The Psychological Characteristics of Sexual Murderers

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Dedication

This thesis is dedicated to the hundreds of people world-wide who lose their lives each year to sexually-motivated violence. If this work, and hopefully subsequent works that follow, can help prevent even one person from dying in such a degrading and unnecessary way, then it will all have been worthwhile.

Acknowledgements

I want to take this opportunity to thank a number of people who have been instrumental in my efforts to complete this work. Firstly, I wish to thank my supervisor, Professor Anthony Beech, for guiding me throughout the journey. His knowledge of forensic psychology is truly encyclopaedic and I feel lucky to have been given the opportunity to work with him. Secondly, I wish to thank Dr. David Murphy (Principal Psychologist) for his advice and support during the interviewing of my subjects. He is a true expert in the clinical and forensic assessment of mentally disordered offenders and I feel that I benefited a great deal from his advice. Additionally, I want to thank a few others who have been sources of strength during my studies. These include Ms. Nicola Wallis, Dr. Emily Glorney and Ms. Samantha Gregg (Forensic Psychologists) for their humour, level headedness, and just being there when times got tough, and Dr. Victoria Wilkes (Principal Forensic Psychologist) for her support in my write-up and during the final few months before submission. Finally, I want to say a few words of gratitude to my mum. It was my mum who provided me with that extra bit of encouragement to complete this degree. Thank you!

Abstract

This thesis explores the offence of sexual homicide in psychiatric and non-psychiatric forensic populations using a variety of methods. Overall, this thesis reports a number of findings that are consistent with existing literature: firstly, the offence of sexual homicide is extremely complex and cannot be understood without consideration of both internal and external factors; secondly, severe forms of childhood physical and/or sexual abuse as well as other critical early life events are important in understanding the offence and may be reflected in an individual's crime(s); thirdly, severe forms of mental illness and other types of psychopathology are apparent in sexual killers detained in hospital, which are likely to impact on the offender's thinking at the time of the offence and a highly disorganised crime scene. Finally, defining the offence, which has proved difficult for academics, is less important than an accurate formulation detailing motive and clear treatment targets. Clinical implications and limitations of the research are also discussed.

Chapter 1

Introduction

1.1 Sexual homicide: a brief historical overview

In general, a homicide can be considered 'sexual' if it includes sexual activity before, during, or after a killing (Porter, Woodworth, Earle, Drugge & Boer, 2003). It is not a new phenomenon. Over four hundred years ago in Pericles, Prince of Tyre, Shakespeare wrote: "One sin I know another doth provoke, murder's as near to lust as flame to smoke". Even before this time, however, there have been numerous accounts of men and some women that have killed within the context of satisfying some sort of perverted sexual drive. The 15th Century French nobleman Gilles de Rais served as a soldier alongside Joan of Arc and became one of the wealthiest men in France. He was also a serial sexual killer of at least 150 peasant children (Benedetti, 1972). Rais killed the children (mostly young boys) after torturing them. He would dress his young victims in fine clothes, force them to consume alcohol and then sodomize and hang them. He would sometimes have intercourse with them whilst they were dying and would often ejaculate onto their corpses. At his trial, Rais confessed to the killings. He also reported being a paedophile, homosexual, and of taking part in the practice of black magic. He was executed by guillotine, but before he died he cautioned parents to raise their children with discipline and morality so that they could avoid idleness, laziness, and excesses that would result in "evils" (Schlesinger, 2004).

In the UK, one of the earliest recorded sexual killings occurred in 1867. The perpetrator, Frederick Baker, raped and killed an 8-year-old girl after luring her away from friends (Wilson & Seaman, 1996). It is possible that the Whitechapel killer who terrorized the east end of London in the late 1880s was also motivated by sex. In a letter to the central news agency in 1888 he wrote "I am down on whores and shan't quit ripping them until I do get

buckled". 'Jack the Ripper', as the press dubbed him, has never been identified. He (assuming the killer was a he) murdered approximately five prostitutes. His victims were mutilated with their abdomens slit open and their intestines and genitals removed. There have been many theories as to the identity of the killer with some hypothesising doctors and surgeons, others espousing artists, and still others accusing royalty (Marriner, 1992). A more likely hypothesis is to suggest that the *real* Jack the Ripper was, in fact, an everyday citizen of London who was familiar with the east end