed significantly to the death of a human being, or the person could foresee the victim's death as a result of the act or omission (Riordan, 1993).

In the United States, there were 16,974 homicides in 1998 and 15,533 homicides in 1999 (Federal Bureau of Investigation (FBI), 1999; <http://www.fbi.gov/>) and in Australia there were 284 homicides in 1998 (McLennan, 2000). The number of homicides has decreased in both countries since the early 1990s, especially in the rural areas. The number of persons murdered in the United States in 1999 represented an 8% decrease from the 1998 estimate. The 1999 figure also represents a 28% decline in comparison to the 1995 estimate and a 34% decrease in contrast to the 1990 nationwide estimate. In 1999, only .01% of crimes committed were homicides whereas 10% of crimes committed were auto-thefts and 60% were larceny-theft (FBI, 1999).

### *1.1 Definition of problem*

Most research tries to define homicidal behaviour as if it was an extension of aggression and as if it was a single action (e.g., Dietz, 1987; Godwin, 2000; Gottfriedson & Hirschi, 1990; Munnich, 1993). However, no studies have found that it is purely an extension of aggressive tendencies and deeper examination of homicide shows the complex nature of the behaviour (Cloninger, Svrakic & Svrakic, 1997).

A comprehensive understanding of homicidal behaviour would require that all the factors that contribute to homicide be considered. It is clear that research exists about the pre-homicide influences on homicidal behaviour (e.g., Dietz, 1987; Gottfriedson & Hirschi, 1990; Johnson & Becker, 1997; Lewis et al., 1988; Van Hasselt & Hersen, 2000; Wilson, 1991; Yarvis, 1991), and extrapolations can be made about the nature of criminal behaviour on the basis of crime scene examination (e.g., [http://www.apbonline.com/crimesolvers/douglas/1999/08/douglas\\_story.html](http://www.apbonline.com/crimesolvers/douglas/1999/08/douglas_story.html); Ressler, Burgess & Douglas, 1998). However, little is known about the way in which people respond during the actual perpetration of homicidal behaviour.

### *1.2 Overview of thesis*

This thesis will examine a range of factors that have contributed to the understanding of why people commit homicide. Next, a method for assessing peri-homicidal reactions will be considered. Examining a peri-homicidal reaction is extremely challenging. Some research suggests enhancing recall of events with hypnotism (Schefflin, Spiegel & Spiegel, 1999) or using disinhibiting drugs to elicit an abreaction (Kopelman, Christensen, Puffett & Stanhope, 1994). The major fault with these techniques is that they override the psychophysiological arousal, which normally would be evident during an act of homicide. As a way of recreating the psychophysiological response and the psychological reaction at the time of the event, guided imagery can be applied. The success of guided imagery in examining traumatic events is well documented (e.g., Holmes, Williams & Haines, 1998; Orr et al., 1998; Shalev, Orr & Pitman, 1993).

A guided imagery technique has the potential of being one mechanism for systematically testing and establishing one scientific criterion by which all people who commit homicide are measured. It elicits a realistic response by accessing



physical reaction, psychological response, and personality states and traits as they influence psychophysiological reactions, while recreating the event. By using personalised guided imagery, the examiner is able to recreate the memory of the event, present it to the individual in stages, and concurrently measure efferent outflow and psychological response (Haines, Williams, Brain & Wilson, 1995).

Following from this, four case studies will be presented that employ a personalised, staged, guided imagery methodology. These case studies will highlight the complexity of peri-homicidal reactions and the results of these studies will form the basis of a proposition for the classification of homicidal behaviour that takes into account varying manifestations of peri-homicidal reaction. Directions for future research will be considered.

## **Chapter 2**

### **Factors associated with Homicidal Behaviour**

There are multiple theories that attempt to explain homicidal behaviours ranging from biological to cognitive. Debate exists over the nature of biological deficits and the way in which biological deficits interact with environmental influences (e.g., Lange, 1999), whether environmental influences are sufficient to cause homicidal behaviour (e.g., Frye & Wilt, 2001), and to what extent homicidal behaviour can be understood as a cognitive event (e.g., Holcomb, 2000). All attempt to account for the established precursors of homicidal behaviour.

## *2.1 Precursors of homicidal behaviour*

### *2.1.1 Biological factors*

The literature about homicide has considered data from a variety of sources. There are a vast number of studies that cite research that shows biological abnormalities in the brain structure of people who commit homicide (e.g., Elliot, 1988; Golden, Paterson-Rohne, Jackson & Gontkovsky, 2000; Johnson & Becker, 1997; Money, 1990; Wilson, 1991). For example, people who committed homicide had been demonstrated to have reduced glucose metabolism in the prefrontal cortex, superior parietal gyrus, corpus callosum and left angular gyrus indicating abnormal cortical and subcortical brain processes (Raine, Buchsbaum & LaCasse, 1997). Damage to these areas may predispose the perpetrators to violent behaviour since these areas are thought to control impulsivity, self-control, planning and levels of emotionality. Danto (1982) mentioned organic brain disorders resulting from epilepsy, brain deterioration, and hereditary diseases or from head trauma as common biological factors in persons who commit homicide.

Further research has supported the notion of biological factors influencing homicidal behaviour. Langevin et al. (1988) found 33% of people who commit homicide were significantly cognitively impaired whereas only 17% of people who

commit another violent crime and none of the non-violent offenders displayed evidence of cognitive impairment. Reduced cognitive functioning as measured by IQ was evident in 73% of a violent criminal population (Golden et al., 2000). In that study, deficits in integration of sensory information, ability to concentrate, ability to plan and organise, and ability to execute goal-directed behaviours were specifically identified.

Some biological research examined the effects of acquired brain injury and illness in childhood (Johnson & Becker, 1997; Lewis, et al., 1988; Yarvis, 1991) whereas other research examined congenital brain abnormalities (Barratt, Stanford, Kent & Felthous, 1997; Elliot, 1988; Golden, et al., 2000; Jarosova, 1999; Money, 1990; Raine, et al., 1997). Most research on childhood acquired brain injury or birth abnormalities indicated that these physical attributes contributed to homicide by predisposing the persons to deviant behaviour when triggered by an environmental cue. However, this makes finding the cause of deviance almost impossible since the data cannot conclusively say what made the person react the way they did. It does not consider why some people with an abnormality and a trigger kill whereas others commit non-violent crimes or no crime at all. Clearly, some other factor or factors need to be considered.

### *2.1.2 Psychological adjustment*

It is apparent that some perpetrators of homicide have poor psychological adjustment and may be diagnosed with a psychiatric disorder (Holcomb, 2000; Pincus, 2001). For example, it has been determined that two-thirds of mothers who kill their children are psychiatrically ill (Stroud & Pritchard, 2001). Specific types of psychiatric disorders have been noted among homicide perpetrators, most commonly drug or alcohol abuse, antisocial personality disorder, and schizophrenia (Woodward,

Nursten, Williams & Badger, 2000).

A strong connection between substance abuse and homicidal behaviour, particularly alcohol abuse, has been consistently reported (Miller & Sheppard, 2000; Sharma, 1995; Spunt, Brownstein, Goldstein & Fendrich, 1995; Yarvis, 1994). Alcohol has a disinhibiting effect that increases impulsive actions (Fendrich, Mackesy-Amini, Goldstein & Spunt, 1995) and aggressive behaviour (McKenzie, 1995). Even if a perpetrator strongly believes that homicide is wrong, under the influence of alcohol they may act in an unplanned way resulting in the death of another person. The intoxicating effects of alcohol lead the person to make poorer choices than he or she normally would have made (Danto, 1982). Homicides perpetrated by women may involve alcohol although at a lesser rate than is evident with male perpetrators of homicide (Lester, 1992; Muzinic-Masle & Goreta, 2000). Alcohol is used to self-medicate as a way of reducing stress (Colder, 2001).

Multiple studies have shown that alcohol plays a much larger role in crimes than other drugs (Blount, Silverman, Sellers & Seese, 1994; Spunt, et. al., 1995). Nevertheless, a combination of drugs and alcohol can escalate aggressive behaviours (Salloum, Daley, Cornelius & Kirisci, 1996). Over one-third of the perpetrators were under the influence of drugs (including alcohol) at the time of the incident and almost two-thirds of the homicides were considered to have occurred due to drugs. Alcohol and cocaine, usually crack, were the drugs most related to homicides in the United States (Spunt et al., 1995).

A relationship also has been found between drug use and participation in violent acts in young people. The research suggested that these young people had experienced violence and loss in their own lives and had a tendency to self-medicate when severe trauma was experienced (Crimmins, Cleary, Brownstein, Spunt &

Warley, 2000).

Personality disturbance is evident in some homicidal individuals (Meloy, 2000). In one study, most criminals were found to be mildly impulsive and high in harm avoidance. A combination of mild to moderate impulsiveness and high harm avoidance was seen in people with explosive outbursts, whereas mild to moderate impulsiveness with low harm avoidance was seen in people with antisocial personality disorders. Both of these personality characteristics were seen in more violent criminal cases than non-violent cases (Cloninger, et al., 1997). Violent criminals often displayed low self-directedness, which was evident in their lack of impulse control, discipline and substance abuse. This population rarely verbalised their feelings and often struggled with inner guilt or anger about being insulted or embarrassed (Danto, 1982).

A psychopathic offender kills due to social maladjustment. These offenders have not adopted society's norms and values. They have no feeling of connection to other people, no sensitivity of the need or rights of others, and a cynical outlook on life. These offenders are considered to have a defect in their conscience (Wille, 1974).

People who commit psychopathic homicides are emotionally detached and autonomically hyporeactive to events that are normally associated with heightened emotion and arousal. They lie more, make poorer judgements, are egocentric, impulsive, hedonistic and narcissistic. They can also be antisocial and highly intelligent (Godwin, 2000). An individual with psychopathy who commits homicide generally lacks empathy and is unable to recognise when a guilty response is required. This may lead to their strong disposition to violent behaviour. As a result, these people commit homicide to reach their goals without remorse or concern for the

people they harm (Geberth & Turco, 1997). Psychopathy is common among people who repeat homicidal acts and those whom engage in serial homicide (Lowenstein, 1992; Teles, 1995). A serial murderer has been defined as a person who kills in two or more separate incidents (Egger, 1986).

An association is evident between homicidal behaviour and schizophrenia, although the rates are generally overestimated. For example, only 27% of persons who committed non-sexual homicide were considered psychotic at the time they committed the crime (Langevin, 1991) and there was no greater propensity for psychosis in prisoners than in the general population (Coid, 1984). In comparison with homicide perpetrators with a mood disorder, those with schizophrenia were demonstrated to be more likely to kill an unrelated victim, be older at the time of the first criminal offence, were less often intoxicated at the time of the homicidal act, were more likely to be in a stage of psychological distress or experiencing an interpersonal conflict, and were more likely to engage in premeditated homicides. The homicides tended to occur as a consequence of psychotic symptomatology that resulted in the development of homicidal plans. At times of increased symptomatology, control over behaviour is lost (Montanez, 2000).

### *2.1.3 Demographic and epidemiological characteristics*

The majority of homicides are committed by males between 20 and 40 years of age with an average age of approximately 25 years (Douglas, Burgess, Burgess & Ressler, 1992). They have achieved a lower level of schooling than the general population (Robert, 1996). The trend in the 1990s was for a decrease in adult violent crimes and an increase in adolescent violent crimes (FBI, 1999).

Female perpetrators of homicide may evidence different characteristics from their male counterparts (e.g., Adinkrah, 2001; Floyd, 2000) or, at least, are treated

differently within the criminal justice system (e.g., Mitchell, 1997). For example, it would appear that the nature of interpersonal relationships has a large impact on female-perpetrated homicide (e.g., Campbell & Robinson, 1997; Johnson, 1996). Of course, this may be true for both sexes as marriage has been determined to significantly contribute to the homicide rate, at least in Canada (Leenaars & Lester, 1994). However, there are a number of studies that have highlighted the vulnerability to homicidal behaviour of women who are the victims of domestic violence (e.g., Grant & Curry, 1993; Hamilton & Sutterfield, 1997; Rodriguez & Henderson, 1995).

There are multiple factors associated with battered women's experiences that can increase the likelihood that they will perpetrate homicide. Battered homicidal females compared with battered, non-homicidal females were more likely to have been sexually assaulted, have had poor school attendance, have had an erratic work pattern, have co-habited with the partner, have had substance abuse problems and have attempted suicide by self-poisoning (Roberts, 1996). Additional information suggested that battered women who committed homicide were older, had longer and more violent relationships, and had sustained more serious injuries (O'Keefe, 1997).

Even in the absence of criminal or violent histories, battered women who have killed their spouses can be prosecuted to the full extent of the law (Leonard, 2001). This contrasts sharply with the much milder legal outcomes for women who kill their children (e.g., D'Orban, 1990; Pitt & Bale, 1995). Indeed, battered women who kill their abusers present special challenges to legal systems that are ill prepared to cope with the perpetration of such crimes (Grant, 1995).

Specific epidemiological factors have been identified. Violent crimes, homicide included, tend to occur disproportionately late at night or in the early morning on weekends, that is between 8:00 p.m. and 2:00 a.m. on Friday, Saturday



and Sunday (Leyton, 1986). Most homicides occur outside of the home, 48% are committed by someone known to the victim with 14% related to the victim and 34% acquainted with the victim, and seven of ten involve firearms (FBI, 1999). Sixty percent of offenders had been drinking alcohol prior to the event (Fitzpatrick, 1974), 25% to 67% had a history of childhood violence, a majority had previous criminal records, came from lower socio-economic backgrounds, and most were emotionally unstable (Danto, 1982). Minorities are over represented in violent criminal populations excluding persons who committed serial homicides who are more often white (Godwin, 2000).

Environmental factors also influence the perpetration of homicide. People who committed homicide had experienced difficulties in childhood. Both male and female homicide perpetrators have experienced emotional, physical, and sexual abuse during childhood (Schurman-Kauflin, 2000). Eleven percent of offenders ran away from home as a child and 40% recalled having temper tantrums (Langevin, 1991). Research has found 33% of offenders experienced childhood enuresis after the age of five years (Langevin et al., 1988) compared to 7% non-offenders (Fergusson, Horwood, Kershaw & Shannon, 1986).

## *2.2 Instrumental versus expressive homicide*

Broken down into the most simplistic form, homicides can be categorised on the basis of their motive or their cause. First are instrumental homicides that are committed for personal gain (Decker, 1996). These are more likely to be perpetrated by a person with a psychological condition and include homicides associated with rape and robbery (Pollock, 1999). Second are expressive homicides that are committed because of interpersonal relationship difficulties. These are more impulsive than instrumental homicides (Decker, 1996). Examples of expressive

homicides are those perpetrated by battered women or resulting from arguments that lead to unplanned death. Expressive homicides not only occur between people who intimately know one another but are just as likely to occur when the perpetrator and the victim are acquaintances or even strangers (Decker, 1996).

Although a large number of homicides must be committed during an unplanned situation associated with escalating distress, there are few published reports (Williams, Haines, Glading, Sale & Davidson, 2001a). The research does show that strong and cohesive families, a sense of belonging in the community, and religious affiliation are protective measures against committing homicide. The strong sense of social organisation decreases the likelihood of committing crime. The exception would be in cultures that condone violence as a way of maintaining honour. These societies value greater social organisation because it is associated with a strong endorsement of violence in certain circumstances (Cohen & Nisbett, 1994).

### *2.3 Summary*

There are multiple factors that impact on homicide ranging from biological abnormalities such as congenital abnormalities to psychological adjustment. In addition, the demographic and epidemiological studies have shown characteristics such as age, gender and even the time of the day are all factors involved in homicide. However, not all homicides are influenced in the same way. Indeed two types of homicide are evident, instrumental and expressive that, by their very nature, would be influenced by different factors.

## **Chapter 3**

### **Assessment issues: Recreating Past Events**

### 3.1 *Assessment difficulties*

The lack of information about peri-homicidal reactions may be a reflection of the evident difficulty in accessing states associated with unique behaviours. Unfortunately, previously used methods of researching homicide cannot give a clear picture as to what was happening at the time of the event. Prior methods only examined the factors that contributed to the behaviour. Brain or physiological abnormalities are difficult to identify or characterise and it is difficult to determine the link with homicidal behaviour (Lewis et al., 1988; Raine, et al., 1997). Psychological assessment can give skewed data if the perpetrator answers untruthfully (Orr & Pitman, 1993; Wetter & Deitsch, 1996). Crime scene information is a hypothetical system first created by the Behavioural Sciences Unit of the FBI (Ressler, et al., 1998) and then expanded to fit different theorists' explanations. The research is lacking a more objective measurement of psychological and psychophysiological reaction, specifically reactions that were occurring at the time of the homicide. This is made even more difficult because an attempt is being made to examine an event that occurred once and occurred in the past.

Without understanding all the factors at the time of the event, it is difficult to discern the motivations behind the act. Therefore, a method is needed that recreates a homicidal act irrespective of its nature. It is suggested that guided imagery can be used to recreate the reactions to homicidal acts.

### 3.2 *Uses of guided imagery*

In 1979, Lang demonstrated that measurements of psychophysiology showed specific somato-motor and visceral activity based upon the content of the cognitive event conveyed through guided imagery. Research has indicated that there was virtually no difference between the response to an actual event and the response to the

event when imaged. For example, the same psychophysiological results were found in swimmers who imaged themselves swimming and when they were actually swimming even though they were not guided through the process (Beyer, Weiss, Hansen, Wolf & Seidel, 1990). In a similar study, target shooters responded similarly to mental imagery of shooting and actual target shooting (Deschaumes-Molinaro, Dittmar & Vernet-Maury, 1991).

The content of what is imaged can affect the psychophysiological response. Hirota and Hirai (1986) concluded that response oriented imagery (the things that the person did at the scene) results in more effective psychophysiological response than stimulus oriented imagery (descriptions of context and reasoning) (Lang, Kozack, Miller, Levin & McLean, 1980).

The strongest and most appropriate responses to imagery come from information directly taken from the person's experiences. Taking information from the person's repertoire can help overcome the limitation of having poor imagery ability (Miller, et al., 1987), although there is no success in increasing the response by increasing the number of stimulus modalities (Holzman & Levis, 1989). Therefore, data from imagery studies showed techniques could recreate the psychophysiological state as if it were happening (Pitman & Orr, 1993; Pitman, Orr, Forgue, de Jong & Claiborn, 1987). As a way of controlling the rate at which the images were recalled and to structure the images in a sequential manner, the images were presented in stages (Haines, et al., 1995). Furthermore, this methodology helped the researchers to chart the development of the behaviour by examining the different components of the event. In particular, this guided imagery methodology was successfully used in examining homicidal behaviour (Glading, Williams, & Haines, 2001; Glading, Williams, Haines, & Sale, 2001; Haines, Williams, Sale & Glading, 2001; Haines,

Williams, Sale, Glading & Davidson, 2001; Williams, Haines, Glading, Sale & Davidson, 2001a, 2001b; Williams, Haines, Sale & Glading, 2001). Williams and colleagues (Williams & Haines, 2001; Williams, Haines & Casey, 2000) were able to show guided imagery could be used in the insanity defence in a filicide case (*R v. Horton*, 1986). They were able to demonstrate that the mother-child interaction pattern was reinforcing escalating punitive behaviour by the mother, ultimately resulting in the death of the child.

Therefore, a method exists for the examination of the peri-homicidal reactions of a homicide perpetrator. This method uses imagery and the use of imagery has a long history of successful application to the examination of aberrant reactions and behaviours.

## **Chapter 4**

### **Case One: Escalation of Conflict**

#### *4.1 Case*

The first case was of an expressive homicide that occurred as a reaction to an escalation of interpersonal conflict. Amanda was a 33-year-old female who had been incarcerated since 1999. She was physically attractive, friendly, and outgoing. She was the eldest of two children and reported no childhood violence and no previous criminal record. Her parents were married and raised their children in a religious family. They lived in a small town while the children were growing up. Amanda set high standards for herself. She matriculated and completed additional training in a semi-professional job. She was employed at the time of the event. She had been in a relationship that lasted almost 12 years. She was married for 18 months of that time, but the relationship had dissolved six months prior to the homicidal event. She was living in a unit by herself and was fearful of being home alone. She was often frightened and had kept a knife near the backdoor for self-defence.

The marriage had ended upon her husband's request after he disclosed that he was gay. Amanda had difficulty dealing with the separation, firstly because she had deep feelings for her husband, and secondly because her religious beliefs complicated her reaction to her husband's disclosure. The break-up of the relationship lead to Amanda being prescribed antidepressant medication for agitated depression. Amanda also tried to self-medicate with alcohol. She had no psychiatric history other than the problems she experienced as a result of her marriage breakdown.

Immediately prior to the night of the event, her husband had returned for a visit and the perpetrator's sister was about to give birth. These circumstances made the perpetrator regret her life outcomes and the way her life was headed. Amanda and her husband shared their dogs and the husband was to pick up the dogs on the day of the homicide so Amanda could attend the birth of her sister's baby. The husband was



late in picking up the dogs and Amanda's attempts to locate him had failed. Amanda had been drinking and had become increasingly upset as she continued to wait for her husband.

The victim was a young adult female in-law of the perpetrator, although the victim was merely an acquaintance. The two had met only about 8 times in 12 years. The last meeting was about 18 months before the event occurred. The victim arrived at Amanda's home and wanted to take the dogs. Amanda disagreed with this request and an argument ensued in the back doorway with the victim blaming Amanda for the sexual orientation of her husband. The argument quickly escalated and the victim was described as confrontational and aggressive. The victim physically attacked Amanda. Without clear recollection of the event, Amanda stabbed the victim with the knife she kept by the back door. Immediately after, Amanda denied being aware of having seriously harmed the victim.

Amanda was found guilty of murder. She received a 12-year sentence with and 8-year non-parole period. Amanda was remorseful of her actions.

## **4.2 Method**

### ***4.2.1 Participant***

Amanda is currently serving a sentence at Her Majesty's Prison Risdon, Tasmania. The Director of Nursing contacted her at the prison hospital to determine if she wished to participate in the study. The researcher then met with Amanda following informal agreement to participate.

The University of Tasmania Research Ethics Committee and the Department of Justice and Industrial Relations approved the study. Amanda signed two consent forms. The first form detailed an agreement to participate and the second form

granted the researcher permission to publish and/or present data regardless of possibility of identification. Participation was strictly voluntary. Copies of the consent forms and the information sheet that was supplied to the participant are presented in Appendix A.

#### *4.2.2 Design*

This study used a single case study method (Barlow & Hersen, 1984) to assess individual psychological and psychophysiological reactions during three guided imagery scripts. Three scripts consisting of the homicide event, a non-violent aggressive event, and an emotionally neutral event were drafted for each participant. The scripts were presented in five stages: setting the scene, approach, incident, consequence, and resolution. Measures of psychological and psychophysiological responses to each stage of the script were taken.

#### *4.2.3 Materials*

##### *4.2.3.1 Psychological tests*

A range of psychological tests were administered to provide a descriptive psychological profile of the perpetrator.

The Clinical Analysis Questionnaire (CAQ; Krug & Cattell, 1980) was administered to assess personality and psychological symptomatology. It measures 16 normal personality traits (e.g., reserved vs. outgoing), and 12 clinical scales (e.g., anxiety and depression). This test has been demonstrated to have good test-retest reliability and good factor pattern coefficients.

The State-Trait Anger Expression Inventory (STAXI; Spielberger, 1996) was used to measure aggressive experiences and expressions. It considers both state anger (emotional states marked by subjective feeling that vary according to what is currently occurring) and trait anger (a disposition to perceive a wide range of situations as

annoying or frustrating and the tendency to respond to these situations in a similar manner. In addition, scales are provided that assess the inward or outward direction of anger, the ability to express anger, and the ability to control anger. Psychometric tests of this instrument support its validity and reliability.

The Ways of Coping Questionnaire - Revised (Folkman & Lazarus, 1988) was administered to determine coping skills available to the perpetrator. There are five scales for this test that measure different aspects of coping: problem focused, seeking social support, wishful thinking, blaming self, and avoidant coping. The construct validity of this scale has been determined to be adequate (Edwards & Baglioni, 1993).

The Beliefs Inventory (Davis, Eshelman & McKay, 1988) assessed the perpetrators' attitudes and beliefs that predispose a person to the experiences of stress and distress. Although it has been suggested that all measures of irrational beliefs need future psychometric work, this and other tests all have excellent face validity (Woodward, Carless & Findlay, 2001).

The Dissociative Experiences Scale (DES; Bernstein & Putnam, 1986) measured level of trait dissociation and has been used in non-clinical and clinical populations. The test has been demonstrated to have good reliability as well as good convergent validity, predictive validity (van Ijzendoorn & Schuengel, 1996), and construct validity (Holtgraves & Stockdale, 1997).

#### *4.2.3.2 Subjective peri-homicidal measures*

Visual Analogue Scales (VASs; McCormack, Horne & Sheather, 1988) were employed to record subjective reactions to imagery using bipolar dimensions. Scores ranged from 0 to 100 on all VASs. The VASs were not anxious-anxious, not angry-angry, normal-unreal, not fearful-fearful, not agitated-agitated, and not guilty-guilty. On these six visual analogue scales, a higher score indicated a more negative

experience.

Two VASs were used as controls to subjectively record the participants' ability to mentally recreate the event. These were not close to real life-close to real life, and images not clear-images clear. A higher score on these two scales indicated increased ability to mentally recreate the event. The ratings made by all participants on these scales are presented in Appendix B.

#### *4.2.3.3 Imagery scripts*

Personalised, staged scripts were used to guide the person through the images and scenes while recording the psychophysiological reactions during homicidal, non-violent aggressive and emotionally neutral acts. The content of the imagery scripts was derived only from interview, extracting information about environment, cognitions, behaviours, emotions and psychophysiology associated with each event. From this information the five 60-second stages for each of the three scripts were prepared. The scripts reflected the development of the event over time. The five stages were: setting the scene (circumstances surrounding the event), approach (events occurring immediately before the event), incident (the actual event), consequence (events that occur immediately after the event), and resolution (events surrounding departing the scene). Table 1 presents the content for each stage of each script.

Table 1.

*The content of each stage of each script for Case One (Amanda).*

Script	Stage	Content
Homicide	Setting the Scene	In an agitated state because of preceding events, Amanda answered the door to the victim.
	Approach	An argument developed between Amanda and the victim in the doorway.
	Incident	A physical altercation developed and the victim was stabbed.
	Consequence	Amanda viewed the victim through the window and then went to attend to her dogs.
	Resolution	Amanda returned to the laundry and discovered the bloody knife.
Aggression	Setting the Scene	Amanda was completing a visit at the prison with friends.
Approach	Amanda left to work on a computer in another room.	
	Incident	Others entered the room with prohibited items they had received.
	Consequence	Amanda went to friends to express her anger over others having prohibited items.
	Resolution	Amanda calmed down after her friends agreed with her point of view.
Neutral	Setting the Scene	Amanda got her mug, coffee and teaspoon and went to the kitchen.
	Approach	She put her milk in the mug and filled it with hot water from the urn.
	Incident	Amanda toasted two slices of bread.
	Consequences	She sat at the table and spread her toast with marmalade.
	Resolution	Amanda sat at the table and drank her coffee and ate her toast.

#### 4.2.4 Apparatus

Heart rate (HR) was measured and recorded on an Acer TravelMate 514T computer, and a 4-channel portable Powerlab using Chart 4.0.1 software. Heart rate (HR) was selected as a robust and reliable measure of psychophysiological arousal (Arena & Hobbs, 1995; Blanchard, Hickling & Taylor, 1991; Burns, Ferguson, Fernquist & Katkin, 1992; Holland, Bouffard & Wagner, 1992). HR was measured

by using adhesive electrodes fitted at the second rib on both sides of the midriff. An adhesive electrode was attached at the left mastoid process and served as an earth reference.

#### *4.2.5 Procedure*

The participant was interviewed at the prison for background information and about the homicide, an aggressive interaction and an emotionally neutral act. The researcher prepared the scripts before the next session with the participant, when electrodes were attached. One experimenter verbally administered imagery scripts and a second experimenter took the psychophysiological recordings. A 60-second baseline was taken while the participant was sitting with her eyes closed. This was followed by the verbal presentation of the first stage of the first script. After the first stage was completed, a 10-second pause occurred and then the participant closed her eyes and the next stage of the script was presented. This proceeded until all stages of the script had been administered. Then, the participant rated the VASs based upon how she was feeling at each stage. Prompts were used to help the participant remember the content of each of the stages. The VASs were administered after the resolution stage of each script to maintain continuity of imagery. After the VASs were presented for one script, the next script was administered in the same way. Amanda was debriefed about the findings in a follow-up session.

#### *4.2.6 Data transformation and scoring*

Heart rate data was scored by extracting a 30-second scoring period from the baseline and each stage. A mean was calculated in beats per minute from this 30 second scoring period. This scoring method has been used elsewhere (Brain, Haines & Williams, 1998; Haines, Josephs, Williams & Wells, 1998; Haines, et al., 1995; Wells, Haines, Williams & Brain, 1999).

#### *4.2.7 Data Analysis*

Data were manipulated in three ways. Firstly, descriptive data from psychological testing is presented either with indication of clinical significance or in comparison with normative data. Secondly, across stage responses to imagery are described relative to script content. Thirdly, between script differences at each stage are determined to be clinically significant if more than 3.29 standard deviations above the mean of the stages of the neutral script (see Tabachnick and Fidell (1989) for a discussion of the identification of outliers).

### **4.3 Results**

#### *4.3.1 Psychological Measures*

Table 2 presents the scores obtained for the personality and clinical factors of the CAQ. Personality trait scores from 1-3 or 8-10 are considered to be clinically significant as are clinical factors scores of 8 or above. This test indicated that Amanda was an intelligent and self-sufficient woman although she had a tendency to be unadventurous. All clinical factor scores were in the normal range. The protocol was valid.

Table 2.

*The scores obtained on each of the subscales of the CAQ for Case One (Amanda).*

Personality subscales	Score	Clinical Measures	Score
Warmth	5	Hypochondriasis	5
Intelligence	8 *	Suicidal Depression	2
Emotional Stability	4	Agitation	6
Dominance	7	Anxious Depression	4
Impulsivity	7	Low Energy Depression	5
Conformity	5	Guilt and Resentment	6
Boldness	7	Boredom and withdrawal	6
Sensitivity	6	Paranoia	2
Suspiciousness	6	Psychopathic Deviation	6
Imagination	3 *	Schizophrenia	5
Shrewdness	5	Psychasthenia	7
Insecurity	5	Psychological inadequacy	4
Self-sufficiency	8 *		
Self-Discipline	6		
Radicalism	6		
Tension	6		

\*denotes clinical significance

Amanda's T scores for the different sub-scales on the STAXI are summarised in Table 3. Clinical significance was denoted if the scores obtained were greater than 2 standard deviations greater than the mean. With a mean T score of 50 with a standard deviation of 10, scores that fell outside of two standard deviations away from the mean were deemed to be clinically significant. Her Anger-In percentile rank was very high, indicating marked self-blame, as was her Control percentile rank which showed Amanda invested a great deal of energy into preventing herself from expressing anger which could result in depression and withdrawal (Spielberger, 1996). Her Anger Out and Anger Expression percentiles were also elevated.



Table 3.

*The percentile scores obtained for the scales and subscales of the STAXI for Case One (Amanda).*

Scales	Subscales	Percentile Scores
State Anger		50
Trait Anger		39
	Angry Temperament	64
	Angry Reaction	45
Anger In		98 *
Anger Out		78 *
Anger Control		96 *
Anger Expression		77 *

\* denotes clinical significance

Amanda endorsed 8 of the 27 items on the DES for a score of 12.75%. Although the frequency of items endorsed was below the normative sample results, the severity of dissociative experiences was elevated relative to the normative data.

Table 4 presents Amanda's scores for the different ways of coping. Clinical significance was denoted if the scores obtained were greater than 2 standard deviations greater than the mean.. This profile shows someone who uses strategies like avoiding or ignoring the problems as a way of coping or wishful thinking to deal with a problem.

Table 4.

*The scores for the subscales of the Ways of Coping scale for Case One (Amanda).*

Subscale	Score
Problem focused	39
Seeking social support	14
Wishful thinking	29 *
Blaming self	7
Avoidant coping	38 *

\* denotes clinical significance

Table 5 presents the level of endorsement for each irrational belief. The greatest endorsed beliefs were “the past determines the present” and “there are evil and wicked people in this world”. Her lowest scores were for “happiness by inaction” (Davis et al., 1988). Scores above 5 are identified as of clinical significance.

Table 5.  
*The level of endorsement for each irrational belief for Case One (Amanda).*

Irrational belief	Score
It is an absolute necessity for people to have love and approval from peers, family and friends.	6 *
You must be unfailingly competent and almost perfect in all you undertake.	6 *
Certain people are evil, wicked and villainous, and should be punished.	8 *
It is horrible when things are not the way you would like them to be.	6 *
External events cause most human misery- people simply react as events trigger their emotions.	4
You should feel fear or anxiety about anything that is unknown, uncertain or potentially dangerous.	6 *
It is easier to avoid than face life’s difficulties and responsibilities.	7 *
You need something other or stronger or greater than yourself to rely on.	7 *
The past has a lot to do with determining the present.	8 *
Happiness can be achieved by inaction, passivity, and endless leisure.	1

\* denotes clinical significance

#### 4.3.2 Psychophysiological response to imagery

Figure 1 (with a line denoting 3.29 above the mean of the neutral script stages) presents the mean heart rate responses for baseline and each of the five stages of each of the scripts. As a result of an ongoing conflict, and in an intoxicated and distressed state, Amanda answered the door to the victim during the scene stage (99.0 bpm). There was a substantial increase in arousal from baseline (79.5 bpm) to this first stage of imagery. An argument ensued during the approach stage (101.0 bpm). The victim then attacked Amanda by punching her and pulling her hair (95.3 bpm). Amanda stabbed the victim. At the consequence stage (85.3 bpm), there was a reduction in

heart rate as Amanda closed the door and observed the victim standing outside. Amanda reported being very depersonalised and a reduction in arousal at this time could be noted. During the resolution stage (82.7 bpm), she returned to the laundry where the altercation took place, and noticed the knife with the blood on it.

The aggression script described increasing anger at the behaviour of fellow prisoners (range from 76.6 to 80.59 bpm). Although there was a slight increase in heart rate over the course of the stages, the pattern of arousal did not match that of the homicide script. The level of arousal to the neutral script that described having breakfast at the prison did not substantially vary across stages (range from 74.0 to 77.6 bpm) or between the neutral and aggression scripts.

When between script comparisons were made, it was evident that all stages of the homicide script were significantly different from the neutral script. In comparison, the level of arousal to the aggression script did not differ from the neutral event.

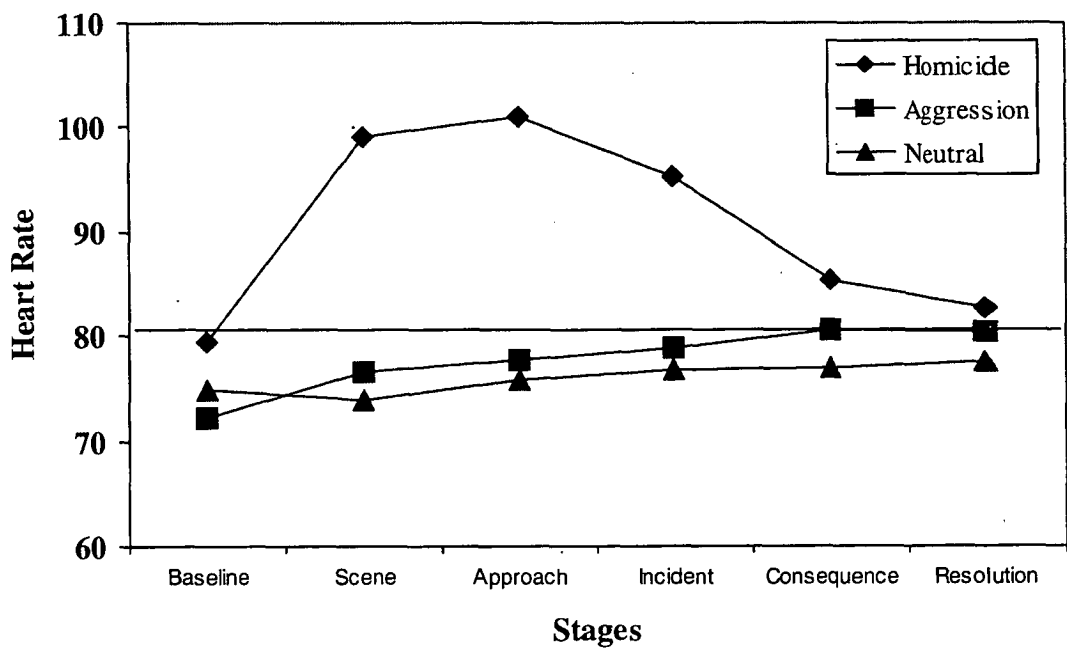


Figure 1.  
*The mean heart rate for the baselines and each stage of each script for Case One (Amanda).*

#### *4.3.3 Psychological response to imagery*

Figure 2 presents the ratings for the VAS not anxious-anxious for each stage of each script. The level of anxiety reported at each stage of the homicide script varied as a function of the reported events. Anxiety was rated as high to the first three stages (76, 98 and 98 respectively). The reduced rating at the consequence stage (34) coincided with reports of two events: a belief that the victim was not seriously harmed, and intense depersonalisation. The depersonalisation alone could be enough to have reduced anxiety at that time. Anxiety escalated again at the resolution stage (96) when the perpetrator returned to the laundry and saw the bloodied knife.

The pattern of response to the aggression script was associated with increasing anxiety as the aggressive interaction unfolded (from 3 to 52), and decreasing anxiety as Amanda was able to talk to her friends about the situation (from 52 to 2). It was evident that the neutral script elicited no anxiety (range from 1 to 2).

Between scripts comparisons indicated the ratings for all stages of the homicide script were elevated relative to the neutral script. Further, the ratings for the approach, incident and consequence stages of the aggression script were above the confidence interval calculated for the neutral script.

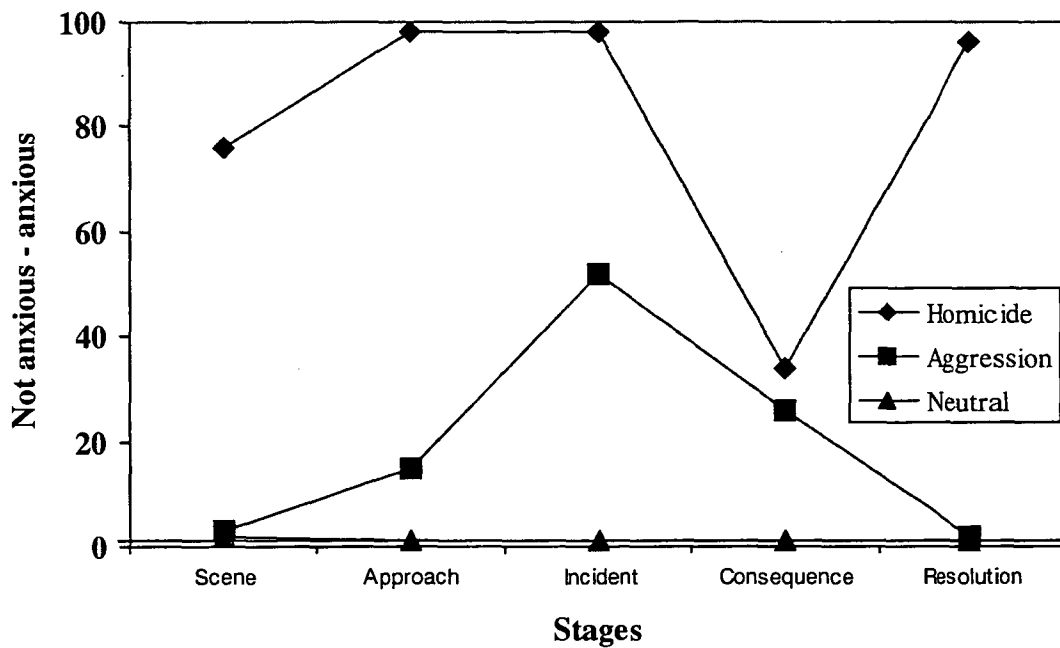


Figure 2.  
*The ratings for the not anxious-anxious VAS for each stage of each script for Case One (Amanda).*

Figure 3 presents the ratings for each stage of each script for the VAS not angry-angry. High ratings of anger for the first three stages of the homicide script were noted (94, 96, 96 respectively). The feelings of anger were related to the factors that led up to the arrival of the victim, and the developing conflict with the victim. Anger was reported to have reduced at the consequence stage (52) after the altercation was over, and had completely dissipated by the resolution stage (14).

Low levels of anger in the scene (3) and approach (18) stages of the aggression script were consistent with the content of imagery. The moderately high ratings of anger during the incident (74) and consequence (74) stages were consistent with the description of the initial response to the behaviour of the fellow prisoners and the subsequent discussion of their behaviour with her prisoner friends. By the resolution stage (3), anger had reduced and the event was concluded. The neutral script did not elicit angry feelings (ratings of 1 for all stages).

The homicide script elicited higher ratings of anger than did the neutral script at all stages when between scripts comparisons were made. When comparison was made between the aggression and neutral scripts, noteworthy differences were apparent at the approach, incident and consequence stages.

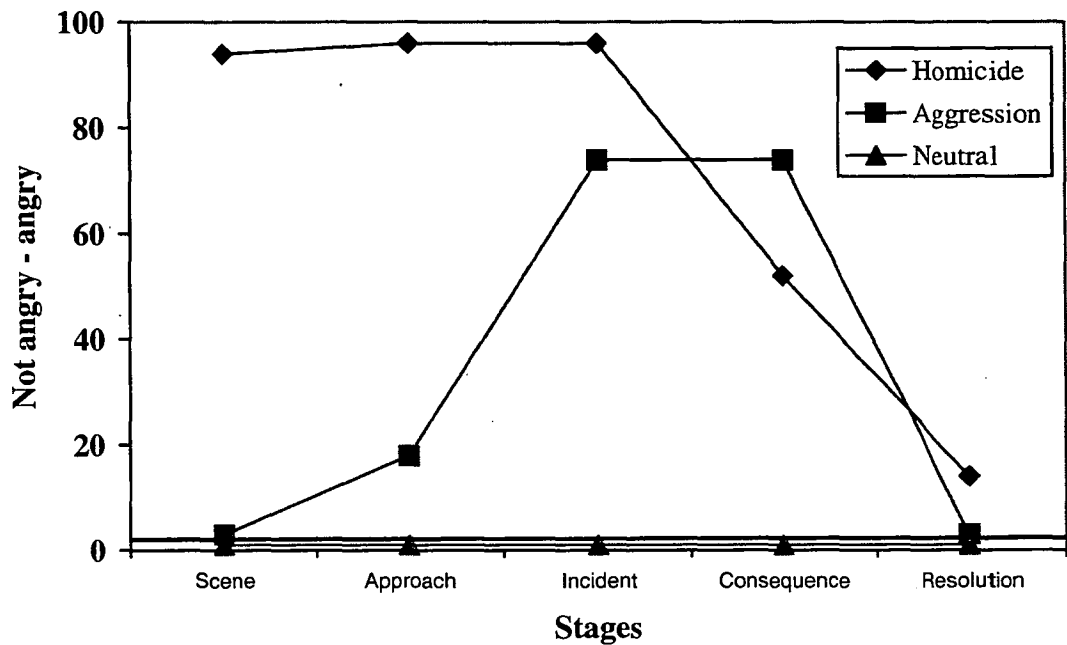


Figure 3.  
*The ratings for the not angry-angry VAS for each stage of each script for Case One (Amanda).*

Figure 4 presents the ratings on the VAS normal-unreal for each stage of each script. The homicide script initially elicited a moderately high score of 78 in the scene stage but decreased at the approach stage to 48 when the initial interaction between Amanda and the victim occurred. The actual perpetration of the homicidal act was associated with a rating of 97 in the incident stage but decreased to 35 in the consequence stage. The rating rose again to 72 in the resolution stage when she saw the bloodied knife.

There was little variation in the level of unreality over the stages of the aggression script and there were no differences across stages for the Neutral script.

Between script comparisons indicated that all stages of the homicide script elicited elevated ratings relative to the neutral script. With regard to the aggression script, the ratings made at the approach and incident stages were most noticeably deviated from the ratings made to the content of the neutral script.

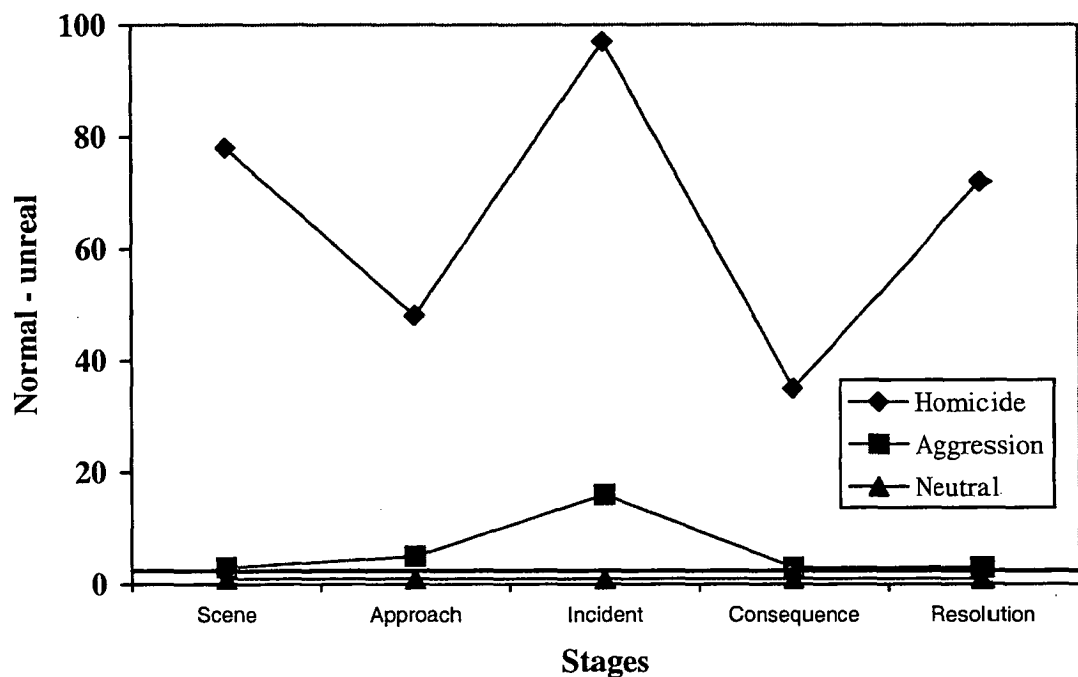


Figure 4.  
*The ratings for the normal-unreal VAS for each stage of each script for Case One (Amanda).*

Figure 5 presents the ratings for the VAS not fearful-fearful for each stage of each script. In relation to the homicide script, an initially moderately high level of fear at the scene stage (64) gave way to a reduction of fear during the approach stage (13). An extreme rating of fear was related to a description of the altercation between Amanda and the victim (96). A marked reduction of fear was reported at the consequence stage (5), which was congruent with the content of imagery that

indicated that Amanda was not aware of the seriousness of the attack. Increased fear at the resolution stage (95) was related to the description of becoming aware of the bloodied knife in the laundry.

In contrast, little fear was evident in relation to the aggression script (range from 3 to 20) and the neutral script elicited no fear at all (rating of 1 at all stages).

Comparison of scripts indicated that the ratings for all stages of the homicide script were elevated relative to the neutral script. In addition, the first four stages of the aggression script were elevated in comparison with the neutral script.

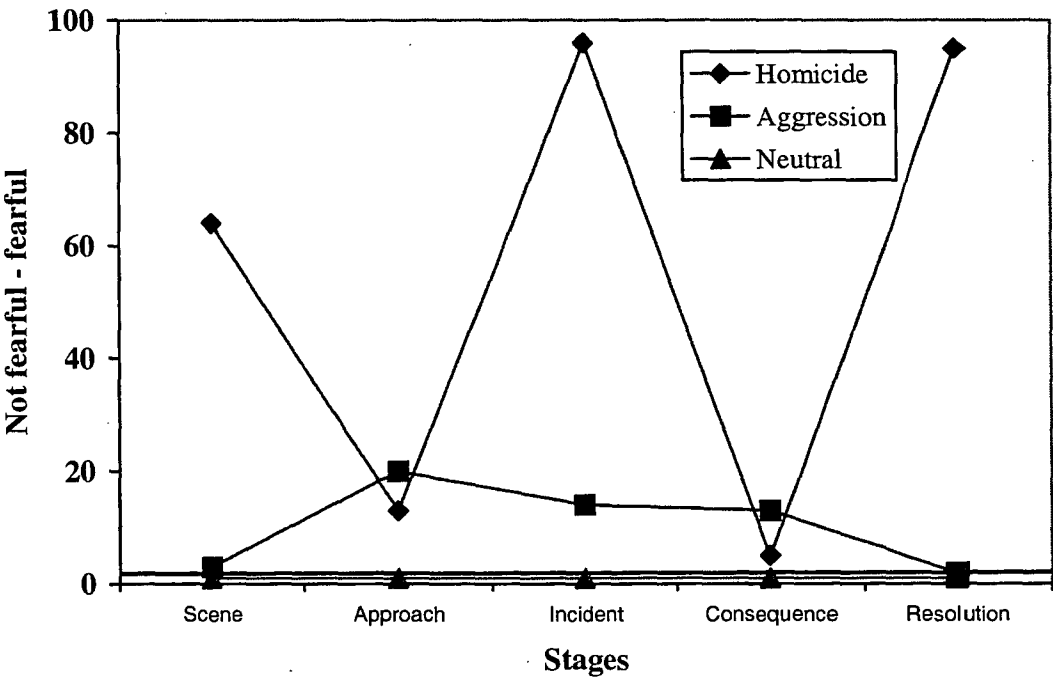


Figure 5.  
*The ratings for the not fearful-fearful VAS for each stage of each script for Case One (Amanda).*

Figure 6 presents the ratings for the VAS not agitated-agitated for each stage of each script. As mentioned, Amanda reported being depersonalised during the consequence stage of the homicide script. She did not believe that the victim was badly hurt and she attended to her upset dogs. This was reflected in her reduced level



of agitation at the consequence stage (49). Her agitation again increased when she saw the bloodied knife (85).

The pattern of agitation for the aggression script was noticeably different from the response to the homicide script. Agitation was highest at the incident (59) and consequence (61) stages of the aggression script. During the consequence stage, Amanda reported discussing her concerns with friends and, although her anxiety about the matter had reduced, her friends' supportive and outraged reaction helped her to maintain her agitation throughout the fourth stage. The neutral script did not elicit any feelings of agitation (ratings of 1 at all stages).

It was apparent from the between script comparisons that the homicide script elicited higher ratings of agitation than did the neutral script at all stages. When comparing the aggression and the neutral scripts, elevated ratings of agitation were evident at the scene, approach, incident and consequence stages but not the resolution stage.

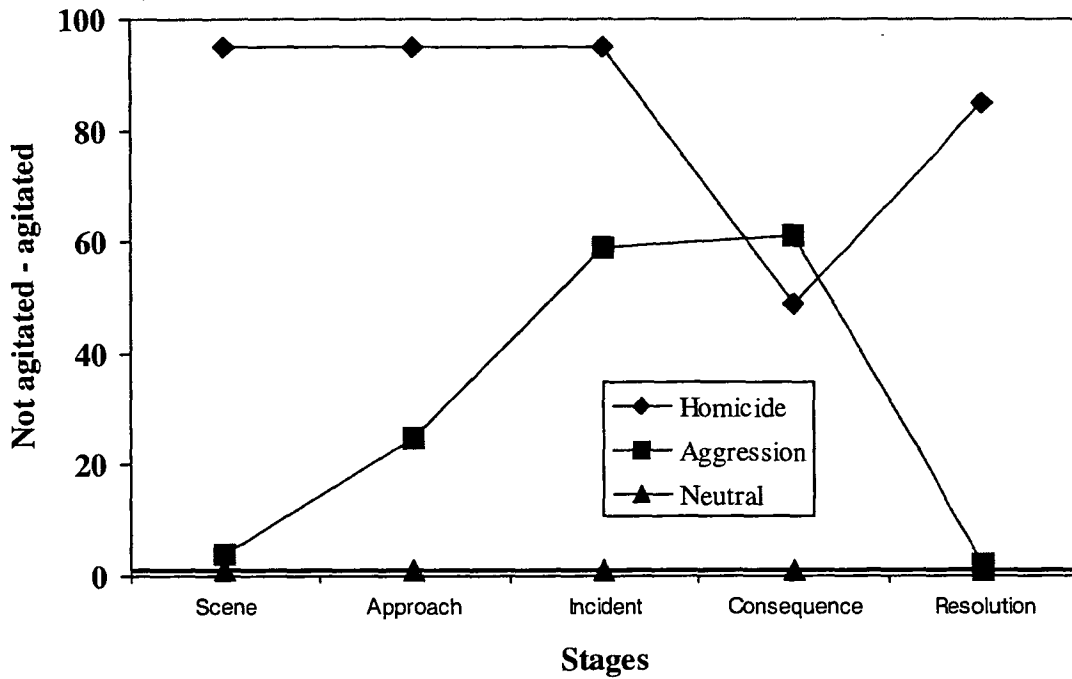


Figure 6.  
*The ratings for the not agitated-agitated VAS for each stage of each script for Case One (Amanda).*

Figure 7 presents the ratings for each stage of each script for the VAS not guilty-guilty. In relation to the homicide script, there was an increase in guilty feelings from a low level at the scene stage (8), to a high level at the approach stage (79) when a description was provided of the accusations made by the victim and the hurtful things said by Amanda. Guilt was again reduced at the incident stage (3) as the description of the victim attacking Amanda and the subsequent altercation was provided. A slight elevation in ratings at the consequence stage (34) related to Amanda's concern that her dogs had been upset by the conflict. The increase in guilt at the resolution stage (50) was associated with the discovery of the bloodied knife and the realisation that the victim must have been hurt.

Neither the aggression script (range from 2 to 5) nor the neutral script (range from 1 to 2) elicited feelings of guilt across any of the stages of these scripts.

Between script comparisons indicated that the homicide script elicited higher ratings of guilt than the neutral script at all but the incident stage. Only the approach stage of the aggression script elicited a higher rating of guilt than did the neutral script.

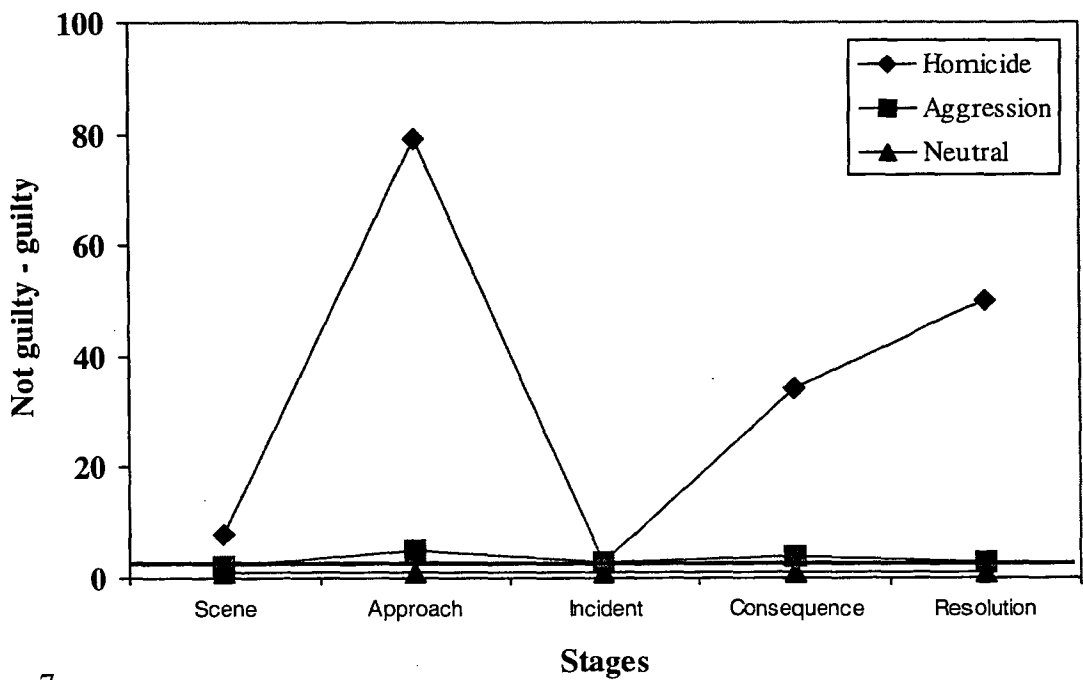


Figure 7.  
*The ratings for the not guilty-guilty VAS for each stage of each script for Case One (Amanda).*

4.4 Discussion

Amanda’s personality profile indicated many positive traits that would have allowed her to function well and achieve goals prior to the homicide. However, the results of the anger assessment indicated that she had the capacity to outwardly express built up anger and this would make her vulnerable at times of high distress and interpersonal conflict to act impulsively. It has been shown that women with higher levels of internally directed impulsive behaviours exhibited more anger than

women with lower internally directed impulsive behaviour (Milligan & Waller, 2001). According to Scarpa and Raine (2000), there is a connection between an escalation in violence associated to heightened anger and impulsivity.

It was clear that in the six months leading up to the homicide, Amanda had been distressed. She reported feelings of intense depersonalisation throughout this period. Sahu and Misra (1995) found a positive correlation between life stress, emotional exhaustion and depersonalisation, even though they found that people only tended to associate stress with depersonalisation.

In addition, Amanda held certain beliefs about the world that would have contributed to her distress as evidenced by her responses to the Belief Inventory. In particular, it would have been very difficult for Amanda to deal with being rejected by her husband and failing with regard to her marital relationship. Her desire to have someone other than herself to rely on, her tendency to worry about the future, and a propensity to avoid life problems all would have contributed to her distress. In work by Stebbins and Pakenham (2001), the stronger the person held irrational beliefs, the higher the level of psychological distress, especially if the irrational beliefs of the person were related to worry.

Amanda was ill equipped to deal with this crisis. Her typical ways of coping, specifically her tendency to engage in wishful thinking and to avoid the problem situation, resulted in no amelioration of her distress over that six-month period. To cope with her psychological response to the breakdown of her marriage, Amanda began to overuse alcohol. In Sayette's (1999) research, alcohol consumption was correlated with a reduction in stress reactions. This is congruent with Amanda's reported reasons for drinking. People who drink as a way of coping with stress typically increased their rate of alcohol consumption over time and escalating alcohol

use has been strongly linked with anxiety and depression symptoms (Holahan, Moos, Holahan, Cronkite & Randall, 2001).

On the night of the homicide, Amanda, who was an emotionally labile person who had been distressed for six months, and who had been using alcohol as a means of coping and for compensating for a general inability to deal with personally problematic situations, became involved in an argument that resulted in the death of another person.

The results of the guided imagery assessment support a situational conflict motive. After the distressing and angry interaction, there was a reduction in psychophysiological response, particularly at the consequence and resolution stages. As stated, this pattern of arousal is consistent with her statement that she was not aware of the seriousness of the injury to the victim.

The reduction of arousal also fits with her description of being strongly depersonalised, beginning at the incident stage. It is interesting to note that Amanda reported having intense depersonalisation experiences in the 6 months prior to the homicide. Depersonalisation is a reaction to intense distress and anxiety and may serve to protect the person from this distress (Nuller, 1982; Williams, Haines, Sale & Doherty, 1999). It is also interesting to note that now that Amanda is much more settled, she no longer experiences these depersonalisation states.

There is debate about the extent to which depersonalisation as a form of dissociation lessens the normal constraints on a person's behaviour (Frasquilho & Oakley, 1997; Kuley & Jacobs, 1988). This lack of clarity is problematic when the laws pertaining to automatism are considered (see [http://www. thelaw.tas.gov.au/](http://www.thelaw.tas.gov.au/) for local laws pertaining to automatism). Whereas the law can accommodate complete dissociation resulting in amnesia for the event, intense depersonalisation as a form of

dissociation cannot be accommodated as easily.

The extent to which her dissociative experiences contributed to her poor recall of the actual stabbing is an interesting question. Clinically, there would be little dispute that intense depersonalisation could disrupt recollection. However, the matter becomes more complex in a forensic setting (Spiegel & Schefflin, 1994), particularly in relation to the controversy over recovery of repressed memories in child abuse cases (Knapp & VandeCreek, 2000; Walcott, 2000) but also in relation to homicide. There may be a stronger motivation not to recall events when the individual is being prosecuted for a serious crime.

Clearly, this homicide was expressive or reactive (Decker, 1996). It was unplanned, impulsive and occurred as a result of an escalating conflict. There was nothing in this person's background that would have made the homicide acceptable for her. Indeed, Amanda responds poorly to words such as "murder" and "stabbing" because they seem alien to her self-concept.

Her strong religious beliefs should have been one factor in a combination of factors that should have protected her from the development of such a situation (Cohen & Nisbett, 1994). However, these same religious beliefs probably contributed to both her overall level of distress in the time leading up to the event and, in some way, to the event itself. Clearly, her religious beliefs made it very difficult for her to come to terms with her husband's disclosure of his sexual orientation (see Fulton, Gorsuch & Maynard, 1999; Hoffman et al., 2000; Taylor, 2000). The argument on the night of homicide centred on groundless accusations by the victim of Amanda's contribution to the sexual preferences of Amanda's husband.

There is little doubt that increased alcohol use in the six months leading up to the homicide and on the actual night significantly contributed to the events that

ensued. The increased impulsivity as a result of alcohol use can be compounded by pre-existing depression (Dixit & Crum, 2000) and this combination of factors increases the likelihood of homicidal behaviour. What occurred was an unplanned, unfortunate, tragic event.

## **Chapter 5**

### **Case Two: The Battered Woman**



### *5.1 Case*

The second case was of an expressive homicide that occurred on a background of chronic abuse. Alice was 30 years of age at the time of assessment and had been incarcerated for approximately one year. She was petite and polite and was initially reserved. There had been an improvement in her psychological functioning over the course of her sentence after initial difficulty adjusting to prison life.

Alice was the youngest of three children raised in a middle class family in a suburban area. Her parents were together but she questioned the quality of their relationship. As a teenager she was rebellious, often truanting from school and engaging in a range of risk taking behaviours. Alice left school after Year 10 but returned a few years later to complete two more years of education and technical training from a local college. She was trained in information systems but often gained employment in the hospitality industry. She was living with a partner at the time of the event.

A string of intense and conflictual relationships often placed Alice in situations where she was vulnerable to physical abuse. Alice's partner (the victim) had also physically harmed her during their repeated argumentative interactions. The police were aware of Alice and her partner, both having called the police for assistance with the other partner on different occasions.

Her life could be characterised by chronic chaos. Alice's polysubstance dependence problems most likely contributed to her lifestyle and the difficulty she experienced with her relationships. Abuse of alcohol, prescription medications and illicit drugs (e.g., amphetamines, marijuana) was quite possibly at the root of her problems. Alice's contacts with psychiatric services typically centred about her polysubstance abuse

and lead to a range of diagnoses.

It is not surprising that Alice had two contacts with the criminal justice system prior to her arrest for the homicide. The first was related to the possession of an illegal substance for which she received a suspended sentence. The second, and more relevant to this case, resulted in another suspended sentence for stabbing a previous partner in the abdomen during a heated argument. The reduced sentence was due to her partner at the time strongly supporting her.

In the current case, the victim was Alice's cohabiting partner. The partner had polysubstance abuse problems as well. The incident occurred during a week when both of them were making an effort to decrease their amount of substance use. Interpersonal difficulties flared as a result of the pressure the couple was under. Alice had scheduled a consultation with a psychiatrist in a public mental health facility but she failed to keep the appointment when she was kept waiting on the day of the appointment. Alice was distressed and she began to contemplate hanging herself in the alley behind the mental health facility.

The homicide occurred in the evening after a day of intense interpersonal conflict. The victim had reacted poorly to Alice's claims of depression. While Alice's partner was away from the home, Alice became extremely angry and poured water on his bed and damaged some of his property. She then packed some of her possessions and went down to the beach. While she was there, she drank some beer then returned home after the weather deteriorated.

When she arrived back at the house, the victim was talking with the police about having Alice evicted and legally restrained. After the police left, the situation quickly

escalated out of control and resulted in Alice taking a knife out of her beach bag and stabbing her partner in the upper abdomen after he moved threateningly towards her. Her partner would not let her see the wound and he called the police. Although concerned about her actions, she did not believe that her partner was seriously hurt. She had stabbed a previous partner in a similar way without adverse consequence. Unfortunately, the knife, driven upwards, had reached the victim's heart. He collapsed on the floor. Alice tried to cool the victim with a wet towel and, after he lost consciousness, she administered CPR until the ambulance arrived.

Later, when her blood was tested, it was evident that Alice had consumed alcohol and diazepam that day and there were traces of tetrahydrocannabinol. Alice estimated that she had consumed between 15 and 20 5 mg diazepam tablets on the day of the homicide.

When charged, Alice pleaded guilty to manslaughter and was given a four year sentence. She claimed that she did not plead self-defence because the victim had not hit her on the day of the event. Alice had not intended to kill the victim.

## **5.2 Method**

The method was the same as for Case One except with regard to script content. Table 6 presents the content of the imagery scripts used for this participant.

Table 6.

*The content of each stage of each script for Case Two (Alice).*

Script	Stage	Content
Homicide	Scene	Alice came back from beach to find the victim at the house with a police officer.
	Approach	An argument developed and the victim approached Alice in a threatening way.
	Incident	Alice stabbed the victim and the victim put his hands over wound.
	Consequence	Victim called police then collapsed to the floor.
	Resolution	Alice attempted resuscitation and police arrived.
Aggression	Scene	Alice came home after working all night to find boyfriend absent.
	Approach	Alice waited for the boyfriend to return after night out.
	Incident	The boyfriend arrived back and confessed to spending night with another woman.
	Consequence	Alice walked down the road to get beer with boyfriend following.
	Resolution	Alice walked home with beer in a calmer state of mind. Boyfriend followed.
Neutral	Scene	Alice went down from cell to kitchen to make breakfast.
	Approach	Alice made a cup of coffee.
	Incident	Alice drank coffee and made toast.
	Consequence	Alice drank coffee and waited for toast to cool.
	Resolution	Alice spread butter and jam on toast and ate the toast.

### 5.3 Results

#### 5.3.1 Psychological measures

Table 7 presents the scores obtained for the personality and clinical factors of the CAQ. With a valid protocol, the test results indicated that Alice has a tendency to be easily upset and feels persecuted and inferior. She is detached from people, disregards rules and is shrewd, calculating, controlled and inhibited. She reports a range of clinical characteristics. Most noticeably, she scored highly on guilt and depression. She is withdrawn, suspicious and feels psychologically inadequate. Despite the high score on the Schizophrenia subscale, she is not psychotic.

Table 7.

*The scores obtained on each of the subscales of the CAQ for Case Two (Alice).*

Personality subscales	Score	Clinical subscales	Score
Warmth	2 *	Hypochondriasis	6
Intelligence	6	Suicidal depression	7
Emotional stability	2 *	Agitation	5
Dominance	6	Anxious depression	7
Impulsivity	7	Low energy depression	9 *
Conformity	1 *	Guilt and resentment	10 *
Boldness	4	Boredom and withdrawal	9 *
Sensitivity	7	Paranoia	10 *
Suspiciousness	6	Psychopathic Deviation	2
Imagination	4	Schizophrenia	10 *
Shrewdness	10 *	Psychasthenia	7
Insecurity	8 *	Psychological inadequacy	9 *
Self-sufficiency	6		
Self-discipline	9 *		
Radicalism	6		
Tension	5		

\* denotes clinical significance

The scores on the anger assessment suggested that Alice was prone to experience and express angry feelings to the degree that her functioning was impaired. Since Alice also had high Trait Anger and Anger-In, or internally directed anger scores, it was more likely that her anger was a chronic anger that could flare in certain situational contexts. Table 8 presents the T scores obtained for the STAXI.

Table 8.  
*The percentile scores obtained for the scales and subscales of the STAXI for Case Two (Alice).*

Scales	Subscales	Percentile Scores
State Anger		89 *
Trait Anger		71 *
	Angry Temperament	74 *
	Angry Reaction	78 *
Anger In		97 *
Anger Out		62
Anger Control		38
Anger Expression		94 *

\* denotes clinical significance

Alice did report some depersonalisation on this assessment. She endorsed 17 items, which was one above the population norm, and her average endorsement was markedly elevated; 14.7% compared to 4.38% for the population norm.

Table 9 presents Alice’s scores for the different ways of coping. This assessment indicated that Alice tends to avoid facing problem situations. She also has the tendency to blame herself more often than the norm and is overly dependent upon social support.

Table 9.  
*The scores for the subscales of the Ways of Coping scale for Case Two (Alice).*

Subscale	Score
Problem focused	28
Seeking social support	32 *
Wishful thinking	12
Blaming self	11 *
Avoidant coping	29 *

\* denotes clinical significance

Table 10 presents the level of endorsement by Alice for each irrational belief. Alice endorsed a number of beliefs that would have predisposed her to distress. She strongly believed that the unknown or uncertainties in life should be feared or should cause anxiety. She also believed it is horrible if things do not go the way you want them to go.

Table 10.  
*The level of endorsement for each irrational belief for Case Two (Alice).*

Irrational belief	Score
It is an absolute necessity for people to have love and approval from peers, family and friends.	7 *
You must be unfailingly competent and almost perfect in all you undertake	6 *
Certain people are evil, wicked and villainous, and should be punished.	2
It is horrible when things are not the way you would like them to be.	8 *
External events cause most human misery-people simply react as events trigger their emotions.	7 *
You should feel fear or anxiety about anything that is unknown, uncertain, or potentially dangerous.	10 *
It is easier to avoid than face life's difficulties and responsibilities.	3
You need something other or stronger or greater than yourself to rely on.	4
The past has a lot to do with determining the present.	6 *
Happiness can be achieved by inaction, passivity, and endless leisure.	3

\* denotes clinical significance

### 5.3.2 Psychophysiological response to imagery

Figure 8 presents the mean heart rate for baseline and each stage of each script. There was an increase from baseline to the scene stage. During this stage (112.61 bpm), Alice had returned from the beach and found the victim there talking to the police about having Alice restrained from approaching him and having her removed from the lease. There was a very slight decrease in heart rate at the approach stage (107.98 bpm) that coincided with imagery of the argument between the victim and Alice. Another slight reduction in heart rate was evident at the incident stage (103.79 bpm) when Alice took her knife from the top of her bag and lunged towards the victim, stabbing him in the top of the stomach. During the consequence stage (102.12 bpm), the victim called the police and Alice screamed for him to call the ambulance. The victim staggered and fell to the



floor. There was a marked increase in heart rate at the resolution stage (118.38 bpm) when imagery was presented of Alice attending to the victim, applying pressure to the wound and wiping his forehead with a cold towel. She heard the police arrive and she began CPR. Alice said she was feeling panicked and afraid because she finally realised that he might be seriously hurt.

In contrast to her reaction to the homicide script, her response to the aggression script was markedly different. Although describing a distressing interaction with her then partner, the level of arousal to the script never reached the elevated level apparent with the homicide script (range from 83.03 to 89.45 bpm). The neutral script describing making breakfast at the prison elicited the lowest heart rate with little variation across stages (range from 77.52 to 80.72 bpm).

When a comparison was made between scripts, it was evident that all stages of the homicide event were markedly different from the response to the neutral event. In contrast, only the consequence stage of the aggression script was associated with an elevation of response from the neutral event.

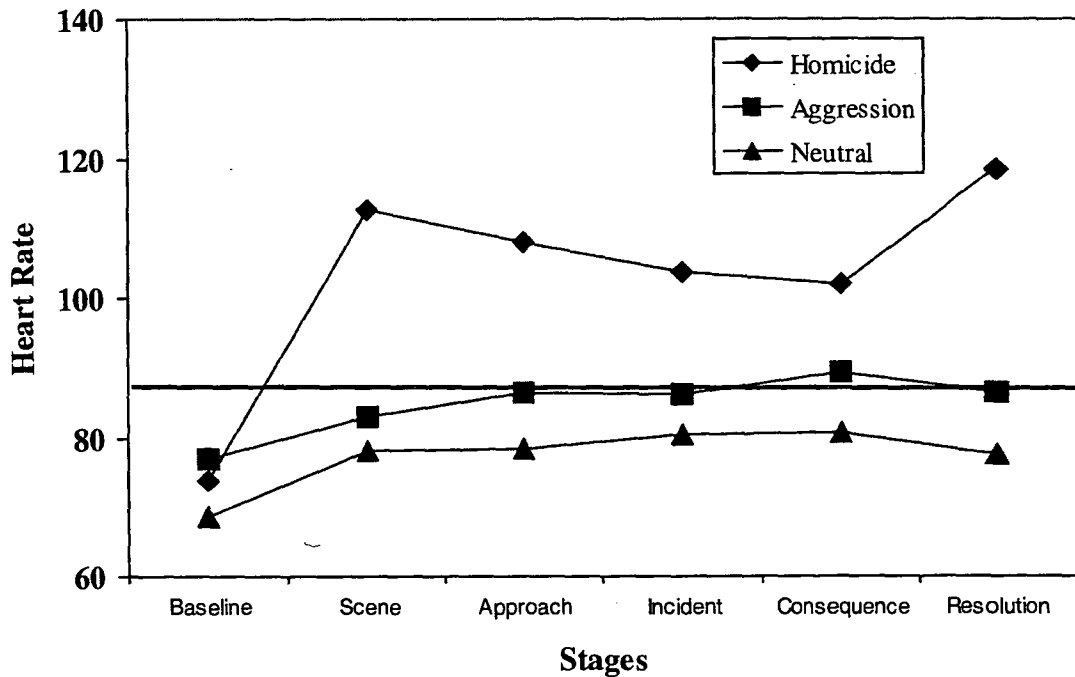


Figure 8.  
*The mean heart rate for the baselines and each stage of each script for Case Two (Alice).*

### 5.3.3 Psychological response to imagery

Figure 9 presents the ratings for the VAS not anxious-anxious for each stage of each script. Elevated ratings of anxiety during the scene (83) and approach stages (83) of the homicide script, increased to an extreme level at the incident stage and remained high thereafter (range from 94 to 96).

In response to the aggression script, there was an increase in anxiety over the first three stages of imagery from a moderate level to a high level and remained elevated for the remaining stages (range from 55 to 89). Anxiety ratings were low for all stages of the neutral script (range from 34 to 2). The relative elevation at the scene stage (34) related to a dislike of early rising.

A comparison between scripts in relation to ratings of anxiety demonstrated that the homicide script elicited higher ratings than did the neutral script at all stages. The aggression script elicited higher ratings than the neutral script at all stages.

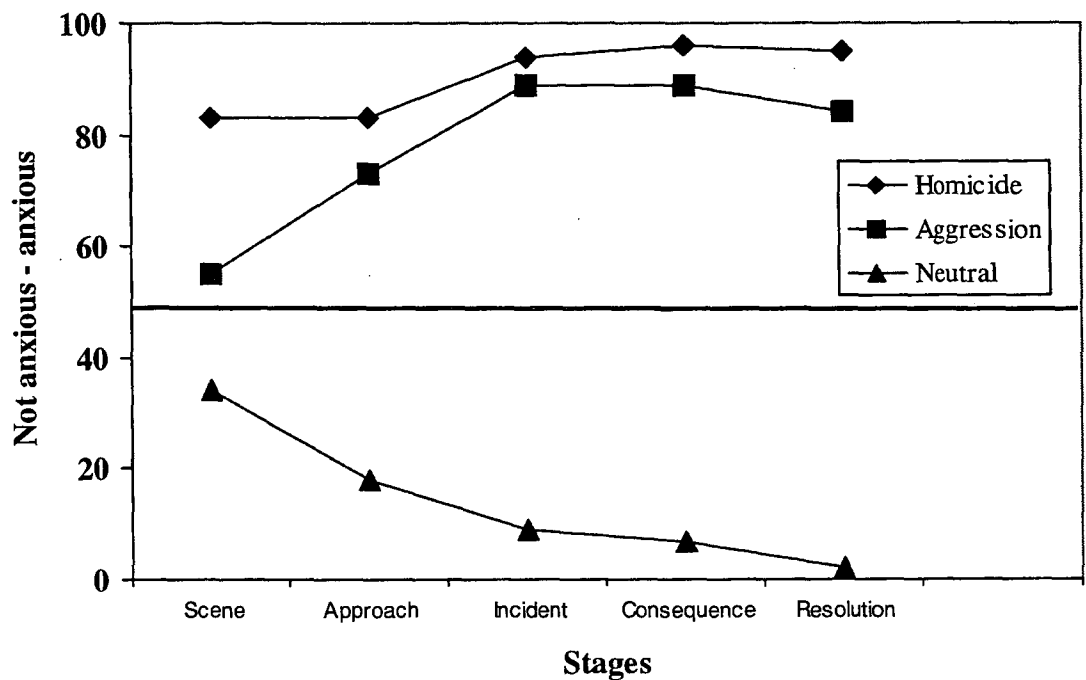


Figure 9.  
*The ratings for the not anxious-anxious VAS for each stage of each script for Case Two (Alice).*

Figure 10 presents the ratings for the VAS not angry-angry for each stage of each script. In response to the homicide script, Alice reported high levels of anger for the first four stages of the script (range from 84 to 93). These feelings of anger coincided with the arguing prior to the attack and the actual attack, as well as continued feelings of anger at the consequence stage that were related to the belief that the victim was not badly hurt. Anger reduced at the resolution stage (48) when it became apparent that the victim was becoming physically distressed and the likelihood of death was increased.

The pattern of response to the aggression script was not dissimilar to the homicide script except for a lower initial level of anger (57) and the continued experience of moderately high levels of anger at the resolution stage (73). The pattern of response to the aggression script fits with the script content. In contrast, little anger was experienced in relation to the neutral script and there was little variation across the stages of the script (range from 2 to 12).

Elevated ratings of anger at all stages of the homicide script and the aggression script relative to the neutral script were demonstrated.

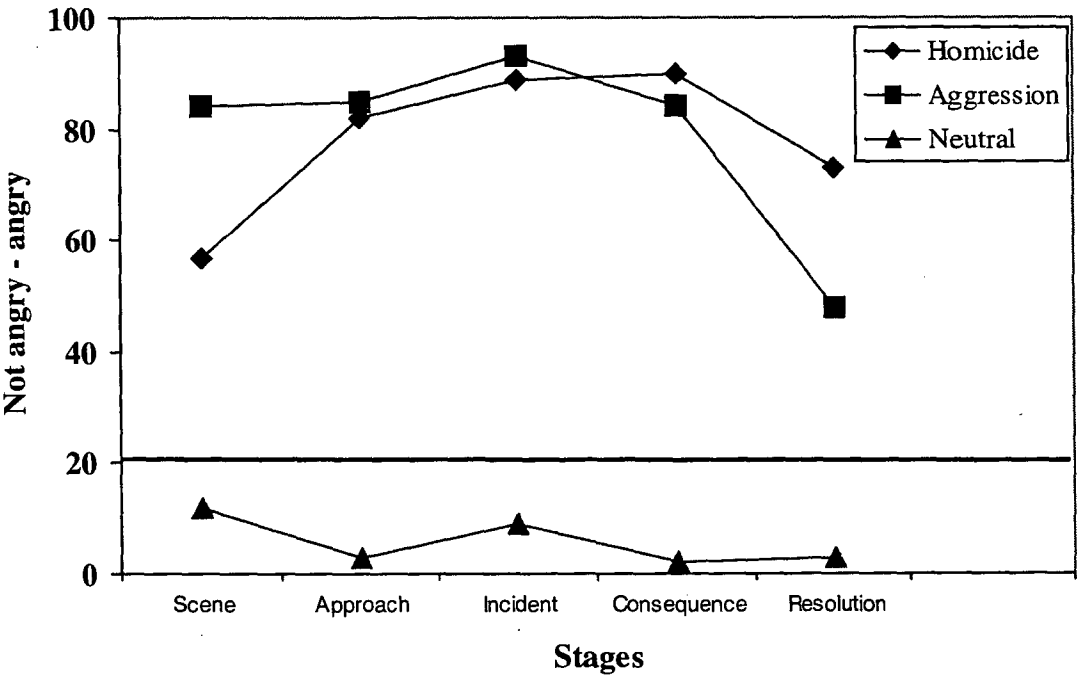


Figure 10.  
*The ratings for the not angry-angry VAS for each stage of each script for Case Two (Alice).*

Figure 11 presents the ratings for the VAS normal-unreal denoting depersonalisation for each stage of the homicide script and each stage of the aggression script except the scene stage. The homicide script ratings started at 87 indicating that by the time the escalation of conflict occurred, Alice was experiencing depersonalisation. A slight decrease at the approach stage to 72 was followed by an increase in ratings to an extreme level at the incident stage. This was maintained throughout the remainder of the event (range from 94-96).

The aggression script was rated as moderately unreal (52) in the scene stage and then began to steadily increase over the next three stages (68, 88, 90). The rating for the resolution stage showed a slight decrease as she felt more calm (80). There was no evidence of depersonalisation for the neutral script as would be expected and no variation across the stages (range from 3 to 4).

A between script comparison indicated that the ratings at all stages of the homicide and aggression script were elevated relative to the neutral script.

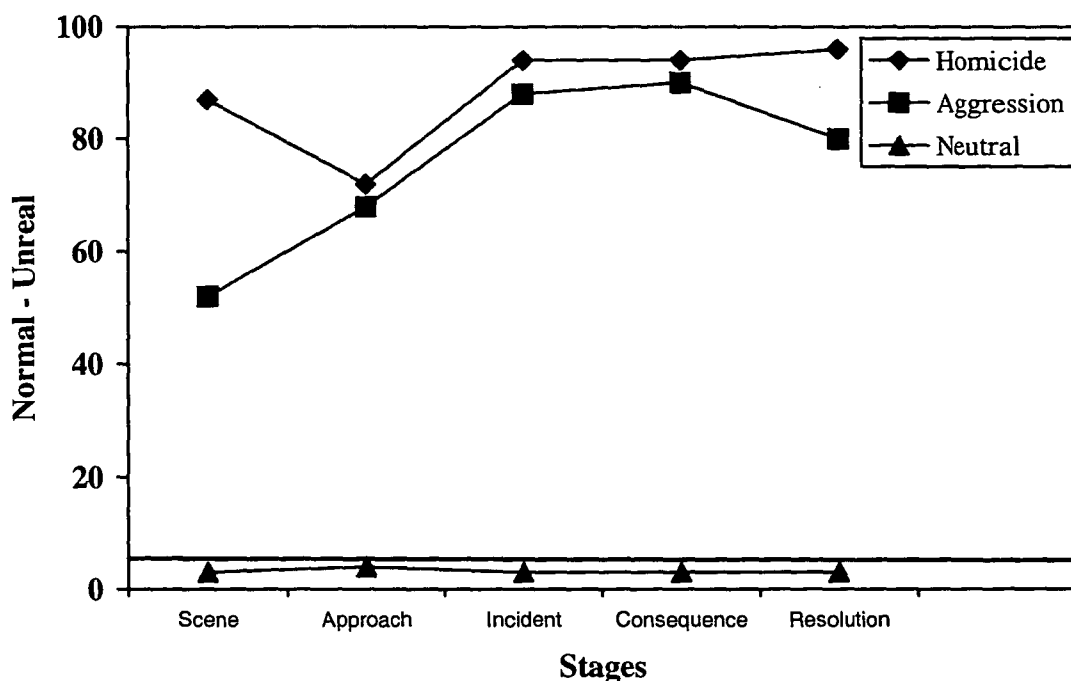


Figure 11.  
*The ratings for the normal-unreal VAS for each stage of each script for Case Two (Alice).*

Figure 12 presents the ratings for the VAS not fearful-fearful for each stage of each script. Starting from a point of moderately high fear (77), Alice reported increased fearfulness over the course of the homicidal event (range from 84 to 98). Her fear levels were maintained at a high level throughout the entire event.

In contrast, the initial levels of fear prior to the aggressive interaction with her then boyfriend (69) gave way to lower levels of fearfulness in relation to the aggression script (down to a rating of 46). The neutral script elicited little fear and contrasted markedly with the homicide and the aggression scripts.

A comparison between the scripts demonstrated that the homicide script and the aggression script elicited higher ratings of fear than did the neutral script at all stages.

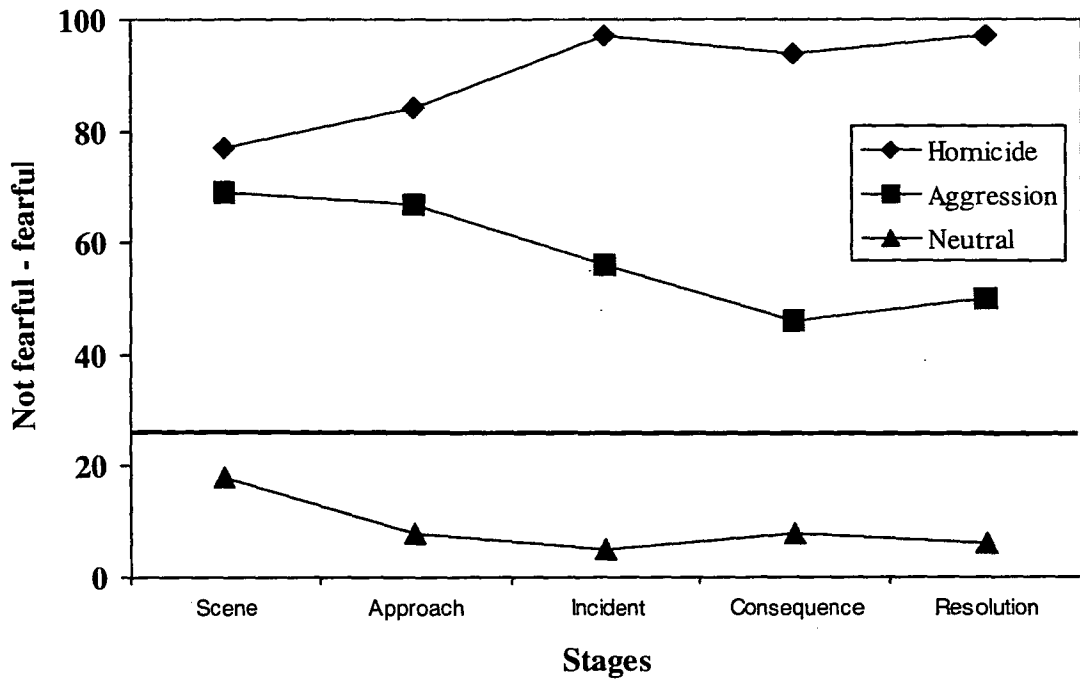


Figure 12.  
*The ratings for the not fearful-fearful VAS for each stage of each script for Case Two (Alice).*

Figure 13 presents the ratings for the VAS not agitated-agitated for each stage of each script. In response to the homicide script, levels of agitation were reported to be very high with extreme ratings given at the incident, consequence and resolution stages of imagery when the stabbing was described and Alice began to realise the seriousness of her actions (range from 85 to 97).

Agitation was reported to increase from a moderately high level to an extreme level over the first four stages of the aggression script (69 to 95) with a reduction in the resolution stage (70) to the level apparent in the first stage of this script. The neutral script did not elicit feelings of agitation (range from 6 to 12).

Between script comparisons indicated that both the homicide and the aggression scripts elicited higher ratings of agitation than did the neutral script at all stages.

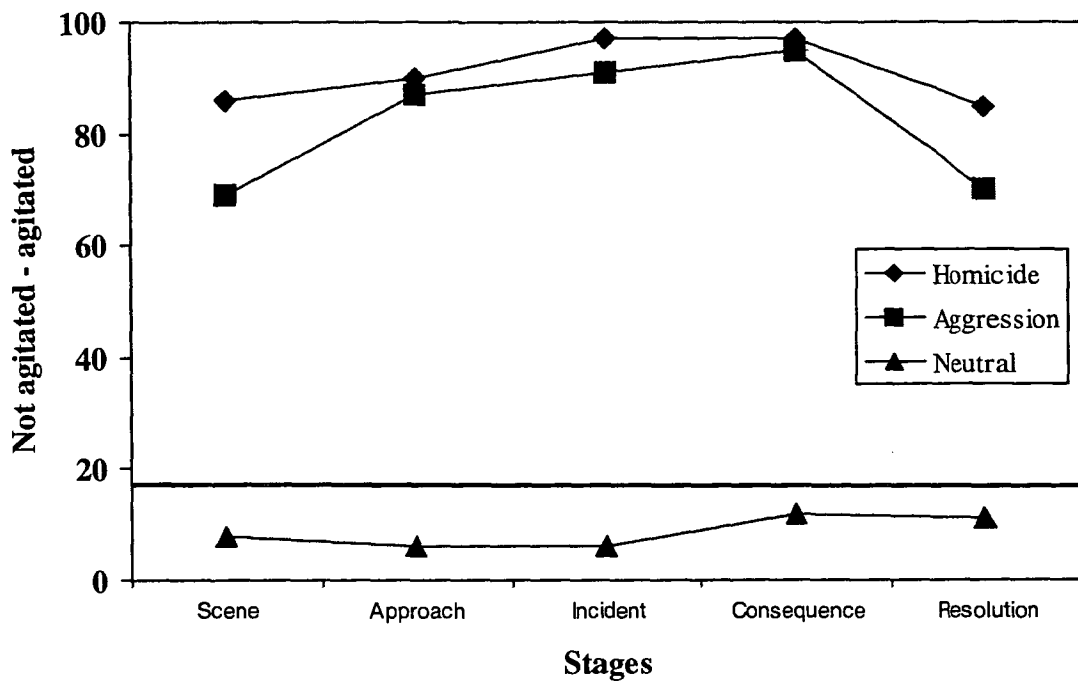


Figure 13.  
*The ratings for the not agitated-agitated VAS for each stage of each script for Case Two (Alice).*

Figure 14 presents the ratings for the VAS not guilty-guilty for each stage of each script. There was an increase in feelings of guilt from a moderate level at the scene stage of the homicide script (59) to the approach stage (91). From the incident stage, guilty feelings became extreme and remained at this level for the duration of the remaining stages (range from 98 to 100).

An initial increase in guilt from the scene (34) to the approach stage (56) of the aggression script brought the ratings to a moderate level. There was little variation in the ratings over the final four stages of the aggression script (range from 54 to 57). There was no notable evidence of guilty feelings in relation to the content of the neutral script (range from 6 to 17).



The between script comparison indicated that the homicide script and the aggression script elicited higher ratings of guilt than did the neutral script at all stages.

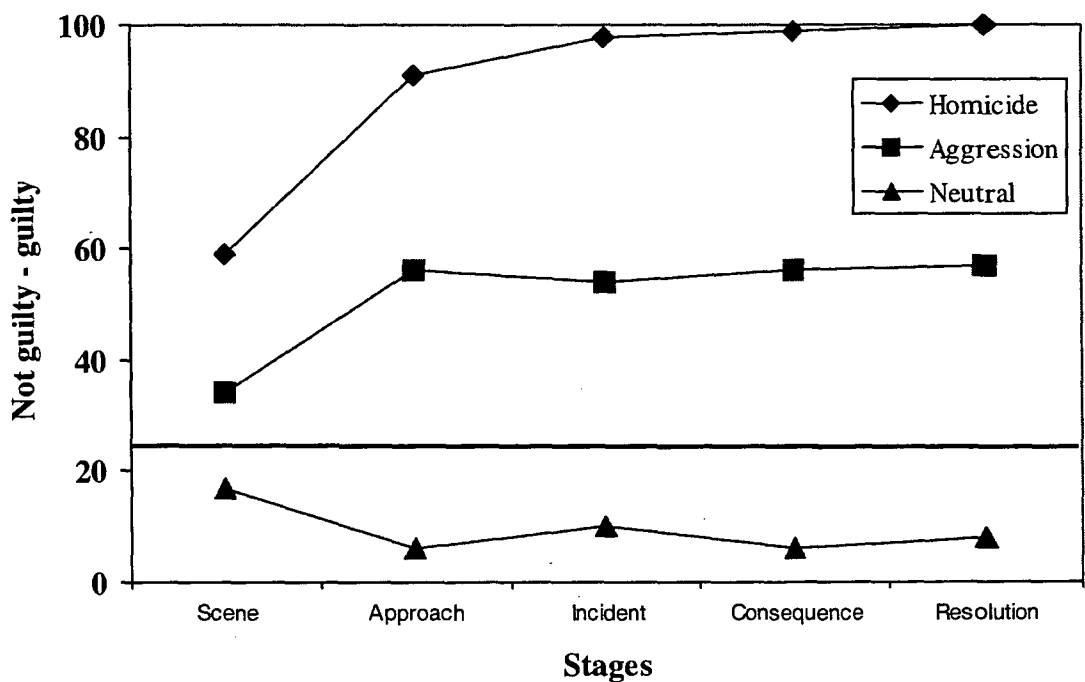


Figure 14.  
*The ratings for the not guilty/guilty VAS for each stage of each script for Case Two (Alice).*

5.4 Discussion

The psychological assessment results indicated the level of psychological maladjustment experienced by this woman. Her personality characteristics were indicative of a hostile individual who disregards societal norms. There was evidence of pathological levels of psychological maladjustment, particularly in areas characterised by social withdrawal, suspiciousness and resentment. There is evidence to support depressive symptomatology at the time of the assessment which occurred around the first anniversary of the homicidal act.

Alice's anger profile was one of a person who would experience intense feelings of anger that would be suppressed as much as possible (Spielberger, 1996). She would be overly sensitive to criticism and negative evaluations of others. These types of characteristics would make interpersonal relationships problematic for Alice. In research by Davis and DiNitto (1996), drug abuse was associated with problems controlling violence. According to Campbell (2000), forensic clients had experienced trauma as well as frequent alcohol and drug abuse before committing a violent act, after which they reported dissociation. An increased level of dissociation was associated with emotional awareness deficits, a lack of impulse control, increased levels of anger and hostility, and both verbal and physical aggression.

Consistent with Alice's strong tendency to be emotionally rigid was the endorsement by Alice of beliefs related to a need to be in control to prevent feelings of anxiety and apprehension. Given the chaotic nature of life characteristic of polysubstance use (Maeve, 1997), it is not surprising that Alice's mood fluctuated in the time leading up to the homicide as a result of the distress she would have been feeling. Polysubstance abuse has been identified as a predictor and a consequence of suicide ideation, increased anxiety, hostility, increased impulsivity and a decrease in supportive relationships (Vargas, 1996). McCormick and Smith (1995) found polysubstance users scored higher on hostility and on aggression and used an escape-avoidance or self-blaming coping style to deal with interpersonal conflict.

This was an expressive or reactive homicide (Decker, 1996). The psychophysiological response pattern is indicative of intense and extreme distress. These results are consistent with her descriptions of fear at the time of the event and the panic

after the event.

The initial level of distress as the argument developed gives some indication of the nature of their previous interactions. A pattern of repeated conflict with high levels of distress would indicate a likelihood of high arousal and her becoming upset when arguments happened even in the absence of a significant stressor. That is, arousal would increase because they were arguing rather than because they were arguing about something very serious. Add to this equation the disinhibiting effects of multiple substances and it is not surprising that the situation escalated out of control.

Evidence for the escalation of the interaction could be demonstrated from the psychophysiological results of this assessment. During baseline, this woman's minimum heart rate was 59 beats per minute. It increased during the resolution stage to a maximum of 138 beats per minute. Even from baseline to the first stage of imagery, that is, within 60 seconds, her heart rate more than doubled signifying her distress. It has been suggested that a change from baseline of 20% of the baseline heart rate is clinically significant (Blanchard & Young, 1973) although the stringency of this proposed criterion has since been revised (Blanchard, personal communication). It was apparent that Alice's psychological ratings were congruent with her statements about the event and her reaction to it.

It has been suggested that battered women are more likely to kill their abusers if they do not have access to community resources including police assistance (Hamilton & Sutterfield, 1997). However, this perpetrator engaged in homicidal behaviour despite receiving psychiatric support and despite having repeated intervention from law enforcement officers.

Of course, at least two factors about this homicidal act may have overridden the protective aspects of community and legal support. Firstly, this was not a planned homicide, perpetrated with the intention of escaping from a desperate situation and enacted as a reaction to imminent danger (Stevens, 1999). It was reactive with the situation developing as a consequence of escalating distress. Secondly, it may be that the previous stabbing episode may have desensitised her to the behaviour and increased the likelihood that she would behave in this way again in the right set of circumstances. This view is supported by the fact that there were no real social and legal ramifications of her previous injurious behaviour; she was given a suspended sentence and her boyfriend forgave her. A person who had previously engaged in such behaviour without negative consequence and who was already disinhibited because of the consumption of multiple substances may well choose to manage a conflictual situation in a similar way.

The fact that this woman faced a manslaughter charge rather than a charge of murder was a reflection of the fact that there is an increased likelihood of female homicide perpetrators facing reduced charges (Mitchell, 1997) and the fact that she had a known history of being battered. This history would have increased this woman's fearful response to threats from the victim. In America, expert testimony on the battered women syndrome is not always admissible in court and the confession of the woman may be the only evidence used. There appears to be a great need to educate the public and the legal system as to the nature of the battered women syndrome and its characteristics. Australian law does not always allow for the use of self-defence in the battered women's syndrome and defendants use the defence of provocation much more often (Bradfield, 1998; Hubble, 1999).

An argument of self-defence typically requires that the battered woman believe that there is a clear and imminent danger of death or serious injury during an abusive episode (Regehr & Glancy, 1995). This was not the case in this instance. The victim was not armed and perpetrator stated that she could not be sure that the victim had intended to harm her at that time. Nevertheless, in face of a likely plea in mitigation based on the abusive history of the relationship with the victim, the Crown Solicitor did not pursue a murder charge.

## **Chapter 6**

### **Case Three: Homicide and Psychopathy**

## 6.1 Case

This case was one of instrumental homicide carried out to meet the psychological needs of the perpetrator. Toby was 28 years of age at the time of assessment and had been incarcerated since 1990. He was superficially friendly, handsome, and seemingly cooperative. While incarcerated, Toby had never been punished for inappropriate behaviour, although he says he finds some of the rules and regulations difficult to understand.

Toby was the second oldest of four boys raised in a two parent home in suburban areas. He came from a working class family and although Toby began Year 11, he failed to complete his education. Throughout his childhood and adolescence, Toby had difficulties controlling his anger. He was often in trouble at school for fighting and for his aggressiveness. Toby's impulsivity combined with his aggression caused problems for him on the sporting fields. When he felt unable to control his anger, Toby would run through bushland, smashing plants and small trees until he was exhausted.

The first contact with the police occurred after Toby was caught stealing from his employer at his retail job. The employer had strongly suspected Toby had stolen money and set a trap for him. Toby claimed that he knew a trap had been set but was driven to steal despite his knowledge. He was incapable of controlling his behaviour even though he knew he was under surveillance.

Of more relevance to the homicide were two previous attempts to engage in similar behaviour. When Toby was aged 16 years, a friend failed to collect him for football training one evening and this caused him to become angry and frustrated. Without lengthy premeditation and, he says, in response to the unpleasant feelings of

disappointment and anger, he followed a young girl and stabbed her once which cause only minor injury. He quickly fled the scene. The victim was unknown and seemingly randomly selected. This event will be referred to as assault 1.

Less than one week later, Toby randomly selected another young girl, followed her and repeatedly stabbed her, then dragged her through a paddock and dropped a rock on her head. This time the wounds were severe. Toby believed that he had killed the girl. In fact, the girl survived but was in a coma for many weeks. Toby denied that he had premeditated this act of violence and, in retrospect, stated that he felt the he committed the act because he must still have been angry about the same minor incident that had occurred the week before and had precipitated the previous attack. Toby was questioned by police about this matter although no charges were laid. In response, the family moved away from the area. This event will be referred to as assault 2.

The homicide occurred twelve months after assault 2 when Toby was aged 17 years. The victim of the homicide was a young female schoolgirl who was known to Toby. He described their relationship as boyfriend/girlfriend but that they were no longer together when the homicide occurred. Toby has given two versions about who contacted whom to make arrangements to meet in person. In one version she called him and in another he called her. The balance of the evidence suggests that he contacted his victim and arranged to meet.

The two met in the afternoon and took a walk to a bushy area. Toby claimed that they had consensual intercourse, although the pattern of bruising on the young girl at post-mortem suggested otherwise. Following intercourse, Toby repeatedly hit the victim on the head with the shape blade of a tomahawk until she was dead. He claimed that he



was unsure whether he had intended to kill her but it is clear that he took a tomahawk with him and the possibility had crossed his mind.

Toby was soon apprehended and pleaded guilty to murder and attempted murder. He was given a sentence of the Term of his Natural Life. He had no fixed sentence because he received his sentence before the Truth in Sentencing legislation was introduced.

## **6.2 Method**

The method for this case was the same as for Case One with two variations. Two additional imagery scripts relating to assaults 1 and 2 were also administered. Table 11 presents the content of all five imagery scripts.

In addition, the Hare Psychopathy Checklist: Screening Version (PCL:SV; Hart, Cox & Hare, 1995) was used to determine the presence of psychopathy in this individual. Two independent clinicians were used to rate the presence of a range of variables indicative of the presence of psychopathy.

Table 11.

*The content of each stage of each script for Case Three (Toby).*

Script	Stage	Content
Homicide	Scene	Toby met with the victim and walked through the bush.
	Approach	Sexual intercourse took place.
	Incident	The victim was hit on the head with a tomahawk.
	Consequence	Toby attempted to hide the body.
	Resolution	Toby fled the scene.
Aggression	Scene	Sat in fire truck deciding on next action.
	Approach	Got the go ahead from HQ to proceed.
	Incident	Female firefighters became fearful and Toby became angry with them.
	Consequence	Proceeded through fire.
	Resolution	Arrived at clearing and proceeded to fight fire.
Neutral	Scene	Toby stood in prison yard waiting for lunch.
	Approach	Custodial officers prepared to give signal.
	Incident	Signal given and men lined up for parade.
	Consequence	Names called then people filed off to go to lunch.
	Resolution	Toby walked past custodial officer and out of yard towards lunchroom.
Assault 1	Scene	At corner store. Noticed victim
	Approach	Followed victim.
	Incident	Stabbed victim.
	Consequence	Moved away from victim.
	Resolution	Fled scene.
Assault 2	Scene	Kicked football with brother on front lawn.
	Approach	Left for football training. Noticed and followed victim.
	Incident	Repeatedly stabbed victim.
	Consequence	Moved victim and dropped rock on her head.
	Resolution	Fled scene.

## 6.3 Results

### 6.3.1 *Psychological measures*

On the PCL:SV (Hart et al., 1995), Toby obtained a score of 21 from one rater and a score of 19 from the other which placed him above the cut-off score of 18 indicating that clinically significant psychopathic tendencies were evident. The conclusion was reached despite the relatively lower score for psychopathic deviation on the CAQ, the less sensitive of the two measures of psychopathy.

Table 12 presents the scores obtained for the personality traits and clinical syndromes of the CAQ. Clinical significance is denoted. Toby was demonstrated to be an intelligent person, shrewd and self-disciplined. However, he also indicated little conformity to societal rules and a tendency to break rules. For the clinical factors, Toby was considered to be depressed and withdrawn or bored. The scores indicated that he feels inadequate when he compared himself to others. The response profile was deemed valid.

Table 12.

*The scores obtained on each of the subscales of the CAQ for Case Three (Toby).*

Personality subscales	Score	Clinical subscales	Score
Warmth	4	Hypochondriasis	6
Intelligence	9 *	Suicidal depression	6
Emotional stability	3	Agitation	3
Dominance	4	Anxious depression	5
Impulsivity	4	Low energy depression	9 *
Conformity	2 *	Guilt and resentment	6
Boldness	3	Boredom and withdrawal	9 *
Sensitivity	9 *	Paranoia	4
Suspiciousness	2 *	Psychopathic Deviation	4
Imagination	4	Schizophrenia	4
Shrewdness	10 *	Psychasthenia	6
Insecurity	5	Psychological inadequacy	8 *
Radicalism	8 *		
Self-sufficiency	1 *		
Self-discipline	8 *		
Tension	5		

\* denotes clinical significance

Table 13 presents the T scores obtained for the STAXI. Six out of 8 anger percentiles for Toby were outside of the norms. For State, Trait, Temperament, Anger-In and Anger Expressed, Toby's scores were above the 75<sup>th</sup> percentile and for Anger Control Toby was below the 25<sup>th</sup> percentile.

Table 13.

*The percentile scores obtained for the scales and subscales of the STAXI for Case Three (Toby).*

Scales	Subscales	Percentile Scores
State Anger		98 *
Trait Anger		94 *
	Angry Temperament	98 *
	Angry Reaction	51
Anger In		77 *
Anger Out		99 *
Anger Control		1 *
Anger Expression		99 *

\* denotes clinical significance

The results of the DES indicated that Toby endorsed the same number of items as endorsed by the normal population and his severity score (7.30) was only slightly elevated (4.38 for the normal population). There was no indication that he was experiencing dissociation.

Toby's scores for the Ways of Coping scale are presented in Table 14. He scored one standard deviation below the norm for seeking social support. However his wishful thinking, self-blame, and avoidance scores were all clinically elevated.

Table 14.  
*The scores for the subscales of the Ways of Coping scale for Case Three (Toby).*

Subscale	Score
Problem focused	23
Seeking social support	3
Wishful thinking	25 *
Blaming self	11 *
Avoidant coping	30 *

\* denotes clinical significance

Table 15 presents the scores obtained for each of the irrational beliefs assessed by the Beliefs Inventory. Toby strongly endorsed the beliefs pertaining to having to have things your way, it is easier to avoid life problems than to deal with them, and the past determines the future. More interestingly, Toby had a score of zero for having to have love and approval from peers and family.

Table 15.

*The level of endorsement for each irrational belief for Case Three (Toby).*

Irrational belief	Score
It is an absolute necessity for people to have love and approval from peers, family and friends.	0
You must be unfailingly competent and almost perfect in all you undertake	5
Certain people are evil, wicked and villainous, and should be punished.	3
It is horrible when things are not the way you would like them to be.	8 **
External events cause most human misery-people simply react as events trigger their emotions.	2
You should feel fear or anxiety about anything that is unknown, uncertain, or potentially dangerous.	6 *
It is easier to avoid than face life's difficulties and responsibilities.	7 *
You need something other or stronger or greater than yourself to rely on.	6 *
The past has a lot to do with determining the present.	7 *
Happiness can be achieved by inaction, passivity, and endless leisure.	4

\* denotes clinical significance

### 6.3.2 Psychophysiological reaction to imagery

Figure 15 presents the mean heart rate responses for baseline and each of the five stages of each of the scripts. The lack of variation in heart rate across the stages of the homicide script should be noted. It was interesting to note that the only evidence of psychophysiological reactivity was short-lived elevations to the mention of the word "tomahawk".

With regard to the aggression script, again there was little variation across the stages of the script. If a comparison was made only between these two scripts, it may be speculated that this stable pattern represents elevated psychophysiological arousal to both scripts. However, this was not the case.

It can be seen that there is little differentiation between the homicide, aggression,

and the neutral scripts. The highest level of arousal was during the consequence stage of the neutral script. Contained in this stage was a description of Toby leaving the yard and walking past a custodial officer. At this time, he routinely made a comment to the custodial officer about what he believed to be the nonsensical nature of parade.

The differences in baseline between the previously mentioned scripts and the two assault scripts are a manifestation of the fact that the assault scripts were recorded on a separate day. The second recording was associated with an overall lower level of arousal. To the first assault, there was little evidence of major alteration of psychophysiological response over the course of the event.

The largest variation in heart rate occurred for the second assault with a reduction in arousal from the scene stage (67.9 bpm) to the consequence stage (62.3 bpm) with an increase again as he was fleeing the scene (66.9 bpm). Despite these representing the greatest variation in response, they would not be considered clinically significant if a change of 20% of baseline heart rate is taken as an indicator of the change being clinically relevant (Blanchard & Young, 1973).

When comparisons were made between scripts, it was evident that the response at no stage of the homicide script or the aggression script deviated from the response to the neutral event.



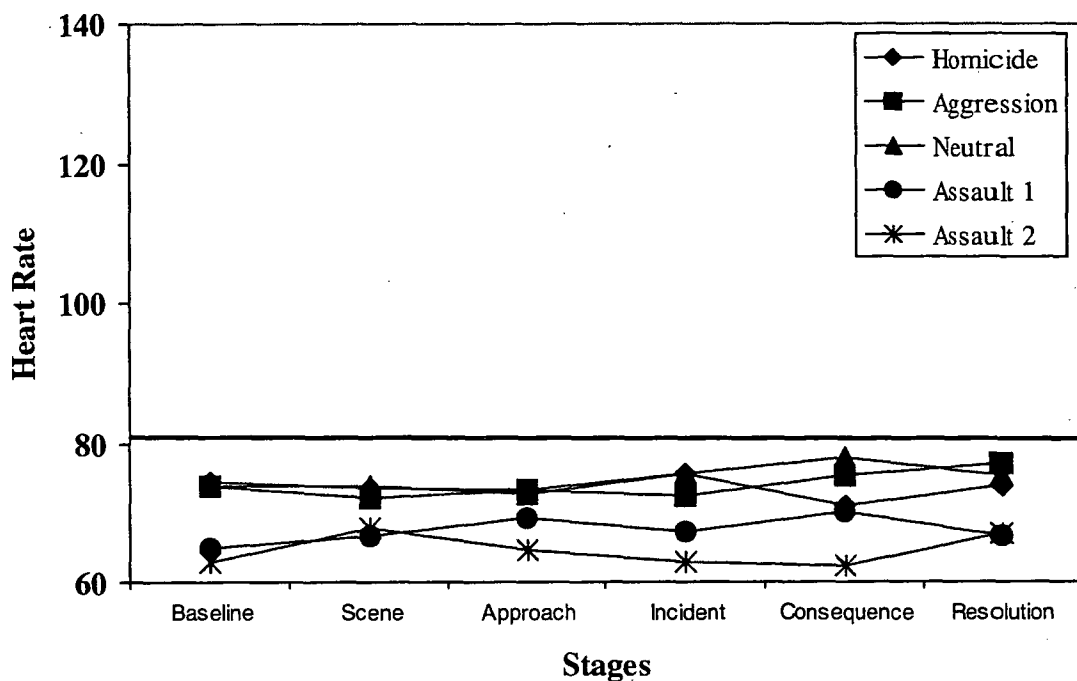


Figure 15.  
*The mean heart rate for the baselines and each stage of each script for Case Three (Toby).*

### 6.3.3 Psychological response to imagery

Figure 16 presents the ratings for the VAS not anxious-anxious for each stage of each script. Toby reported elevated anxiety to the homicide script (88, 79, 84, for the scene, approach and incident stages respectively) except at the actual point of hitting the victim on the head with the sharp edge of a tomahawk (53). However, from the interview material, it would seem that the only spontaneously reported anxiety occurred during the resolution stage when Toby feared being seen leaving the scene of the homicide (81).

The pattern of response to the first assault indicated increasing anxiety from the scene stage (51) with maintenance of the elevation from the incident stage onwards (79, 88, 89, 84). This is the pattern that best matches the heart rate response although the overall level of the heart rate would not indicate such a high rating of anxiety. The

pattern of the anxiety response to the second assault also fits with the description of the events as they occurred. Toby reported being anxious only after the event (90 in the consequence stage and 89 in the resolution stage) when the likelihood of being seen, identified and captured caused him to flee the scene. The ratings for scene (14), approach (45), incident (13) were much lower.

The pattern of response to the aggression script was different from the response to the homicide script. An initially high level of anxiety at the scene stage (82) was followed by a report of a reduction of anxiety during the approach stage (25). The incident (72) and consequence (86) stages were associated with an increase in anxiety, which was followed by a return to a moderate level at the resolution stage (46). There is some variation in reaction to the neutral script (40 to 14).

When the data were considered in relation to differences between scripts, it was evident that elevated ratings of anxiety to homicide imagery relative to neutral imagery were made at the scene, approach, consequence and resolution stages but not the incident stage. For assault 1, elevated ratings were noted at the approach, incident, consequence and resolution stages, but not the scene stage. For assault 2, elevated ratings were apparent at the consequence and resolution stages but not the scene, approach or incident stages. Aggression imagery produced elevated ratings at only the scene, incident and consequence stages.

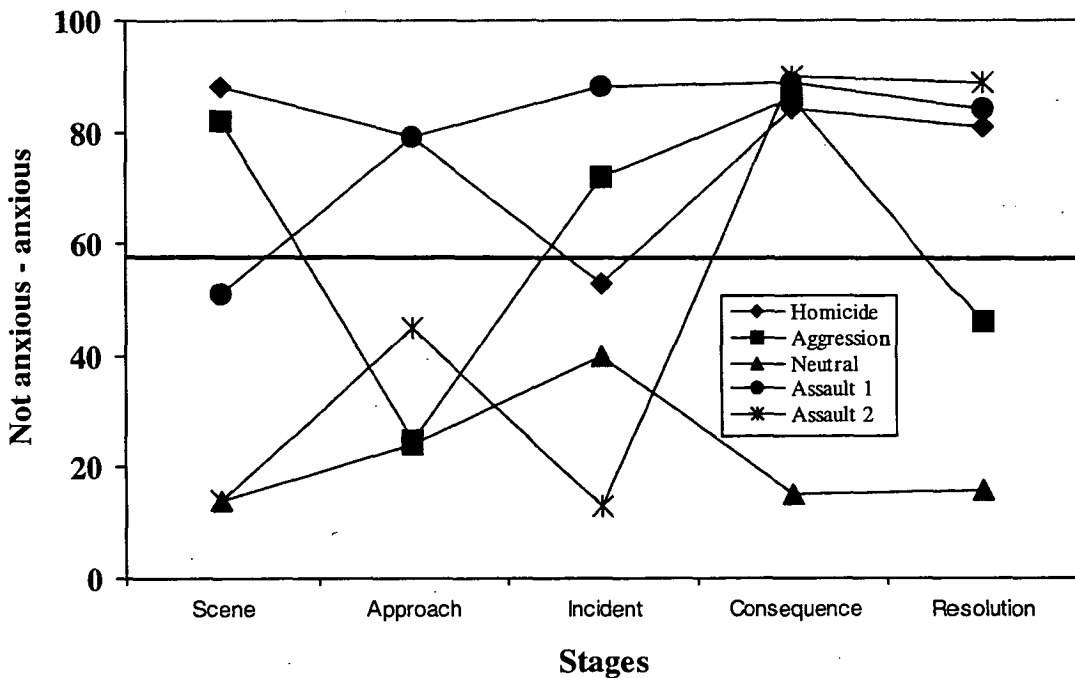


Figure 16.  
*The ratings for the not anxious-anxious VAS for each stage of each script for Case Three (Toby).*

Figure 17 presents the ratings for each stage of each script for the VAS not angry-angry. In relation to the homicide script, there was a pattern of anger reduction, first occurring during the actual homicidal attack with a reduction from 91 at the approach stage to 53 at the incident stage. By the consequence and resolution stages, anger had virtually disappeared (14 and 12 respectively).

The anger reported for the assault 1 event began at 51 and increased over the next two stages (70, 87) until it rapidly decreased to 12 and 14 for the consequence and resolution stages. The assault 2 ratings started with a much lower anger rating (14) and then increased to 29, and to 92 at the incident, and then decreased to 89 and to 52 in the last two stages.

The aggression script began with a moderate level of anger (53) and then decreased to 24 but then increased to 73 at the incident stage and 84 at the consequence stage. Toby then reported a decrease at the resolution stage (24). Toby's anger in the neutral script did not vary.

Between script comparisons indicated some substantial variations. In comparison with the neutral script, the homicide script elicited higher ratings of anger at the scene, approach and incident stages, but not the consequence or resolution stages. The ratings at the scene, approach and incident stages of the assault 1 script also elicited higher ratings of anger than the neutral script but not at the consequence or resolution stages. For the assault 2 script, higher ratings were evident at the approach and incident stages only. Aggression imagery was associated with higher ratings of anger at all stages in comparison with the ratings to the neutral imagery.

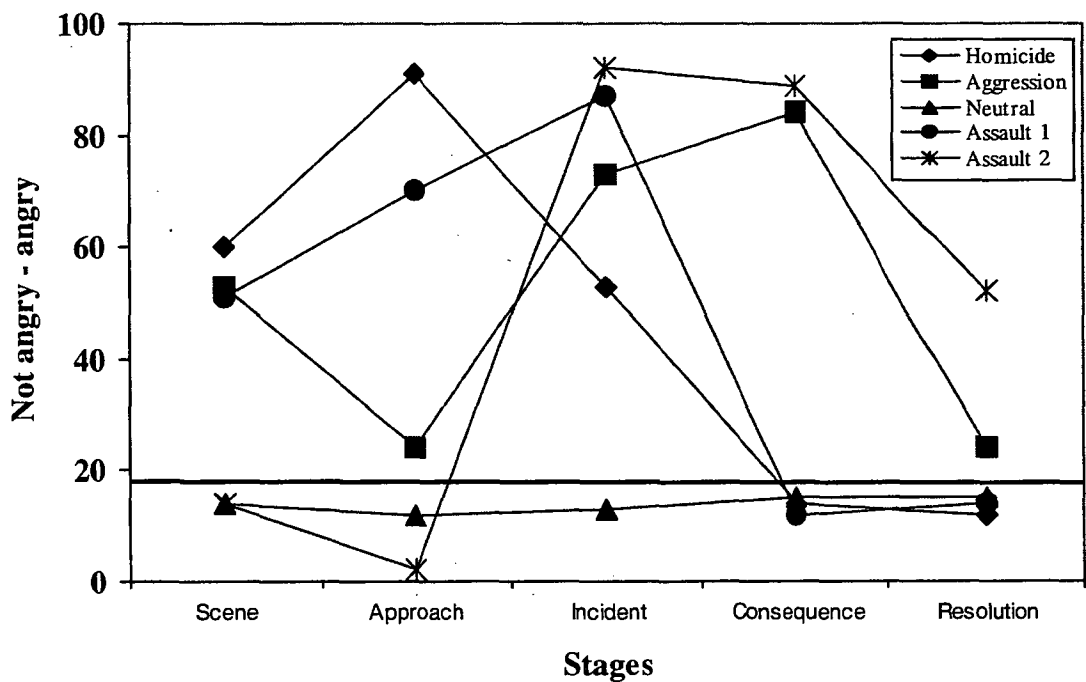


Figure 17.  
*The ratings for the not angry-angry VAS for each stage of each script for Case Three (Toby).*

Figure 18 presents the ratings for the VAS normal-unreal for each stage of each script. Unreality was rated highly to the homicide script's first stage (83) when Toby walked through the bush with the victim and in the approach stage when sexual intercourse took place (90). There was little evidence of depersonalisation or dissociation during the incident stage when he hit his victim with a tomahawk (54). There was an increase in the consequence stage when Toby thought about getting caught and he dragged the body into the bushes. As he ran away and rinsed the blood from the tomahawk, there was a greater sense of normality (10).

For the assault 1 script Toby began with a relatively low rating of 16 in the setting the scene stage but escalated to 89 in the approach stage when he singled out his victim.

His scores continued to stay in the moderately high to high range (87, 88, 85) over the next three stages. A more fluctuating pattern of feelings of unreality was recorded for assault 2 imagery. Toby began with a moderate rating (44) for the setting the scene stage and this increased to 50 for the approach stage. While he was committing the assault, Toby rated a more unreal feeling (81) which continued through the consequence stage (89) and resolution stage (89).

Toby's aggression script began with a report of marked unreality (92) but then dropped to 10 as he talked over the microphone and was excited about driving through the fire. Unreality increased (76) in the incident stage and decreased (55) in the consequence and (23) in the resolution stage when he made a decision to override the professional firefighters decision. The ratings were more towards normality for the neutral script (between 10 and 15) for all five stages.

Between script comparisons indicated that the first four stages of the homicide script were elevated relative to the neutral script. For the assaults, deviations from the neutral script were evident from the approach stage of the assault 1 script, and deviations from neutral were evident for all stages of the assault 2 script. Elevations in the ratings in relation to the aggression script were noted for all stages but the approach stage.

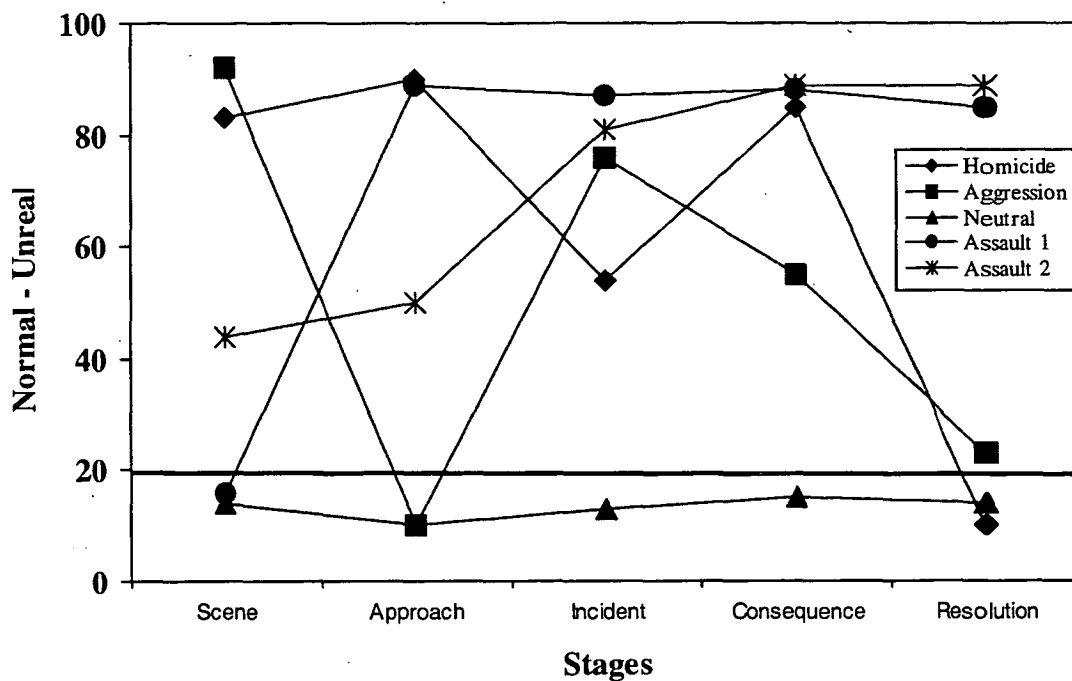


Figure 18.  
*The ratings for the normal-unreal VAS for each stage of each script for Case Three (Toby).*

Figure 19 presents the ratings for the VAS not fearful-fearful for each stage of each script. The homicide script showed a pattern of heightened fear in the first two stages (81 and 89) followed by a decrease in fear at the incident stage (77) when he hit the victim with a tomahawk. In the consequence and resolution stages there was an increase in fear levels (87 for both stages) when Toby feared being caught.

Over the first four stages of the assault 1 script Toby became more fearful (16, 66, 75, 88) as he singled out his first victim and assaulted her. In the resolution stage he maintained his heightened level of fear (84) as he ran away from the scene of the assault. There was a similar pattern for the assault 2 script where fear was rated mildly to begin

(11) but escalated over the next four stages (50, 56, 88, 90). As he committed the assault and became concerned about being caught.

Although Toby's fear levels were elevated in the setting the scene stage (84) of the aggression script, his other stages were rated at a moderate level (57, 54, 56 for the approach, consequence and resolution stages respectively) with the exception of the incident stage where fear ratings increased to 75. Toby's fear ratings for the neutral script ranged from 12 to 15 with little variation.

When comparisons were made between scripts, all stages of the homicide and aggression scripts were associated with elevated ratings of fear relative to the neutral script. For the two assault scripts, ratings were elevated at the approach, incident, consequence and resolution stages, but not the scene stage.

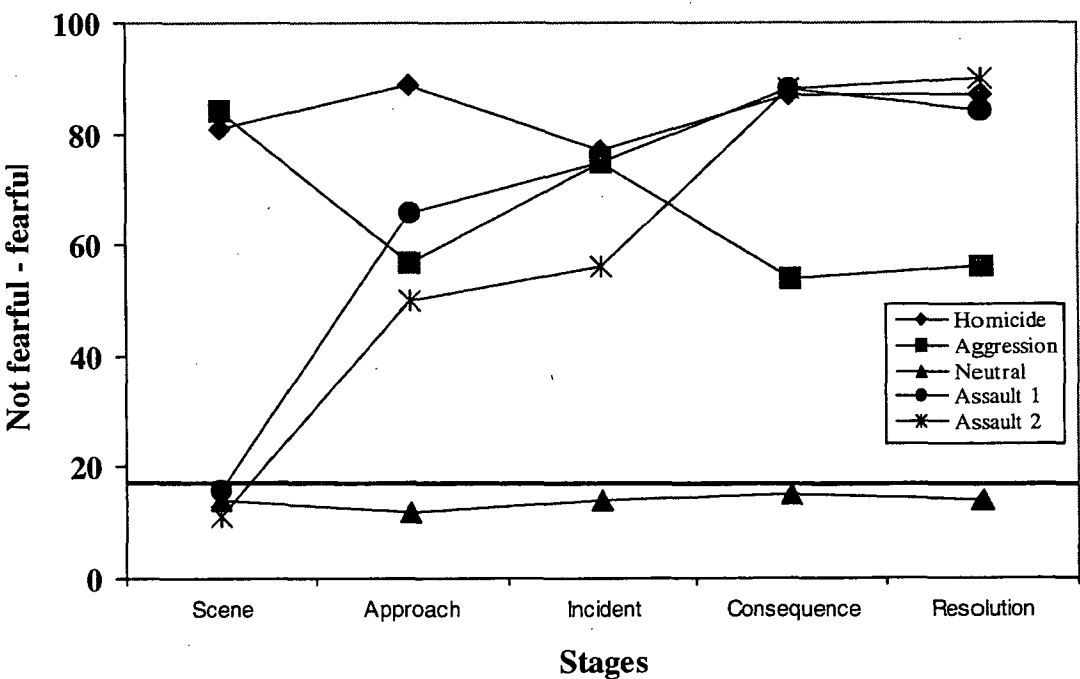


Figure 19.  
*The ratings for the not fearful-fearful VAS for each stage of each script for Case Three (Toby).*



Figure 20 presents the ratings for the VAS not agitated-agitated for each stage of each script. Toby's initial response to the homicide script was at a moderate level of agitation (58) but his agitation increased during the approach stage (88). His agitation level decreased as he struck the victim (53) and decreased even lower when he realised she was dead (15). His agitation rating increase to a moderate level as he fled the scene (52).

The first two stages of the assault 1 script showed increased agitation levels (79, 87) but then there was a steady decrease in agitation after he had assaulted the victim (52, 30, 13). The assault 2 script showed a pattern of escalated agitation from setting the scene (50) and the approach (43) to incident (89). After he assaulted the victim, his agitation levels slightly decreased to 53 and 51 for the last two stages when he feared being apprehended.

In response to the aggression script, Toby reported moderate levels of agitation (54) as the setting the scene stage information was presented. The ratings then decreased to a low level of agitation (15) in the approach stage when he determined that he could take the fire truck directly into the fire. As the other firefighters expressed their apprehension and the truck passed through the fire, Toby's agitation levels increased to 88 and 84 for the incident and consequence stages. His agitation levels decreased to a moderate rating (54) in the resolution stage. Toby's agitation levels for his neutral script ranged from 23 to 41 as he stood in the yard waiting for his name to be called by the prison guards.

Between script comparisons indicated that the scene and approach stages of the homicide script were rated as eliciting greater agitation than the neutral script although subsequent stage ratings did not differ from the neutral script ratings. The ratings at all stages of the aggression and assault 2 script, and all but the resolution stage of the assault 1 script deviated from the neutral script ratings.

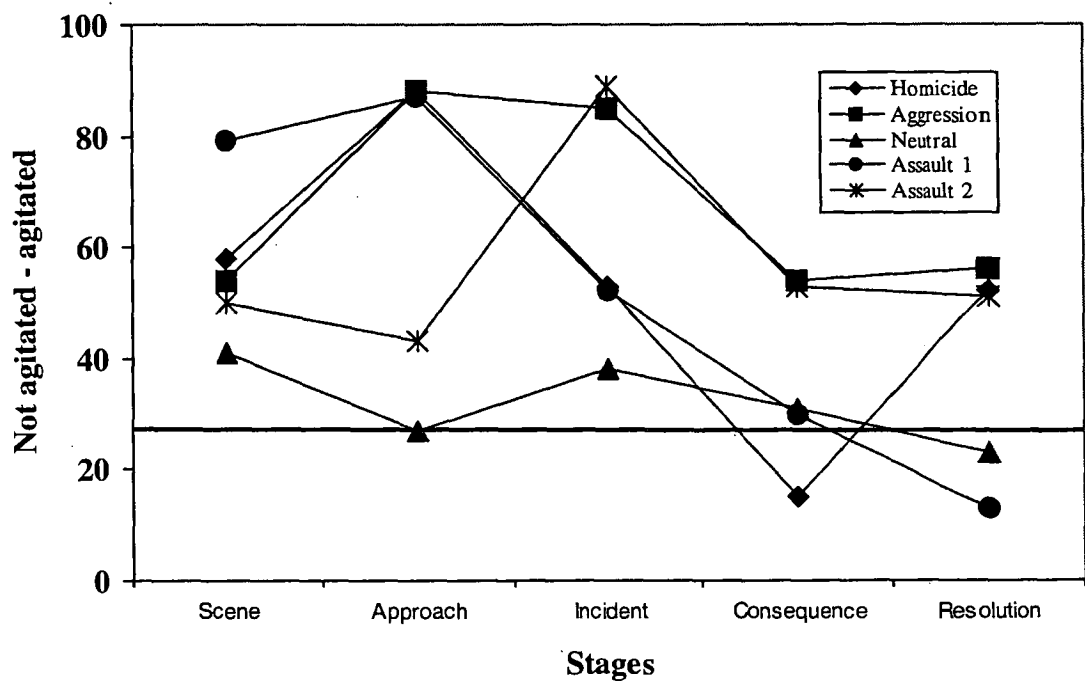


Figure 20.  
*The ratings for the not agitated-agitated VAS for each stage of each script for Case Three (Toby).*

Figure 21 presents the ratings for the VAS not guilty-guilty for each stage of each script. Guilt ratings were elevated in all stages of the homicide script (87-90). In response to the assault 1 script, Toby initially reported little guilt (12 scene and approach) but reported more, but still only moderate, guilt in the incident stage when he stabbed the victim (52). He reported the most guilt in the consequence stage (90) and resolution stage

(89). The assault 2 script elicited relatively low ratings (11) for the first two stages with increased guilt in the incident stage (55), and a further escalation in the consequence stage (73), and in the resolution stage (91).

The beginning of the aggression script was rated with moderate levels of guilt (56) but showed decreased levels (15, 21, 28) in the next three stages. At the resolution stage, his guilt rating increased to its highest level of 79. The ratings of guilt for the neutral script varied only slightly (12-14) over the five stages of the script.

Between script comparisons indicated noteworthy differences. The ratings for the homicide script were elevated relative to the neutral script at all stages. Assault 1 and assault 2 imagery were associated with elevated ratings of guilt at the incident, consequence and resolution stages but not the scene or approach stages. Aggression imagery elicited higher ratings of guilt at all stages except the approach stage.

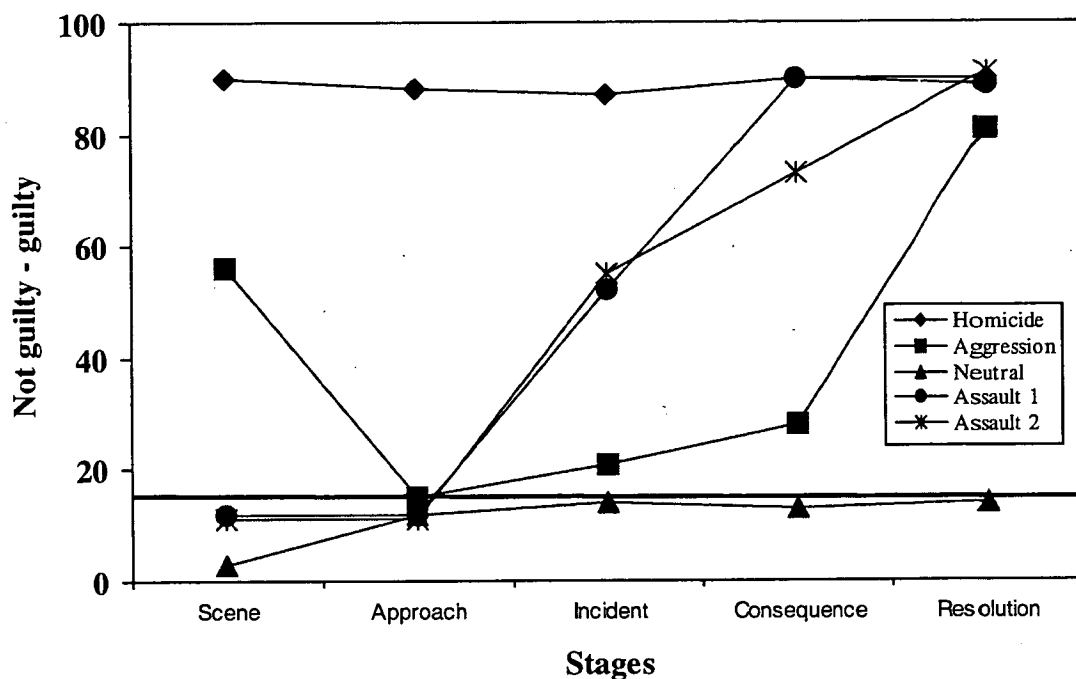


Figure 21.  
*The ratings for the not guilty-guilty VAS for each stage of each script for Case Three (Toby).*

## 6.4 Discussion

Psychopathy is a chronic disorder with symptoms that manifest early and are relatively stable over time (Forth, 1995). It may be that when individual dysfunction in the form of psychopathy (a chronic condition) and environmental pressures (transient conditions) interact, the inhibitions towards violent behaviour are removed and homicidal behaviour occurs (McKenzie, 1995).

It has been determined that people who display psychopathic tendencies are predatory and exploitative and demonstrate marked impulsivity (Quinsey, 1995). All of these characteristics are evident in Toby. The criminal sexual behaviour of these individuals may be characterised as vindictive and opportunistic rather than motivated by

sexual arousal or desire (Barbaree et al., 1994). This fits with the description of Toby's sexual behaviour that occurred immediately prior to the homicide. The homicidal behaviour of young psychopathic perpetrators is associated with the selection of low risk victims, the use of knives as the instrument of homicide, and emotional and behavioural disturbance in the perpetrator (Myers & Blashfield, 1997). Again, these descriptions are evident in the characteristics of this perpetrator and the homicidal act.

The psychophysiological assessment demonstrated little variation in heart rate across the stages of the scripts, or between scripts. This pattern of response appears to be typical of the hyporeaction that is evident in conjunction with psychopathy (Fowles, 2000; Pham, Philippot, & Rime, 2000). Other research has identified a lack of change in electrodermal response to distress cues in both adults (Blair, Jones, Clark & Smith, 1997) and children (Blair, 1999) with psychopathy, although responses to threatening and neutral cues did not distinguish these people from matched control groups.

These results indicate that people with psychopathy do not process emotional information appropriately; their affective interpretation of events may be distorted. There is evidence for this being the case (Blair, Sellars, Strickland et al., 1995; Kroner & Forth, 1995). Of relevance to the perpetration of violent, criminal behaviour, it is apparent that there is a lack of connection between the actions of psychopathic individuals and the negative emotional consequences that would normally be experienced (Pollock, 1999). This is manifested in the fact that few psychopathic individuals become traumatised as a consequence of their violent behaviour.

The results of the current assessment demonstrate some consistency in response within scripts but not between scripts of a similar type. That is, the homicide, assault 1,

and assault 2 script elicited different patterns of psychological response over the stages, despite the similarity in the behavioural content of the scripts. Interestingly, it would appear that the psychological responses to the aggression script, although showing some consistency between measures, did not seem to follow script content. It may be that accurate charting of emotional reactions is problematic for this individual. In some cases, such as with homicidal behaviour, a normative response is evident. That is, a person could identify that they were supposed to experience guilt if they had killed someone. However, the pattern of the guilt response to the aggression imagery would indicate that, without the norms for the experience of guilt, this perpetrator is unable to appropriate label a situation as requiring a no guilt-guilt response.

This view is supported by the examination of remorse by this individual. In general, psychopathic individuals are driven by self-gratification and have little thought for the distress of their victims or the victims' families (Belmore & Quinsey, 1994). This perpetrator seems unable to spontaneously give an expression of remorse although he will provide a statement of remorse if clues are given as to when such a statement is required. His skills in this area have improved over time. It may be that he has learned that certain circumstances demand a remorseful response and is able to express remorse on these occasions.

The presence of psychopathy is a very good predictor of violent recidivism (Hare, 1996; Hart, 1995; Hemphill & Hare, 1995; Serin & Amos, 1995). Personality disorder is common among serial, repeat homicide perpetrators (Adler & Lidberg, 1995), and psychopathy is evident in some (Teles, 1995). It has been suggested that these people develop a cold addiction to violence (Geberth & Turco, 1997), over time developing into

a serial pattern. It may be a learned response that is logical for the perpetrator (Hale, 1993). For example, the perpetrator may be sensation seeking (DeHart & Mahoney, 1994), a motivational explanation that is supported by the overall lack of psychophysiological arousal evident in relation to this individual. Toby expressed no confidence that he would have been able to have resisted further homicidal behaviour had he not been apprehended.

## **Chapter 7**

### **Case Four: Sexual Homicide**



### *7.1 Case*

This final case was an instrumental homicide that was perpetrated following the rape of the victim. Derek was 42 years of age at assessment and had been incarcerated since 1999. Physically, he was a large and imposing man. He was cooperative during the interviews although his presentation was somewhat dramatic. During Derek's incarceration he had claimed to have significant psychological disturbance as a result of the homicide although this claim was regarded with some scepticism by a consultant psychiatrist who assessed his psychological functioning.

Derek was raised in a working class family and was the eldest of six children. His childhood was marred by severe physical abuse by his father. He was raised in a city environment and left school after completing Year 9. At the time of the homicide Derek was employed as a storeman.

At a relatively young age, he married an older woman although this relationship did not last. At the time of the homicide Derek was married with two children and was the father-figure to an 18 year old stepdaughter who he had raised since she was four years of age. He described general dissatisfaction with his marriage that may have been a reflection of current financial difficulties and the fact that he was working very long hours.

In terms of criminal history, there was a report of an early episode of shoplifting. Of more significance was a situation that developed when he was 15 years of age. Derek illegally entered the home of a woman while she was in residence. Although the information provided by Derek about this incident was not detailed, it is clear that he tied

her up and covered her head. As a consequence of his actions, he was given 12 months probation for stealing.

The victim of the homicide was a young lady who was unknown to Derek. She was described as an assertive young lady who seemed capable and confident. While Derek's family was away on holiday, he went out drinking at night. When at a local bar, he met a friend who interacted with the victim although Derek claimed not to have been aware of this. He subsequently abducted this young woman, raped her, and killed her.

It was apparent that Derek became aware of the victim and followed her as she walked home. He parked his car, waited behind a bush, then grabbed her, put a coat over her head, pushed her into the back seat of his station wagon, and bound her hands. He then drove to a secluded area and stopped his car in what he believed was a country laneway. Derek pulled the victim from the car, roughly removed her clothing and raped her while holding her on the bonnet of the car. This action was followed by an attempt to strangle the victim. In the struggle, the victim fell from the car onto the ground.

At this point, Derek was disturbed by a man who needed to travel up the laneway. Derek claimed that his car had broken down and the other man helped the perpetrator to push the car a short way so that the second vehicle could get past. Derek declined further offers of assistance.

After this disruption, and believing that the victim was dead, Derek lifted the body and placed it in the back of the station wagon. When an attempt to reverse the car from the laneway resulted in the car becoming stuck in a small stream, he went to the back of the car to move the body. It was at this time that Derek became aware that the victim was not dead. He pulled the victim from the car and walked the then conscious young woman

through the woodland and over a wire fence. He then strangled the victim with his belt until she was dead and dropped a large rock on her head to ensure her death. He then returned to his car, removed it from the stream, and drove to his home.

He claimed that he had not planned to rape or kill this young woman although there was some evidence of premeditation. However, the period of premeditation was hours or less rather than days.

Derek pleaded guilty to the charges and was sentenced to a minimum non-parole period of 25 years incarceration.

## **7.2 Method**

The method is the same as for Case One with the exception of the script content. In addition, two extra script were administered; an abduction script and a rape/attempted homicide script. These scripts represented components of the single act of homicide. Table 16 presents the content of each of the imagery scripts for this participant. In addition, the PCL:SV (Hart et al., 1995) was administered to establish whether psychopathy was evident in this individual.

Table 16.

*The content of each stage of each script for Case Four (Derek).*

Script	Stage	Content
Abduction	Scene	Victim targeted and followed.
	Approach	Derek parked car and hid behind tree.
	Incident	Derek pounced on victim, threw a coat over her head and pushed her into the back of the car.
	Consequence	Derek bound the victim's hands and punched her in the head.
	Resolution	Derek drove away, talking to the victim.
Rape/ attempted homicide	Scene	Derek parked car in laneway and dragged the victim from the car.
	Approach	Victim raped on the bonnet of the car.
	Incident	Derek attempted to strangle the victim.
	Consequence	Derek viewed body beside the car and made plan to remove body.
	Resolution	Derek disrupted by passer-by.
Homicide	Scene	Derek put body in back of car and attempted to drive away but gets stuck.
	Approach	Derek removed body, realised victim was alive, and forced her into woodland.
	Incident	Derek strangled victim and dropped rock on her.
	Consequence	Derek viewed body then returned to car.
	Resolution	Derek freed car and drove away from scene.
Aggression	Scene	Step-daughter refused to go to school.
	Approach	Yelled at step-daughter to get out of bed.
	Incident	In a rage, Derek banged on door and window.
	Consequence	Derek slammed door, got in car, reversed out of driveway.
	Resolution	Perpetrator drove down street in reckless manner.
Neutral	Scene	Swept floor in prison hospital.
	Approach	Removed dust pan, then filled bucket with water and detergent.
	Incident	Washed floor.
	Consequence	Finished washing floor and emptied bucket.
	Resolution	Got polisher, turned it on and polished floor.

## 7.3 Results

### 7.3.1 Psychological measures

Derek scored 8 on the PCL-SV indicating that there is not evidence of psychopathy. Table 17 presents the scores obtained on the personality and clinical subscales of the CAQ. Derek's endorsed personality traits such as easily upset, disregards rules, and calculating although generally unable to assert himself. The scores for the clinical factors indicated a wide range of symptomatology, especially depression, resentment, suspiciousness and psychological inadequacy.

Table 17.

*The scores obtained on each of the subscales of the CAQ for Case Four (Derek).*

Personality subscales	Score	Clinical subscales	Score
Warmth	4	Hypochondriasis	8 *
Intelligence	6	Suicidal depression	9 *
Emotional stability	1 *	Agitation	4
Dominance	1 *	Anxious depression	8 *
Impulsivity	7	Low energy depression	8 *
Conformity	1 *	Guilt and resentment	10 *
Boldness	6	Boredom and withdrawal	8 *
Sensitivity	7	Paranoia	9 *
Suspiciousness	7	Psychopathic Deviation	1
Imagination	8 *	Schizophrenia	10 *
Shrewdness	10 *	Psychasthenia	8 *
Insecurity	6	Psychological inadequacy	9 *
Radicalism	7		
Self-sufficiency	6		
Self-discipline	5		
Tension	5		

\* denotes clinical significance

Table 18 presents the percentile scores obtained for the STAXI. Derek scored in the 97<sup>th</sup> percentile for Anger-In and the 96<sup>th</sup> percentile for Anger-Expression whereas he scored in the 2<sup>nd</sup> percentile for Anger Control. The scores for the other scales and subscales were well within normal limits.

Table 18.  
*The percentile scores obtained for the scales and subscales of the STAXI for Case Four (Derek).*

Scales	Subscales	Percentile Scores
State Anger		69
Trait Anger		63
	Angry Temperament	69
	Angry Reaction	38
Anger In		97 *
Anger Out		30
Anger Control		2 *
Anger Expression		96 *

\* denotes clinical significance

A non-clinical sample typically endorse 11 items with M=4.38 on the DES (Bernstein & Putnam, 1986). Derek endorsed all of the items with a M = 58.8. Since Derek endorsed all items on the DES, this suggested that the result was invalid. In addition, he highly endorsed items such as hearing voices in his head telling him to do things and feeling like he was two different people. These items are rarely endorsed and suggest his embellishment on the assessment.

The obtained scores for the Ways of Coping scale are presented in Table 19. Derek had elevated scores on the wishful thinking and on the avoidant coping subscales.

Table 19.  
*The scores for the subscales of the Ways of Coping scale for Case Four (Derek).*

Subscale	Score
Problem focused	18
Seeking social support	5
Wishful thinking	28 *
Blaming self	9
Avoidant coping	27 *

\* denotes clinical significance

Table 20 presents the scores obtained for each of the irrational beliefs assessed by the Beliefs Inventory. Two of Derek’s scores were extremely elevated, with all items being endorsed in relation to the need for love and approval, and all but one item being endorsed for fear about the future. Five other irrational beliefs were rated higher than is typical, but to a much lesser degree.

Table 20.  
*The level of endorsement for each irrational belief for Case Four (Derek).*

Irrational belief	Score
It is an absolute necessity for people to have love and approval from peers, family and friends.	10 *
You must be unfailingly competent and almost perfect in all you undertake	7 *
Certain people are evil, wicked and villainous, and should be punished.	7 *
It is horrible when things are not the way you would like them to be.	7 *
External events cause most human misery-people simply react as events trigger their emotions.	6 *
You should feel fear or anxiety about anything that is unknown, uncertain, or potentially dangerous.	9 *
It is easier to avoid than face life's difficulties and responsibilities.	4
You need something other or stronger or greater than yourself to rely on.	5
The past has a lot to do with determining the present.	6 *
Happiness can be achieved by inaction, passivity, and endless leisure.	3

\* denotes clinical significance

### 7.3.2 Psychophysiological response to imagery

Figure 22 presents the mean heart rate for baseline and each stage of each script. The first script described the abduction of the victim. During the scene stage, seeing the victim at the service station was described. Elevated heart rate was noted at this time (90.8 bpm). During the approach stage, a description of Derek hiding behind a bush with a coat to throw over the victim was presented. He imaged the victim walking toward him along the footpath. During the incident stage, Derek was asked to image throwing the coat over the victim's head and forcing her into the back seat of the car. During the consequence stage, he imaged punching the victim in the side of the head and tying her hands together with twine. The resolution stage included information about driving along with the victim in the back seat, pleading to be let go. The pattern of arousal did not



differ over the last four stages of imagery (range from 80.6 bpm to 82.6 bpm) but was elevated relative to other scripts.

Although at a lower level of arousal, the pattern of heart rate across the second script largely mirrored that of the abduction script (83.1 bpm at the scene stage then range from 76.7 to 78.9 bpm for the remainder of the script). Although labelled the rape script, this script also contained information about the first attempt on the victim's life. In the scene stage, Derek parked in a secluded laneway and pulled the victim from the car. During the approach stage, he tore the victim's clothes and raped her. During the incident stage, a description of the attempt to strangle the victim with his hands was provided. The consequence stage described an interaction with a third person. The victim was laying beside the car where she had fallen. A man driving his car wanted to pass by Derek's car that was blocking the lane. Derek told the other man that his car had broken down and the other driver helped him push it out of the way. The resolution stage described Derek lifting the victim and placing her in the back of the station wagon.

The third script described the actual murder. At the scene stage, the car became stuck as Derek tried to back the car out of the laneway. He then went to the back of the car to remove the body and became aware that the victim was still alive (73.6 bpm). During the approach stage, he got the victim to her feet and led her through the bush and over a fence (72.3 bpm). During the incident stage, there was an increase in arousal (81.6 bpm), and he recalled strangling the victim with his belt and dropping a rock on her head. He then returned to the car during the consequence stage (69.8 bpm). During the resolution stage, Derek recalled freeing the car and driving towards home (75.0 bpm).

The three scripts that are pertinent to the crime, were compared with the pattern of response to an aggression script that described Derek's intense anger at his stepdaughter. Of particular interest was the difference in the level of arousal at the incident stage that described his most intense anger in response to his stepdaughter's refusal to do as she was told (71.6 bpm). His arousal level clearly was lower than to the crime-related scripts.

Finally, the pattern of response to the neutral script indicated little variation across scripts and resulted in a lower level of arousal in comparison with all other scripts (range from 64.0 bpm to 67.4 bpm). The neutral script involved a description of sweeping, washing and polishing the floor at the prison.

When comparisons were made between scripts, all stage of the abduction and rape scripts were elevated while only the approach stage of the aggression script and the incident and resolution stages of the homicide script.

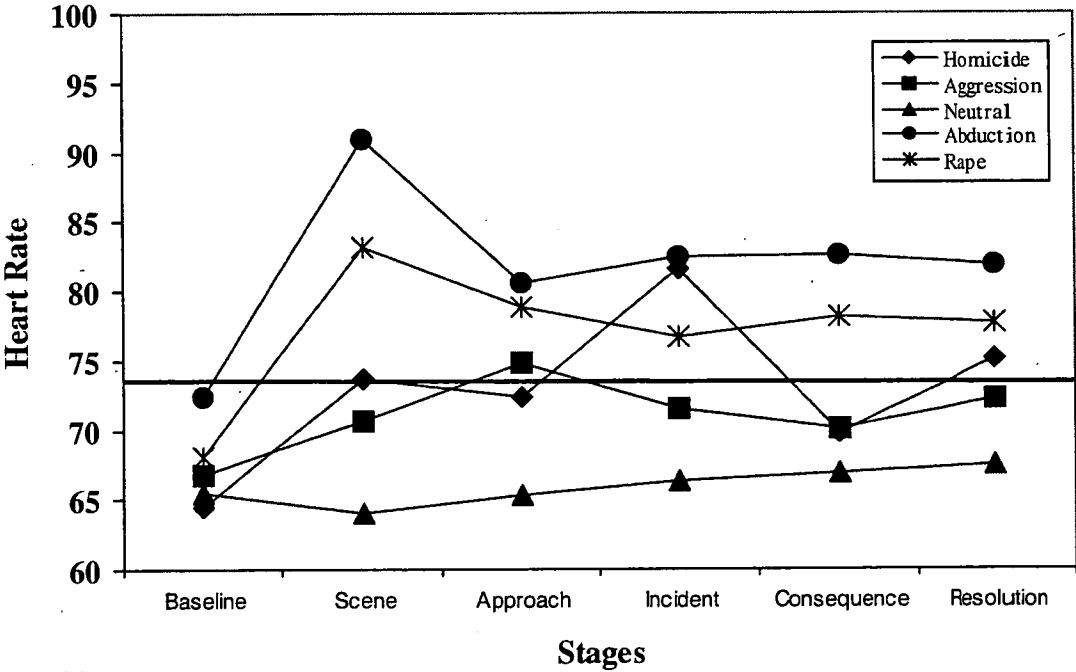


Figure 22.  
*The mean heart rate for the baselines and each stage of each script for Case Four (Derek).*

### *7.3.3 Psychological response to imagery*

Figure 23 presents the ratings for the VAS not anxious-anxious for each stage of each script. In reaction to the abduction script, Derek reported increasing anxiety over the course of the event that remained elevated even when the victim was secured in the back of the car (range from 49 to 85).

Derek rated the events surrounding the rape and homicide attempt as anxiety-provoking across the five stages with similar levels to the abduction in the final three stages (range from 83 to 87). This was despite the fact that the overall level of arousal as measured by the heart rate response was lower for the rape and attempted homicide than for the abduction.

Again, the ratings of anxiety in relation to the homicide script were elevated to a high level (range from 87 to 88) as for the previous script with the exception of a marked decrease in anxiety as the perpetrator was driving away from the scene and looking forward to going home (18).

Extreme ratings of anxiety were noted for the aggression script with little variation in response over the five stages (range from 87 to 88). In contrast, the level of anxiety in relation to washing and polishing the floor in the neutral script was low and remained so over the course of the script stages (range from 13 to 14). Of interest, is the similarity between the ratings of anxiety at the resolution stage when leaving the scene of the homicide and putting the polisher away.

When comparisons were made between scripts it was evident that the abduction, rape/attempted homicide, homicide, and aggression scripts all elicited higher ratings of anxiety than the neutral imagery at all stages.

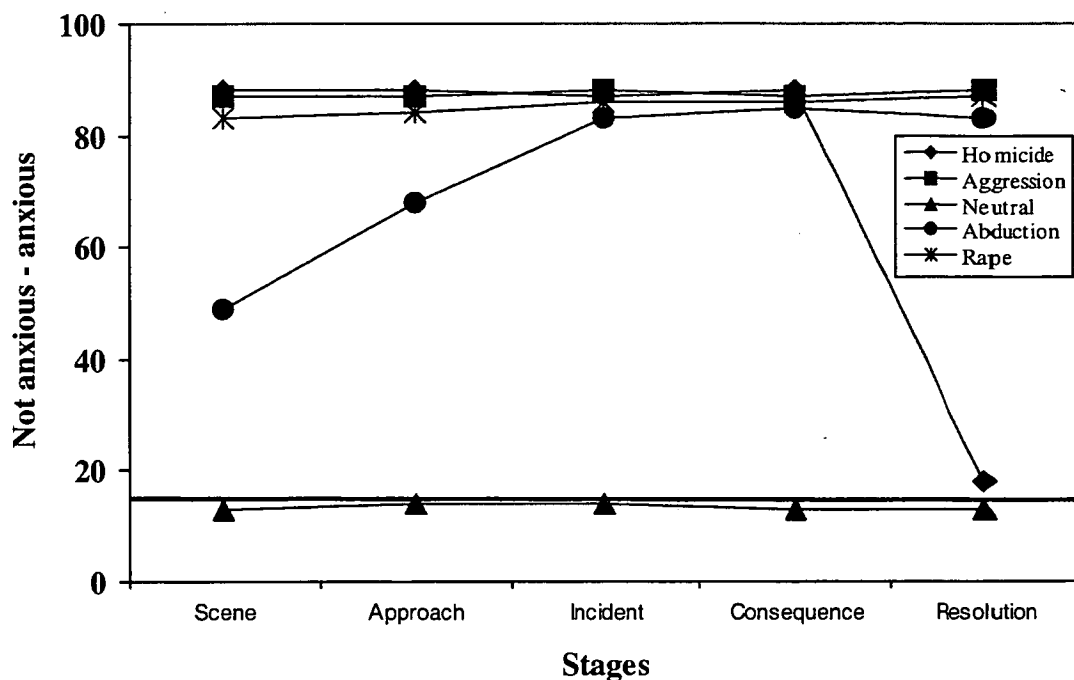


Figure 23.  
*The ratings for the not anxious-anxious VAS for each stage of each script for Case Four (Derek).*

Figure 24 presents the ratings for the VAS not angry-angry for each stage of each script. Although not generated by the victim, Derek reported moderate levels of anger when he first targeted the victim for abduction (58). Anger was reduced when hiding and waiting for the victim at the approach stage (17), but markedly increased when she struggled while being pushed into the car (84). Although Derek had reported being anxious in the final two stages of the homicide script, he did not report being angry at this time (21 and 25 for the final two stages).

In contrast, his anger ratings were elevated during the rape at the approach stage, and attempted homicide at the incident stage, and in relation to his experiences subsequent to the unsuccessful strangling (range from 86 to 87).

The pattern of response to the actual homicide was noticeably similar to the abduction script with the exception of an elevated level of anger at the scene stage (90) when he discovered that the victim was not yet dead. Anger dissipated when walking the victim through the bush (16) but increased again when Derek actually killed the victim (87). Little anger was evident in the immediate aftermath of the murder (19 and 18 for the final two stages of imagery).

The ratings of anger during the aggression script were markedly elevated and did not vary across the stages (range from 87 to 90). These ratings were in keeping with the his description of the intensity of his anger towards his step-daughter. Derek's level of anger in response to the neutral script was minimal as anticipated (range from 12 to 13).

When comparisons were made between scripts it was evident that the abduction, rape/attempted homicide, homicide, and aggression scripts all elicited higher anger ratings than the neutral imagery at all stages with the exception of the approach stage of the aggression script where the rating was comparable with the neutral imagery rating.

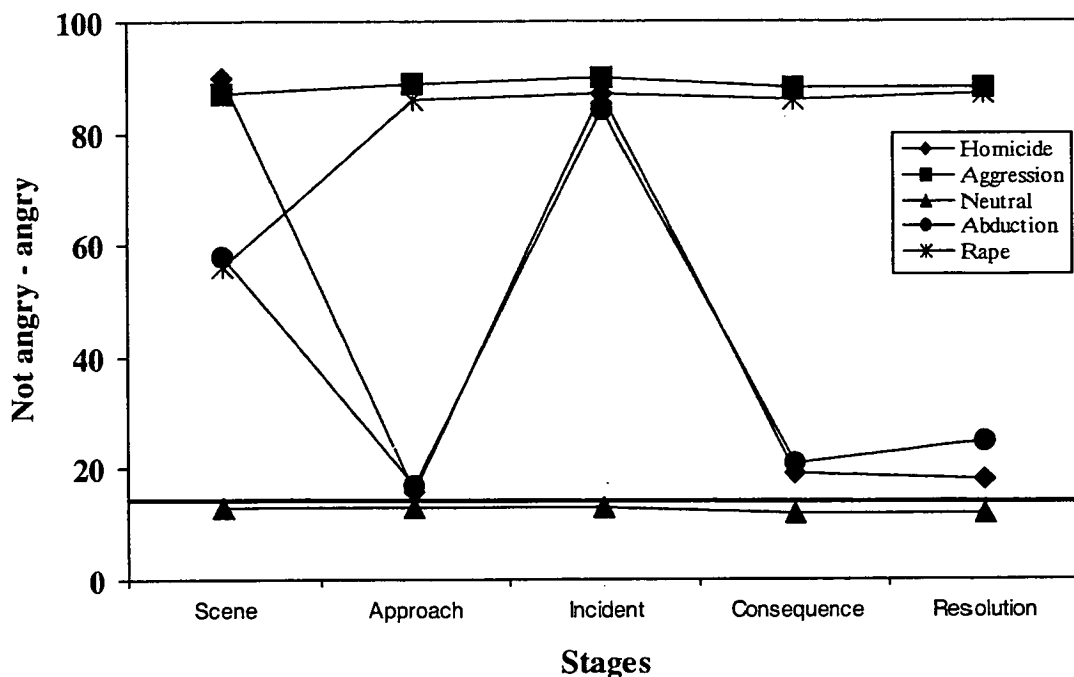


Figure 24.  
*The ratings of the not angry-angry VAS for each stage of each script for Case Four (Derek).*

Figure 25 presents the ratings for the VAS normal-unreal for each stage of each script. Derek's ratings for normalcy were moderate as he began preparing for the abduction (79 for the scene and approach stages). The ratings for the next three stages were elevated to 85, 86 and 85 as he completed the abduction. Then in the rape/attempted homicide script Derek's images were again rated as elevated, ranging from 85 to 88. The highest rating was given to the incident stage when he raped his victim and the lowest score was given to the consequence stage after he had just finished raping her. In the homicide script, Derek rated the scene and approach stages as extremely unreal (90) but as he was actually committing the killing he rated the images slightly closer to normalcy (86). After the act of killing his victim, Derek's rating returned to the extremely unreal (90, 89) range.

Interestingly, Derek's ratings for the aggression script were rated the most like the rape/attempted homicide script. The range of rating was from 87 to 89. Clearly, Derek's neutral script rating were not elevated in comparison to his other scripts. There was little variation in ratings which ranged from 10 to 14.

When comparisons were made between scripts it was evident that the abduction, rape/attempted homicide, homicide, and aggression scripts all elicited higher unreality ratings than the neutral imagery at all stages.

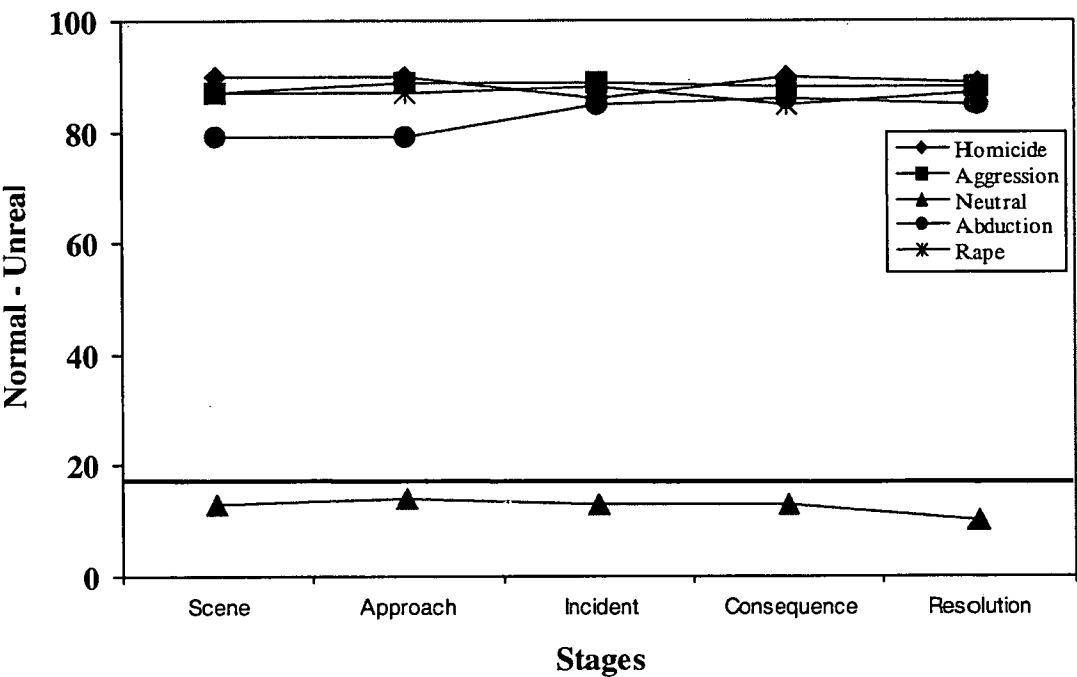


Figure 25.  
*The ratings for the normal-unreal VAS for each stage of each script for Case Four (Derek).*

Figure 26 presents the ratings for the VAS not fearful-fearful for each stage of each script. In relation to the abduction script, fear ratings increased from a moderately high level at the scene stage (78) to an elevated level at the approach stage (83) when the victim was targeted and the preparation to abduct the victim was made. The rating stayed

elevated throughout the remainder of the script (range from 85 to 87). The rape/attempted homicide script was associated with elevated ratings of fear with little variation across the stages (range from 86 to 88). The homicide script also elicited very high ratings of fear (range from 86 to 91) with the exception of the consequence stage when fear was rated as moderately low (28) as he returned to the car after the commission of the homicidal act.

The aggression script elicited fear ratings at the same elevated level as the rape/attempted homicide script with little variation across stages (range from 87 to 90). Neutral imagery elicited little fear (range from 13 to 15).

When comparisons were made between scripts it was evident that the abduction, rape/attempted homicide, homicide, and aggression scripts all elicited higher fear ratings than the neutral imagery at all stages.

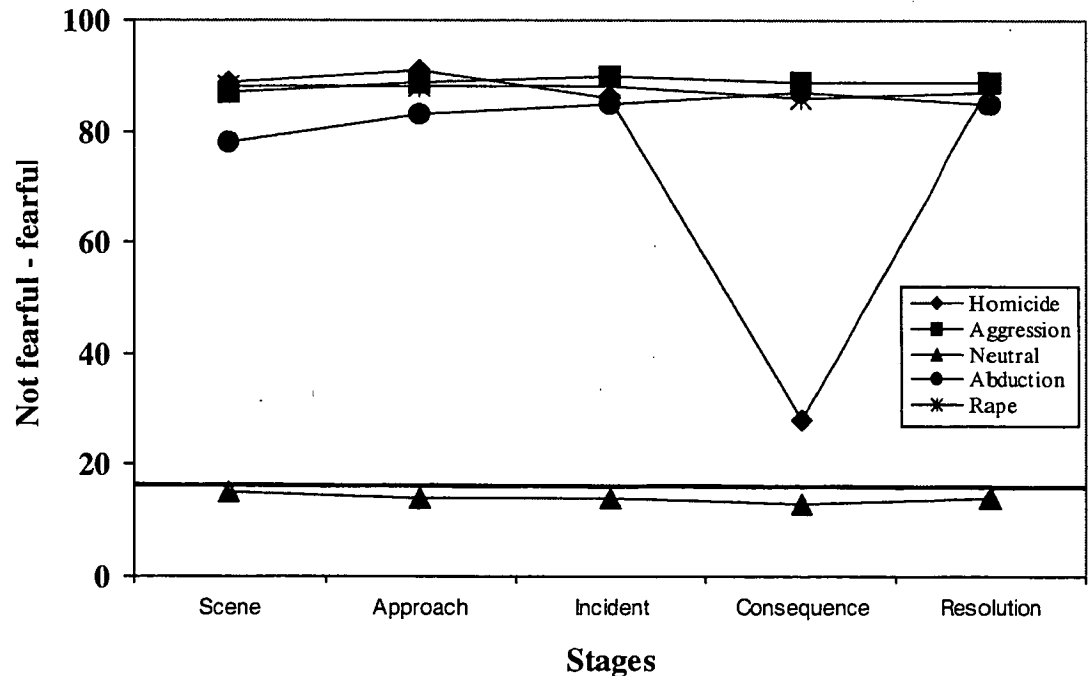


Figure 26.  
The ratings for the not fearful-fearful VAS for each stage of each script for Case Four (Derek).



Figure 27 presents the ratings for the VAS not agitated-agitated for each stage of each script. The pattern of response to all scripts and all script stages for the VAS measuring agitation was virtually identical to the not fearful-fearful VAS.

When comparisons were made between scripts it was evident that the abduction, rape/attempted homicide, and homicide scripts all elicited higher ratings of agitation than the neutral imagery at all stages.

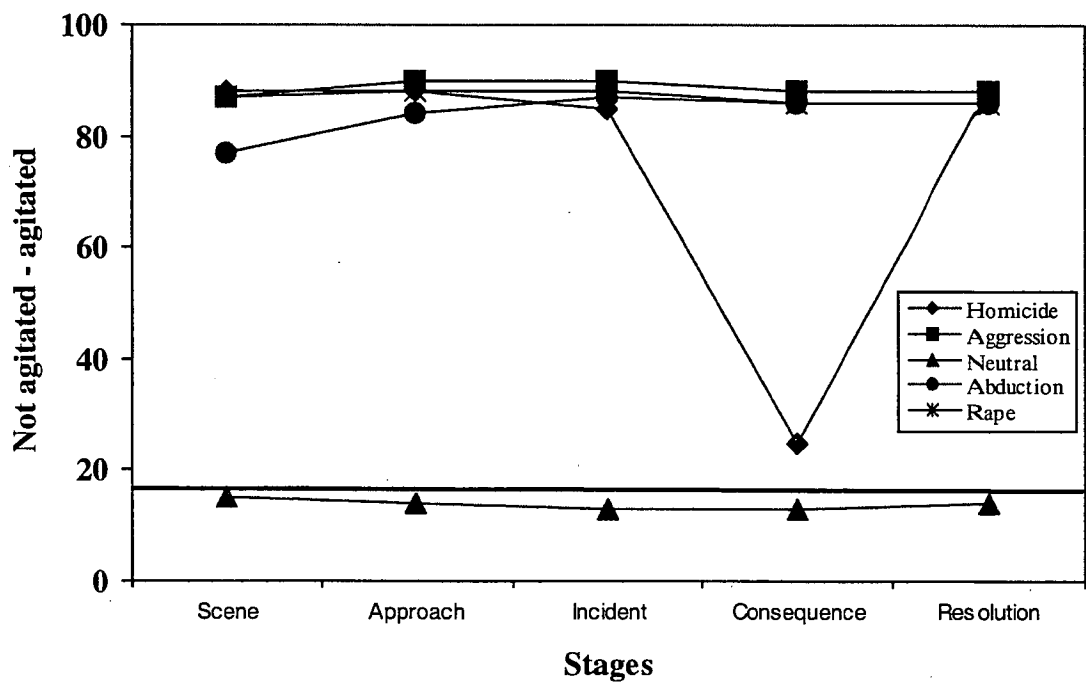


Figure 27.  
The ratings of not agitated-agitated VAS for each stage of each script for Case Four (Derek).

Figure 28 presents the ratings for the VAS not guilty-guilty for each stage of each script. The abduction, rape/attempted homicide, and homicide scripts all elicited very high levels of guilt with little variation across the script stages (range from 79 at the scene stage of the abduction script to 89). Low levels of guilt in the scene and approach stages of the aggression script (14 and 15 respectively) gave way to very high levels of guilt at

the incident stage (90) and this elevation was maintained for the remainder of the aggression script stages (89 and 90 for the final two stages). Neutral imagery did not elicit feelings of guilt (range from 13 to 15).

When comparisons were made between scripts it was evident that the abduction, rape/attempted homicide, homicide, and aggression scripts all elicited higher ratings of guilt than the neutral imagery at all stages except for the scene and approach stages of the aggression imagery.

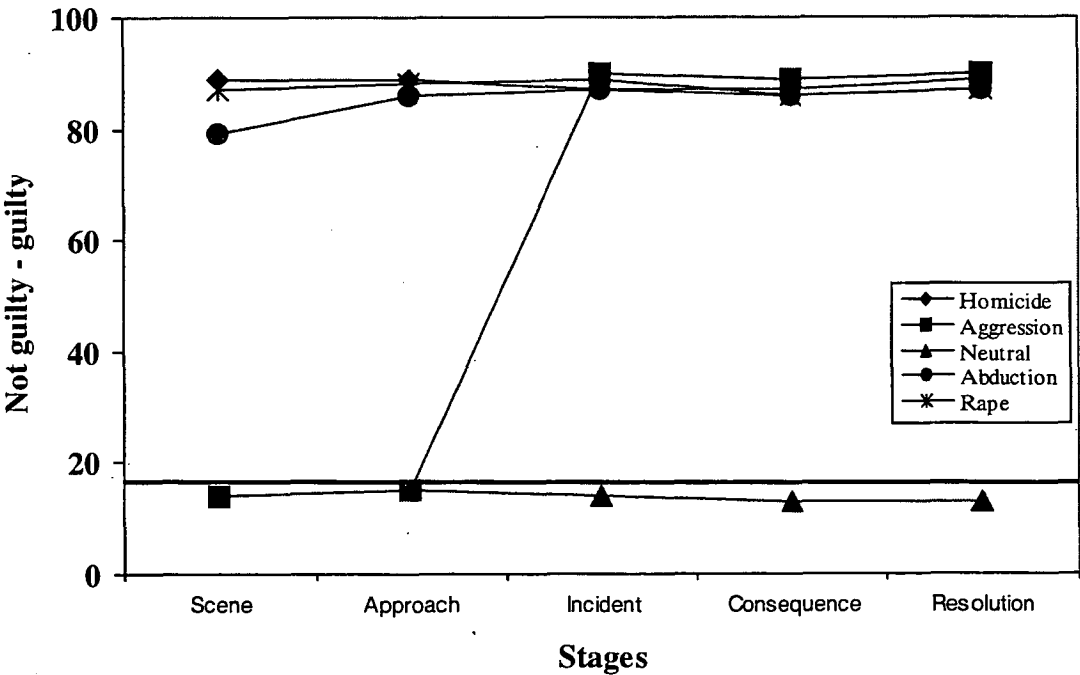


Figure 28.  
*The ratings of the not guilty-guilty VAS for each stage for each script for Case Four (Derek).*

## 7.4 Discussion

Assessment information would suggest that Derek had dysfunctional personality characteristics although was not psychopathic. In addition, there is evidence for the precursors of depressive symptoms prior to the incident in the form of ongoing life stressors such as difficulties with his marital relationship. The link between the experience of life stress and the development of depressive symptomatology is very well established (Garber, 2001; Kendler, Thornton & Gardner, 2001; Kendler, Thornton & Prescott, 2001; Maciejewski, Prigerson & Mazure, 2001; Mazure, Raghavan, Maciejewski, Jacobs & Bruce, 2001) although it is recognised that this relationship may be moderated by factors such as social support (Chou & Chi, 2001; Kalil, Born, Kunz & Caudill, 2001).

The problems experienced prior to the homicide and the resultant symptomatology may be significant contributors to the eventual perpetration of rape and homicide. For example, a comparison of men who raped and men who raped and killed indicated that the group who went on to kill following the rape were characterised by difficulties with interpersonal relationships and suffered from social and emotional isolation (Grubin, 1994). Derek was suspicious of others and has had turbulent interpersonal relationships. He also exaggerated his psychological distress which was evident from the ratings on the VASs, and on the psychological assessments as was apparent from his DES scores.

Derek had reported a history of significant physical abuse by his father. This is common in the family backgrounds of young male homicidal populations (Bailey, 1996), and is also evident in relation to adult homicidal behaviour (Lewis, Yeager, Swica,

Pincus & Lewis, 1997; McKenzie, 1995). Felson (2000) reported that the expression of anger does not necessarily result in a resolution of those feelings; the expression may act as a catalyst for an escalation of an aggressive response. When considering Derek's STAXI expression score, it is apparent that he often expresses his anger even when it is inappropriate. His frequent expressions of anger may have contributed to his aggressive acts at the time of the homicide. Felson also reported that striking out can also be a habitual 'bad reaction' in certain circumstances. If Derek actually expressed his anger at the level he reported then he may well have formed a bad habit of lashing out at the slightest provocation.

The various components of the homicide as presented in the abduction, rape/attempted homicide and homicide scripts resulted in different patterns of psychophysiological arousal either in terms of relative level of arousal or the pattern of arousal changes across the stages. The magnitude of these changes were clinically significant if a marker of clinical significance is taken as a change of 20% or more of the baseline heart rate (Blanchard & Young, 1973). It is interesting to note that the psychological responses to the script content were not always a reflection of the psychophysiological arousal. Under normal assessment conditions, self-report of psychological response is the only information obtained. It is apparent that this information in isolation does not provide sufficient clarification to understand the forces that led to the person engaging in these behaviours.

It would appear that the characteristics of this perpetrator fit with the description of one type of sexually-motivated murderer (Donegan, 2000; Keppel & Walter, 1999; Myers, Burgess, Burgess, & Douglas, 2000; Ressler, et al., 1988). Meloy (2000)

indicated that half of the sexually motivated homicides have perpetrators that leave disorganised crime scenes, typically have mood disorders, personality disorders and feel an excessive need for attachment. These persons are autonomically hyperractive and typically have a history of physical or sexual trauma. Derek fits this profile quite well in that he made no attempt to hide the body or protect himself from discovery except in the most minimal of ways, had underlying depressive symptomatology, had an avoidant coping style, and a need to feel accepted. In addition, his psychophysiology suggested he was autonomically hyperreactive, especially to stress cues and he had a history of abuse.

There is evidence that sexual killers tend to offend when their self-esteem is low. They plan their offence, usually asphyxiation or stabbing (Brittain, 1970). This pattern was evident in Derek. He had been having difficulties with his wife and her absence seemed to cause Derek distress. He had a strong desire to connect with someone and in a pathological way, abducted, raped and killed his victim to achieve this connection. In descriptions of the abduction he used the term “we” that seemed to denote a mutual agreement or stronger relationship than could possibly have been evident (e.g., “We went for a drive”). By strangling her with his belt he achieved even a physically connected death as opposed to shooting which would be a more distant way of committing the homicide. Langevin and colleagues (1988) found that 71% of sexual homicides were committed by strangulation or asphyxiation whereas only 8% of non-sexual homicides were committed by strangulation. Langevin suggested the person who commits the homicide want the closeness and the control that comes with this type of method. The brutality of this homicide was recognised by the court in the severity of the sentence.

## **Chapter 8**

### **Conclusions**

This preliminary investigation considered the value of examining peri-homicidal processes and the utility of a personalised, staged guided imagery methodology in undertaking this.

This study showed that differences exist in the peri-homicidal reactions of the perpetrators of four homicides, two expressive and two instrumental. In summarising the findings, it would be useful to make a comparison between the reactions of the two female perpetrators who had engaged in expressive acts. The response pattern in Case One was associated with an increase in arousal during a conflictual interaction and then a subsequent decrease in arousal after the homicidal act was committed. This was congruent with the perpetrator's statements that she was not aware that she had seriously harmed the victim and her level of dissociation. In Case Two, the second female perpetrator, the response pattern was associated with an increase in arousal with the escalation of a domestic conflict. There was a further increase in the final stage when the perpetrator became aware that the victim was about to die. This response pattern was also congruent with the statements made by the perpetrator that she had not intended to kill the victim and it was also consistent with her level of distress. Knowledge of these peri-homicidal reactions could have assisted in the defence of their actions or provided information on which to mitigate a plea.

In comparison, the two male homicides were perpetrated for instrumental reasons. Case Three was associated with sexual behaviour at the scene of the crime and the other, Case Four, was sexually motivated. Case Three highlighted a hyporeactive arousal pattern that is typically evident with psychopathy. There was virtually no increase or variability in arousal in response to the guided imagery of the homicide. In addition, there

was a lack of autonomic response to imagery of two prior homicide attempts. In contrast, Case Four resulted in a pattern of arousal to an abduction, rape and homicide that was different from the hyporeactive pattern. Nevertheless, although there was an increase in arousal to the homicidal imagery, it quickly dissipated as the immediate situation was resolved. The results of this study could be used to identify the risk of recidivism for individuals with these characteristics.

From these results, it is suggested that there are at least four distinct classifications of peri-homicidal reaction. Two of these fall within the expressive heading. The first could be labelled *expressive-resolution* where an increase in arousal is experienced in relation to an escalation of conflict followed by a decrease in arousal as the situation is resolved. The second could be labelled *expressive-escalation* where there is continued arousal after the perpetration of homicide and in reaction to the aftermath. Instrumental homicides have two further categories that could be identified. First is *instrumental-hyporeaction* where little change in arousal is apparent. This pattern follows what is typically described as psychopathic homicide. Second is *instrumental-hyperreaction* where initial increases in arousal are followed by a decrease in arousal after the action was complete, or the goal was met. The pre-homicide characteristics of the members of these individual groupings would need to be investigated to determine whether these categories formed a basis for a reliable typology of homicidal motives.

As noted, an earlier variant of the guided imagery methodology was employed in the successful defence in a case of filicide. It is proposed that the utility of the methodology as a general forensic procedure should be further tested within the judicial system.



## References

## References

- Adinkrah, M. (2001). When parents kill: An analysis of filicides in Fiji. *International Journal of Offender Therapy and Comparative Criminology*, 45, 144-158.
- Adler, H., & Lidberg, L. (1995). Characteristics of repeat killers in Sweden. *Criminal Behaviour and Mental Health*, 5, 9-13.
- American Law Institute, (1980). Model penal code. Philadelphia, PA: American Law Institute.
- Arena, J.G., & Hobbs, S.H. (1995). Reliability of psychophysiological responding as a function of trait anxiety. *Biofeedback and Self-Regulation*, 20, 19-37.
- Bailey, S. (1996). Adolescents who murder. *Journal of Adolescence*, 19, 19-39.
- Barbaree, H.E., Seto, M.E., Serin, R.C., Amos, N.L., Preston, D.L. (1994). Comparisons between sexual and nonsexual rapist subtypes: Sexual arousal to rape, offense precursors, and offense characteristics. *Criminal Justice and Behavior*, 21, 95-114.
- Barlow, D.H., & Hersen, M. (1984). Single case experimental designs strategies for studying behavior change (2nd edn). Sydney: Pergamon Press.
- Barratt, E.S., Stanford, M.S., Kent, T.A., & Felthous, A. (1997). Neuropsychological and cognitive psychophysiological substrates of impulsive aggression. *Society of Biological Psychiatry*, 41, 1045-1061.
- Belmore, M.F., & Quinsey, V.L. (1994). Correlates of psychopathy in a noninstitutional sample. *Journal of Interpersonal Violence*, 9, 339-349.
- Bernstein, E.M., & Putnam, F.W. (1986). Development, reliability, and validity of a dissociation scale. *Journal of Nervous and Mental Disease*, 174, 727-735.

Beyer, L., Weiss, T., Hansen, E., & Wolf, A., & Seidel, A. (1990). Dynamics of central nervous activation during motor imagination. *International Journal of Psychophysiology*, 9, 75-80.

Blair, R.J.R. (1999). Responsiveness to distress cues in the child with psychopathic tendencies. *Personality and Individual Differences*, 27, 135-145.

Blair, R.J.R., Jones, L., Clark, F., & Smith, M. (1997). The psychopathic individual: A lack of responsiveness to distress cues? *Psychophysiology*, 34, 192-198.

Blair, R.J.R., Sellars, C., Strickland, I., Clark, F., Williams, A.O., Smith, M., & Jones, L. (1995). Emotion attributions in the psychopath. *Personality and Individual Differences*, 19, 431-437.

Blanchard, E.B., Hickling, E.J., & Taylor, A.E. (1991). The psychophysiology of motor vehicle accident related posttraumatic stress disorder. *Biofeedback and Self-Regulation*, 16, 449-458.

Blanchard, E.B. & Young, L.D. (1973). Self-control of cardiac functioning: A promise as yet unfulfilled. *Psychological-Bulletin*, 79, 145-163.

Blount, W.R., Silverman, I.J., Seller, C.S., & Seese, R.A. (1994). Alcohol and drug use among abused women who kill, abused women who don't, and their abusers. *Journal of Drug Issues*, 24, 165-177.

Bradfield, R. (1998). Is near enough good enough? Why isn't self-defence appropriate for the battered woman? *Psychiatry, Psychology and Law*, 5, 57-85.

Brain, K.L., Haines, J., & Williams, C.L. (1998). The psychophysiology of self-mutilative behaviour: Evidence of tension reduction. *Archives of Suicide Research*, 4, 227-242.

Brittain, R. P. (1970). The sadistic murderer. *Medical Science and Law*, 10, 198-207.

Burns, J.W., Ferguson, M.L., Fernquist, S.K., & Katkin, E.S. (1992). Test-retest reliability of inotropic and chronotropic measures of cardiac reactivity. *International Journal of Psychophysiology*, 12, 165-168.

Campbell, C.S., & Robinson, J.W. (1997). Family and employment status associated with women's criminal behavior. *Psychological Reports*, 80, 307-314.

Campbell, L.M. (2000). Dissociative tendencies and violent behavior in a male forensic psychiatric population. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, 60(8-B), 4206.

Chou, K.L., & Chi, I. (2001). Stressful life events and depressive symptoms: Social support and sense of control as mediators or moderators? *International Journal of Aging and Human Development*, 52, 155-171.

Cloninger, C.R., Svrakic, D.M., & Svrakic, N.M. (1997). A multidimensional psychobiological model of violence. In A. Raine, P. A. Brennan, D. P. Farrington, & S. A. Mednick. (Eds). *Biosocial bases of violence*. (pp. 39-54) New York: Plenum Press.

Cohen, D., & Nisbett, R.E. (1994). Self-protection and the culture of honor: Explaining Southern violence. *Personality and Social Psychology Bulletin*, 20, 551-567.

Coid, J. (1984). How many psychiatric patients in prison? *British Journal of Psychiatry*, 145, 78-86.

Colder, C.R. (2001). Life stress, physiological and subjective indexes of negative emotionality, and coping reasons for drinking: Is there evidence for a self-medication model of alcohol use? *Psychology of Addictive Behaviors*, 15, 237-245.

Crimmins, S.M., Cleary, S.D., Brownstein, H.H., Spunt, B.J., & Warley, R.M. (2000). Trauma, drugs and violence among juvenile offenders. *Journal of Psychoactive Drugs*, 32, 45-54.

Danto, B.L. (1982). A psychiatric view of those who kill. In B.L. Danto, J. Bruhns and A.H. Kutscher (Eds.), *The human side of homicide*. New York: Columbia University Press.

Davis, D.R., & DiNitto, D.M. (1996). Gender differences in social and psychological problems of substance abusers: A comparison to nonsubstance abusers. *Journal of Psychoactive Drugs*, 28, 135-145.

Davis, M., Eshelman, E.R., & McKay, M. (1988). *The relaxation and stress reduction workbook*. Oakland, CA: New Harbinger.

Decker, S.H. (1996). Deviant homicide. A new look at the role of motive and victim-offender relationships. *Journal of Research in Crime and Delinquency*, 33, 427-499.

DeHart, D.D., & Mahoney, J.M. (1994). The serial murderer's motivations: An interdisciplinary review. *Omega: Journal of Death and Dying*, 29, 29-45.

Deiker, T.E. (1974). Characteristics of males indicted and convicted of homicide. *Journal of Social Psychology*, 93, 151-152.

Deschaumes-Molinaro, C., Dittmar, A., Vernet-Maury, E. (1991). Relationship between mental imagery and sporting performance. *Behavioural Brain Research*, 45, 29-36.

Dietz, P.E. (1987). Patterns in human violence. In R.E. Hales & A.J. Frances (Eds.), *Psychiatric Update: American Psychiatric Association Annual Review*. (pp. 465-490). Washington, DC: American Psychiatric Press.

Dixit, A.R., & Crum, R.M. (2000). Prospective study of depression and the risk of heavy alcohol use in women. *American Journal of Psychiatry*, 157, 751-758.

Donegan, E.K. (2000). Sexual homicide and potential sexual homicide offenders: An escalating pattern of criminal activity? *Dissertation Abstracts International: Section B: The Sciences and Engineering*, 60 (9-B), 4884.

D'Orban, P.T. (1990). Female homicide. *Irish Journal of Psychological Medicine*, 7, 64-70.

Douglas, J.E., Burgess, A.W., Burgess, A.G., & Ressler, R.K. (1992). Crime classification manual. New York: Lexington Books/Macmillan.

Edwards, J.R., & Baglioni, A.J. (1993). The measurement of coping with stress: Construct validity of the Ways of Coping Checklist and the Cybernetic Coping Scale. *Work and Stress*, 7, 17-31.

Egger, S.A. (1986). An analysis of the serial murder phenomenon and the law enforcement response. *Dissertation-Abstracts-International*. 47(3-A), 1069.

Elliott, F.A. (1988). Violence: A product of biosocial interactions. *Bulletin of the American Academy of Psychiatry and the Law*, 16, 131-143.

Federal Bureau of Investigation (1999). *Crime in the United States*. Washington, D.C.: U.S. Department of Justice.

Felson, R.B. (2000). A social psychological approach to interpersonal aggression.

In V. B. Van Hasselt, and M. Hersen (Eds.), *Aggression and violence: An introductory text*. (pp. 9-22). Needham Heights, MA: Allyn & Bacon, Inc.

Fendrich, M., Mackesy-Amiti, M.E., Goldstein, P., & Spunt, B. (1995). Substance involvement among juvenile murderers: Comparisons with older offenders based on interviews with prison inmates. *International Journal of the Addictions*, 30, 1363-1382.

Fergusson, D.M., Horwood, L.J., Kershaw, K.L., & Shannon, F.T. (1986). Factors associated with reports of wife assault in New Zealand. *Journal of Marriage and the Family*, 48, 407-412

Fitzpatrick, J.P. (1974). Drugs, alcohol, and violent crime. *Addictive Diseases: An International Journal*, 1, 353-367.

Floyd, M. (2000). MMPI-2 and PCL-R characteristics of female prison inmates. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, 60(12-B), 6360.

Folkman, S. & Lazarus, R.S. (1988). Ways of coping questionnaire. Palo Alto, CA: Consulting Psychologists Press.

Forth, A.E. (1995). Psychopathy in adolescent offenders: Assessment, family background, and violence. *Issues in Criminological and Legal Psychology*, 24, 42-44.

Fowles, D.C. (2000). Electrodermal hyporeactivity and antisocial behavior: Does anxiety mediate the relationship? *Journal of Affective Disorders*, 61, 177-189.

Frasquilho, F., & Oakley, D. (1997). Hypnotizability, dissociation and three factors of eating behavior. *Contemporary Hypnosis*, 14, 105-111.

Frye, V. & Wilt, S. (2001). Femicide and social disorganization. *Violence Against Women*, 7, 335-351.

Fulton, A.S., Gorsuch, R.L., & Maynard, E.A. (1999). Religious orientation, antihomosexual sentiment, and fundamentalism among Christians. *Journal for the Scientific Study of Religion*, 38, 14-35.

Garber, J. (2001). Predictors of depressive cognitions in young adolescents. *Cognitive Therapy and Research*, 25, 353-376.

Geberth, V.J., & Turco, R.N. (1997). Antisocial personality disorder, sexual sadism, malignant narcissism, and serial murder. *Journal of Forensic Sciences*, 42, 49-60.

Glading, J., Williams, C.L., & Haines, J. The psychophysiology of acts of murder. *Paper presented at the 1<sup>st</sup> Forensic Psychology Conference, Sydney, Australia, February, 2001.*

Glading, J., Williams, C.L., Haines, J., & Sale, I. Motives for female homicide: A comparison of situational conflict and chronic abuse. *Paper presented at the 21<sup>st</sup> Annual Congress of the Australian and New Zealand Association of Psychiatry, Psychology and Law, Melbourne, Australia, November, 2001.*

Godwin, G.M. (2000). *Hunting serial predators: A multivariate classification approach to profiling violent behavior*. Boca Raton, FL: CRC Press.

Golden, C.J., Paterson-Rhone, A., Jackson, M.L., & Gontkovsky, S.T. (2000). Neuropsychological factors in violence and aggression. In V.B. Van Hasselt & M. Hersen (Eds.), *Aggression and violence, an introductory text*, (pp. 40-53). Sydney: Allyn and Bacon.

Gottfriedson, M.R., & Hirschi, T. (1990). *A General Theory of Crime*. Stanford: Stanford University Press.



Grant, B., & Curry, G.D. (1993). Women murderers and victims of abuse in a southern state. *American Journal of Criminal Justice*, 17, 73-83.

Grant, C.A. (1995). Women who kill: The impact of abuse. *Issues in Mental Health Nursing*, 16, 315-326.

Grubin, D. (1994). Sexual murder. *British Journal of Psychiatry*, 165, 624-629.

Haines, J., Josephs, S., Williams, C.L., & Wells, J.H. (1998). The psychophysiology of obsessive-compulsive disorder. *Behaviour Change*, 15, 244-254.

Haines, J., Williams, C.L., Brain, K.L., & Wilson, G.V. (1995). The psychophysiology of self-mutilation. *Journal of Abnormal Psychology*, 104, 471-489.

Haines, J., Williams, C.L., Glading, J., & Sale, I.M. Fearful problem solving: The influence of cult activity on subsequent homicidal behaviour. *Paper presented at the 21<sup>st</sup> Annual Congress of the Australian and New Zealand Association of Psychiatry, Psychology and Law, Melbourne, Australia, November, 2001.*

Haines, J., Williams, C.L., Sale, I.M., Glading, J., & Davidson, J.A. (2001). The death of a leader: Homicide as a means of group disengagement. (*submitted*).

Hale, R.. (1993). The application of learning theory to serial murder: or "You too can learn to be a serial killer". *American Journal of Criminal Justice*, 17, 37-45.

Hamilton, G., & Sutterfield, T. (1997). Comparison study of women who have and have not murdered their abusive partners. *Women and Therapy*, 20, 45-55.

Hare, R.D. (1996). Psychopathy: A clinical construct whose time has come. *Criminal Justice and Behaviour*, 23, 25-54.

Hart, S.D. (1995). Psychopathy and risk assessment. *Issues in Criminology and Legal Psychology*, 24, 63-67.

Hart, S.D., Cox, D.N., & Hare, R.D. (1995). *The Hare Psychopathy Checklist: Screening Version (PCL:SV)*. New York: Multi-Health Systems.

Hemphill, J.F., & Hare, R.D. (1995). Psychopathy checklist factor scores and recidivism. *Issues in Criminological and Legal Psychology*, 24, 68-73.

Hirota, A., & Hirai, H. (1986). Effects of stimulus or response-orientated training on psychophysiological responses and the propositional structure of imagery. *Japanese Psychological Research*, 28, 186-195.

Hoffman, L.G., Hevesi, A.G., Lynch, P.E., Gomes, P.J., Chodorow, N.J., Roughton, R.E., Frank, B., & Vaughn, S. (2000). Homophobia: Analysis of a "permissible" prejudice: A public forum of the American Psychoanalytic Association and the American Psychoanalytic Foundation. *Journal of Gay and Lesbian Psychotherapy*, 4, 5-53.

Holahan, C.J., Moos, R.H., Holahan, C.K., Cronkite, R.C., & Randall, P.K. (2001). Drinking to cope, emotional distress and alcohol use and abuse: A ten-year model. *Journal of Studies on Alcohol*, 62, 190-198.

Holcomb, W.R. (2000). Matricide: Primal aggression in search of self-affirmation. *Psychiatry: Interpersonal and Biological Processes*, 63, 264-287.

Holland, L.J., Bouffard, M., & Wagner, D. (1992). Rating of perceived exertion, heart rate, and oxygen consumption in adults with multiple sclerosis. *Adapted Physical Activity Quarterly*, 9, 64-73.

Holmes, G.E., Williams, C.L., & Haines, J. Psychophysiological responses to posttraumatic imagery following road trauma: A comparison of Posttraumatic Stress

Disorder and Acute Stress Disorder. *Paper presented at the 9<sup>th</sup> World Congress of the International Organization of Psychophysiology, Taormina, Sicily, Italy, 1998.*

Holtgraves, T., & Stockdale, G. (1997). The assessment of dissociative experiences in a non-clinical population: Reliability, validity, and factor structure of the Dissociative Experiences Scale. *Personality and Individual Differences*, 22, 699-706.

Holzman, A.D., & Levis, D.J. (1989). The effects of increasing the number of stimulus modalities included in a fear-eliciting imagery scene on reported imagery clarity, scene repetition, and sympathetic (fear) arousal. *Cognitive Therapy and Research*, 13, 389-405.

Hubble, G. (1999). Self-defence and domestic violence: A reply to Bradfield. *Psychiatry, Psychology and Law*, 6, 51-56.

Jarosova, I. (1999). Personality profile and the reactivity of the autonomic nervous system. *Homeostasis*, 39, 257-259.

Johnson, B.R., & Becker, J.V. (1997). Natural born killers?: The development of the sexually sadistic serial killer. *Journal of the American Academy of Psychiatry and the Law*, 25, 335-348.

Johnson, I.M. (1996). Female murderers in a Southern city, 1975-1992. *American Journal of Criminal Justice*, 20, 207-204.

Kalil, A., Born, C.E., Kunz, J., & Caudill, P.J. (2001). Life stressors, social support, and depressive symptoms among first-time welfare recipients. *American Journal of Community Psychology*, 29, 355-369.

Kendler, K.S., Thornton, L.M., & Gardner, C.O. (2001). Genetic risk, number of previous depressive episodes, and stressful life events in predicting onset of major depression. *American Journal of Psychiatry*, 158, 582-586.

Kendler, K.S., Thornton, L.M., & Prescott, C.A. (2001). Gender differences in the rates of exposure to stressful life events and sensitivity to their depressogenic effects. *American Journal of Psychiatry*, 158, 587-593.

Kepple, R. D. & Walter, R. (1999). Profiling killers: a revised classification model for understanding sexual murder. *International Journal of Offender Therapy and Comparative Criminology*, 43, 417-437.

Knapp, S., & VandeCreek, L. (2000). Recovered memories of childhood abuse: Is there an underlying professional consensus? *Professional Psychology: Research and Practice*, 31, 365-371.

Kopelman, M.D., Christensen, H., Puffett, A., & Stanhope, N. (1994). The great escape: A neuropsychological study of psychogenic amnesia. *Neuropsychologia*, 32, 675-691.

Kroner, D.G., & Forth, A.E. (1995). Affective processing in psychopaths: A salient-content perspective. *Issues in Criminological and Legal Psychology*, 24, 90-93.

Krug, S.E., & Cattell, R.B. (1980). *Clinical Analysis Questionnaire Manual*. Champaign, Ill: IPAT.

Kuley, N.B., & Jacobs, D.F. (1988). The relationship between dissociative-like experiences and sensation seeking among social and problem gamblers. *Journal of Gambling Behavior*, 4, 197-207.

Lang, P.J. (1979). A bio-informational theory of emotional imagery. *Psychophysiology*, 16, 495-511.

Lang, P.J., Kozak, M.J., Miller, G.A., Levin, D.N., & McLean, A. (1980). Emotional imagery: Conceptual structure and pattern of somato-visceral response. *Psychophysiology*, 17, 179-192.

Lange, R. (1999). A cusp catastrophe approach to the prediction of temporal patterns in the kill dates of individual serial murderers. *Nonlinear Dynamics, Psychology, and Life Sciences*, 3, 143-159.

Langevin, R., Ben-Aron, M.H., Wright, P. & Marchese, V. (1988). The sex killer. *Annals of Sex Research*, 1, 263-301.

Langevin, R. (1991). Biological and psychological factors in human aggression. In M. Haug, & P.F. Brain, (Eds.), *Heterotypical behaviour in man and animals*. (pp. 195-214). London: Chapman & Hall.

Leenaars, A.A., & Lester, D. (1994). Domestic and economic correlates of personal violence in Canada and the United States. *Giornale Italiano di Suicidologia*, 4, 7-12.

Leonard, E.D. (2001). Convicted survivors: Comparing and describing California's battered women inmates. *Prison Journal*, 81, 73-86.

Lester, D. (1992). Alcohol consumption and rates of personal violence in Australia. *Drug and Alcohol Dependence*, 31, 15-17.

Lewis, D.O., Lovley, R., Yeager, C.A, Ferguson, G., Friedman, M., Sloane, G., Friedman, H., & Pincus, J. H. (1988). Intrinsic and environmental characteristics of

juvenile murderers. *Journal of the American Academy of Child Adolescence Psychiatry*, 27, 528-587.

Lewis, D.O., Yeager, C.A, Swica, Y., Pincus, J.H., & Lewis, M. (1997). Objective documentation of child abuse and dissociation in 12 murderers with dissociative identity disorder. *American Journal of Psychiatry*, 54, 1703-1710.

Leyton, E. (1986). *Hunting Humans*. Toronto: McClelland and Stewart.

Lowenstein, L.F. (1992). The psychology of the obsessed compulsive killer. *Criminologist*, 16, 26-38.

Maciejewski, P.K., Prigerson, H.G., & Mazure, C.M. (2001). Sex differences in event-related risk for major depression. *Psychological Medicine*, 31, 593-604.

Maeve, M.K. (1997). Nursing practice with incarcerated women: Caring within mandated ( sic ) alienation. *Issues in Mental Health Nursing*, 18, 495-510.

Mazure, C.M., Raghavan, C., Maciejewski, P.K., Jacobs, S.C., & Bruce, M.L. (2001). Cognitive personality characteristics as direct predictors of unipolar major depression. *Cognitive Therapy and Research*, 25, 215-225.

McCormack, H.M., Horne, D.J.deL., & Sheather, S. (1988). Clinical applications of visual analogue scales: A critical review. *Psychological Medicine*, 18, 1007-1019.

McCormick, R. & Smith, M. (1995). Aggression and hostility in substance abusers: The relationship to abuse patterns, coping style, and relapse triggers. *Addictive Behaviors*, 20, 555-562.

McKenzie, C. (1995). A study of serial murder. *International Journal of Offender Therapy and Comparative Criminology*, 39, 3-10.

McLennan, W., (2000). *Year Book Australia #82*. Canberra: Australian Bureau of Statistics.

Meloy, J.R. (2000). The nature and dynamics of sexual homicide: An integrative review. *Aggression and Violent Behavior*, 5, 1-22.

Miller, G.A., Levin, D.N., Kozak, M.J., Cook, III, E.W., McLean, Jr, A., & Lang, P.J. (1987). Individual differences in imagery and the psychophysiology of emotion. *Cognition and Emotion*, 1, 367-390.

Miller, N.S., & Sheppard, L.M. (2000). Addiction treatment and continuing care in forensic populations. *Psychiatric Annals*, 30, 589-596.

Milligan, R.J., & Waller, G. (2001). *Anger and impulsivity in non-clinical women. Personality-and-Individual-Differences*. 30, 1073-1078.

Mitchell, B. (1997). Diminished responsibility manslaughter. *Journal of Forensic Psychiatry*, 8, 101-117.

Money, J. (1990). Forensic sexology: Paraphilic serial rape and lust murder. *American Journal of Psychotherapy*, 64, 26-37.

Montanez, J. (2000). A descriptive study of variables related to homicide by schizophrenics. (mood disorders). *Dissertation Abstracts International: Section B: The Sciences and Engineering*, 60(7-B), 3554.

Munnich, I. (1993). Personality of the murderer. *Anailse Psicologica*, 1, 129-134.

Muzinic-Masle, L., & Goreta, M. (2000). Alcohol as a criminogenic factors in criminal acts of homicide and attempted homicide. *Socijalna Psihijatrija*, 28, 29-33.

Myers, W.C., & Blashfield, R. (1997). Psychopathology and personality in juvenile sexual homicide offenders. *Journal of the American Academy of Psychiatry and the Law*, 25, 497-508.

Myers, W.C., Burgess, A.W., Burgess, A.G. & Douglas, J.E. (2000). Serial murder and sexual homicide. In V. B. Van Hasselt and M. Hersen (Eds.) *Aggression and violence: An introductory text*. (pp. 237-258). Needham Heights, MA: Allyn & Bacon.

Nuller, Y.L. (1982). Depersonalisation: Symptoms, meaning, therapy. *Acta Psychiatrica Scandinavica*, 66, 451-458.

O'Keefe, M. (1997). Incarcerated battered women: A comparison of battered women who killed their abusers and those incarcerated for other offenses. *Journal of Family Violence*, 12, 1-19.

Orr, S.P., Lasko, N.B., Metzger, L.J., Berry, N.J., Ahern, C.E., & Pitman, R.K. (1998). Psychophysiologic assessment of women with posttraumatic stress disorder resulting from childhood sexual abuse. *Journal of Consulting and Clinical Psychology*, 66, 906-913.

Orr, S.P. & Pitman, R.K. (1993). Psychophysiological assessment of attempts to simulate posttraumatic stress disorder. *Biological Psychiatry*, 33, 127-129.

Pham, T.H., Philippot, P., & Rime, B. (2000). Subjective and autonomic responses to emotion induction in psychopaths. *Encephale*, 26, 45-51.

Pincus, J.H. (2001). *Base instincts: What makes killers kill?* New York: W.W. Norton.



Pitman, R.K., Orr, S.P., Forgue, D.F., de Jong, J.B. & Claiborn, J.M. (1987). Psychophysiological assessment of posttraumatic stress disorder imagery in Vietnam combat veterans. *Archives of General Psychiatry*, 44, 970-975.

Pitman, R.K., & Orr, S.P. (1993). Psychophysiological testing for post-traumatic stress disorder: Forensic psychiatric application. *Bulletin for the American Academy of Psychiatry and the Law*, 21, 37-52.

Pitt, S.E., & Bale, E.M. (1995). Neonaticide, infanticide, and filicide: A review of the literature. *Bulletin of the American Academy of Psychiatry and the Law*, 23, 375-386.

Pollock, P.H. (1999). When the killer suffers: Post-traumatic stress reactions following homicide. *Legal and Criminological Psychology*, 4, 185-202.

Quinsey, V.L. (1995). The prediction and explanation of criminal violence. *International Journal of Law and Psychiatry*, 18, 117-127.

Raine, A., Buchsbaum, M., & LaCasse, L. (1997). Brain abnormalities in murderers indicated by positron emission tomography. *Society of Biological Psychiatry*, 42, 495-508.

Regehr, C., & Glancy, G. (1995). Battered woman syndrome defense in Canadian courts. *Canadian Journal of Psychiatry*, 40, 130-135.

Ressler, R.K., Burgess, A.W., & Douglas, J.E. (1988). *Sexual homicide: Patterns and motives*. Lexington, MA: Lexington Books/D. C. Heath and Company.

Riordan, J.A.(1993). *The Laws of Australia*. Sydney : Law Book Company.

Roberts, A.R. (1996). Battered women who kill. A comparative study of incarcerated participant with a community sample of battered women. *Journal of Family Violence*, 11, 291-304.

Rodriquez, S.F., & Henderson, V.A. (1995). Intimate homicide: Victim-offender relationship in female-perpetrated homicide. *Deviant Behavior*, 16, 45-57.

Sahu, K. & Misra, N. (1995). Life stress and burnout in female college teachers. *Journal of the Indian Academy of Applied Psychology*, 2, 109-113.

Salloum, I.M., Daley, D.C., Cornelius, J.R., & Kirisci, L. (1996). Disproportionate lethality in psychiatric patients with concurrent alcohol and cocaine abuse. *American Journal of Psychiatry*, 153, 953-955.

Sayette, M.A. (1999). Does drinking reduce stress? *Alcohol Research and Health*, 23, 250-255.

Scarpa, A., & Raine, A. (2000). Violence associated with anger and impulsivity. In J.C. Borod (Ed.), *The neuropsychology of emotion. Series in affective science*. (pp. 320-339). New York: Oxford University Press.

Schefflin, A.W., Spiegel, H., & Spiegel, D. (1999). Forensic uses of hypnosis. In A.K. Hess, & I.B. Weiner (Eds.), *The handbook for forensic psychology (2nd edn)*. (pp. 474- 498). New York: John Wiley.

Schurman-Kauflin, D.S. (2000). Profiles of the female multiple murderer. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, 60(11-B), 5759.

Serin, R.C., & Amos, N.L. (1995). The role of psychopathy in the assessment of dangerousness. *International Journal of Law and Psychiatry*, 18, 231-238.

Shalev, A.Y., Orr, S.P. & Pitman, R.K. (1993). Psychophysiological assessment of traumatic imagery in Israeli civilian patients with posttraumatic stress disorder. *American Journal of Psychiatry*, 150, 620-624.

Sharma, V.K. (1995). Alcohol consumption vis a vis medicolegal case. *International Medical Journal*, 2, 127-130.

Spiegel, D., & Schefflin, A.W. (1994). Dissociated or fabricated? Psychiatric aspects of repressed memory in criminal and civil cases. *International Journal of Clinical and Experimental Hypnosis*, 42, 411-432.

Spielberger, C.D. (1996). *State-Trait Anger Expression Inventory: STAXI professional manual*. Odessa, FL: Psychological Assessment Resources.

Spunt, B., Brownstein, H., Goldstein, P., & Fendrich, M. (1995). Drug use by homicide offenders. *Journal of Psychoactive Drugs*, 27, 125-134.

Stebbins, P., & Pakenham, K.I. (2001). Irrational schematic beliefs and psychological distress in caregivers of people with traumatic brain injury. *Rehabilitation Psychology*, 46, 178-194.

Stevens, D.J. (1999). Interviews with women convicted of murder: Battered women syndrome revisited. *International Review of Victimology*, 6, 117-135.

Stroud, J., & Pritchard, C. (2001). Child homicide, psychiatric disorder and dangerousness: A review and an empirical approach. *British Journal of Social Work*, 31, 249-269.

Tabachnick, B.G., & Fidell, L.S. (1989). *Using multivariate statistics*. New York: Harper Collins.

Taylor, T.S. (2000). God good for you, good for your neighbour? The influence of religious orientation on demoralisation and attitudes towards lesbians. *Dissertation Abstracts International Section A: Humanities and Social Sciences*, 60, (12-A), 4472.

Teles, C.B.S. (1995). Psychopathy and antisocial personality disorder: Violent crime and sexual homicide. *Issues in Criminology and Legal Psychology*, 24, 142.

Van Hasselt, V.B. & Hersen, M.. (2000). *Aggression and violence: An introductory text*. Needham Heights, MA: Allyn and Bacon.

van Ijzendoorn, M.H., & Schuengel, C. (1996). The measurement of dissociation in normal and clinical populations: Meta-analytic validation of the Dissociative Experiences Scale (DES). *Clinical Psychology Review*, 16, 365-382.

Vargas, J.H. (1996). Predictors and consequences of drug abuse in adulthood: Associations with psychological distress, intimacy, work adjustment and criminal behavior. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, 57(4-B), 2953.

Walcott, D.M. (2000). Repressed memory still lacks scientific reliability. *Journal of the American Academy of Psychiatry and the Law*, 28, 243-244.

Wetter, M.W., & Deitsch, S. E. (1996). Faking specific disorders and temporal response consistency on the MMPI-2. *Psychological Assessment*, 8, 39-47.

Wells, J.H., Haines, J., Williams, C.L., & Brain, K.L. (1999). The self-mutilative nature of severe onychophagia: A comparison with self-cutting. *Canadian Journal of Psychiatry*, 44, 40-47.

Wille, W. (1974). *Citizens who commit murder*. St Louis: Warren Green.

Williams, C.L., & Haines, J. Psychophysiological characteristics of punitive interactions in a case of filicide. *Paper presented at the 1<sup>st</sup> Australian Forensic Psychology Conference, Sydney, Australia, 2001.*

Williams, C.L., Haines, J., & Casey, S.L. Filicide and the insanity plea: The use of guided imagery. *Paper presented at the 10th European Conference of Psychology and the Law, April, Limassol, Cyprus, 2000.*

Williams, C.L., Haines, J., Sale, I., & Doherty, M.R. (1999). The psychophysiology of dissociative identity disorder. *Paper presented at the 34th Australian Psychological Society Annual Conference, Hobart, Australia, 1999.*

Williams, C.L., Haines, J., Glading, J., Sale, I.M., & Davidson, J.A. (2001a). Female perpetrated expressive homicide: Situational conflict and chronic abuse. *(submitted)*

Williams, C.L., Haines, J., Glading, J.A., Sale, I.M., & Davidson, J.A. (2001b). Psychophysiological and psychological responses to homicidal behaviour: Comparison of psychopathic and sexually motivated homicide. *(submitted)*

Williams, C.L., Haines, J., Sale, I., & Glading, J. Personality disorder and homicide: A comparison of psychopathic homicide and sexually-motivated homicide. *Paper presented at the 21<sup>st</sup> Annual Congress of the Australian and New Zealand Association of Psychiatry, Psychology and Law, Melbourne, Australia, November, 2001.*

Wilson, W. (1991). *Good murders and bad murders: A consumer's guide in the age of information.* London: University Press of America.

Woodward, A.J., Carless, S.A., & Findlay, B.M. (2001). A psychometric evaluation of the Irrational Beliefs Inventory in a marital context. *Australian Psychologist, 36*, 255-261.

Woodward, M., Nursten, J., Williams, P., & Badger, D. (2000). Mental disorder and homicide: A review of epidemiological research. *Epidemiologia e Psichiatria Sociale*, 9, 171-189.

Yarvis, R.M. (1991). *Homicide: Causative factors and roots*. Lexington, Mass: Lexington Books.

Yarvis, R.M. (1994). Patterns of substance abuse and intoxication among murderers. *Bulletin of the American Academy of Psychiatry and the Law*, 20, 133-144.

## **Appendix A**

## STATEMENT OF INFORMED CONSENT

I have read and understood the 'Information Sheet' for this study. The nature and possible effects of the study have been explained to me.

I understand that the study involves:

- Discussing the circumstances surrounding the act of homicide and my feelings at the time;
- Discussing the circumstances surrounding an angry or aggressive experience with another person that did not end in fatal violence;
- Discussing an emotionally neutral event of my choosing;
- Completing published questionnaires that measure personality, the expression of anger, and the way I cope with problem situations;
- Attending a recording session and having electrodes and measurement instruments fitted so that recordings of my heart rate, respiration, skin conductance level and muscle tension can be taken while I am being asked to image aspects of the homicide, the angry interaction, and the emotionally neutral event;
- Rating my psychological responses to each of these events.

I understand that all research data will be treated as confidential. Any questions that I have asked have been answered to my satisfaction. I agree to participate in this study and understand that I may withdraw at any time without prejudice. I agree that research data gathered for the study may be published. I am aware that my name will be changed and the exact circumstances of my experiences will be altered in any published material to protect my identity unless I give written permission for identifying information to be used.

Name of participant: .....

Signature of participant: .....

Date: .....

I have explained this project and the implications for participation in it to this volunteer and I believe that the consent is informed and that s/he understands the implications of participation.

Name of investigator: .....

Signature of investigator: .....

Date: .....



## STATEMENT OF INFORMED CONSENT

I agree to allow information about myself and my actions to be contained in published material. I am fully aware that this information may be read by others and may lead to my identification. I voluntarily give this consent.

Name of participant: .....

Signature of participant: ..... Date: .....

I have explained to this participant that information in published form may lead to his/her identification. I believe that the consent s/he has given is informed and that s/he understands the implications of publication of this material.

Name of investigator: .....

Signature of investigator: ..... Date: .....



UNIVERSITY OF TASMANIA  
School of Psychology

### **The psychophysiology and psychology of acts of homicide.**

The above project is being conducted by Dr Christopher Williams, Dr Janet Haines, and Ms Jodi Glading of the School of Psychology at the University of Tasmania and Dr Ian Sale of the Discipline of Psychiatry at the University of Tasmania. The purpose of the study is to examine the psychophysiological and psychological responses to acts of homicide to learn the factors that contribute to people engaging in this behaviour. This project is being undertaken to clarify the motives for homicide and to explore the potential of developing the particular methodology used in this research as an instrument for assessment in psycholegal settings.

We are interested in comparing the reactions of people to the act of homicide with reactions to aggressive, nonfatal interpersonal events, and emotionally neutral events such as making a cup of coffee.

If you agree to participate, the nature of the homicidal act in which you were involved will be discussed with you. You then will be interviewed about the homicidal act, a aggressive interpersonal act that did not result in death, and an emotionally neutral event. This interview will be recorded on audio cassette to aid in the construction of imagery scripts. The information from the interview will be used to devise imagery scripts that will be used to guide you through the memory of the episodes. In a subsequent session, you will be required to have electrodes and measurement instruments applied so that measures of heart rate and other cardiac responses, respiration, skin conductance level and muscle tension can be taken. These measurements will be taken while you are guided through imagery of the homicide, the aggressive interaction, and an emotionally neutral event of your choosing. You will be asked to rate your psychological response to the content of the imagery scripts.

We wish to emphasise that the information you share with us will be treated in a confidential manner. All written information, computer data files and audio cassettes will be stored with a participation number rather than your name. The data will be secured in a locked cabinet and will not be made available to any third party.

Participation in this study is completely voluntary. If you agree to participate in the study but then change your mind and wish to withdraw, you may do so at any time without prejudice.

If you wish to discuss the project before, during or after participation, please inform Ms Georgina O'Donnell, Psychologist, at the prison hospital who will contact either Dr Christopher Williams, Dr Janet Haines, or Dr Ian Sale and make arrangement for one of these people to visit you at the prison. This project has been approved by the University Ethics Committee (Human Experimentation). If you have any concerns or complaints regarding the ethical nature of the project, you may discuss your concerns with the Chair (Dr Janet Vial) or Executive Officer (Ms Chris Hooper) of the University Ethics Committee (Human Experimentation). This will be arranged for you by Ms Georgina O'Donnell.

We would be happy to discuss your individual results with you. If you decide to withdraw from the project, we would welcome the opportunity to discuss with you any concerns you have about the project and your participation in it.

Please keep this information sheet and, if necessary, refer to the information it contains. In addition, if you agree to participate, you will be asked to sign a statement of informed consent. A copy of this statement will be supplied to you.

Thank you.

## **Appendix B**

Table 21.  
*Ratings for Not close to real life – close to real life and Images not clear – images clear VASs for each stage of each script for Case One (Amanda).*

		Not close to real life/ Close to real life	Images not clear/ images clear
Homicide			
	Scene	7	89
	Approach	6	89
	Incident	2	31
	Consequence	49	88
	Resolution	28	17
Aggression			
	Scene	95	93
	Approach	94	93
	Incident	96	95
	Consequence	96	96
	Resolution	97	96
Neutral			
	Scene	98	97
	Approach	97	98
	Incident	97	98
	Consequence	98	98
	Resolution	98	97

Table 22.  
*Ratings for Not close to real life – close to real life and Images not clear – images clear VASs for each stage of each script for Case Two (Alice).*

		Not close to real life/ Close to real life	Images not clear/ images clear
Homicide			
	Scene	87	93
	Approach	92	94
	Incident	98	99
	Consequence	97	99
	Resolution	98	99
Aggression			
	Scene	67	86
	Approach	75	85
	Incident	88	90
	Consequence	92	96
	Resolution	92	94
Neutral			
	Scene	99	99
	Approach	97	99
	Incident	99	99
	Consequence	99	99
	Resolution	98	98

Table 23.

*Ratings for Not close to real life – close to real life and Images not clear – images clear VASs for each stage of each script for Case Three (Toby)*

		Not close to real life/ Close to real life	Images not clear/ images clear
Homicide			
	Scene	72	82
	Approach	63	82
	Incident	59	78
	Consequence	82	82
	Resolution	77	78
Aggression			
	Scene	58	75
	Approach	62	80
	Incident	64	64
	Consequence	57	55
	Resolution	81	81
Neutral			
	Scene	48	74
	Approach	57	58
	Incident	57	71
	Consequence	66	67
	Resolution	64	80
Assault 1			
	Scene	70	54
	Approach	80	80
	Incident	77	76
	Consequence	81	79
	Resolution	75	83
Assault 2			
	Scene	75	75
	Approach	57	69
	Incident	73	74
	Consequence	83	83
	Resolution	78	79

Table 24.

*Ratings for Not close to real life – close to real life and Images not clear – images clear VAS for each stage of each script for Case Four (Derek).*

	Not close to real life/ Close to real life	Images not clear/ images clear
Homicide		
Scene	82	84
Approach	82	82
Incident	83	83
Consequence	81	81
Resolution	82	81
Aggression		
Scene	83	83
Approach	83	83
Incident	84	83
Consequence	89	83
Resolution	84	85
Neutral		
Scene	83	82
Approach	83	84
Incident	85	85
Consequence	83	84
Resolution	83	84
Abduction		
Scene	71	34
Approach	75	30
Incident	80	80
Consequence	79	27
Resolution	80	33
Rape		
Scene	81	77
Approach	80	81
Incident	82	83
Consequence	81	81
Resolution	82	84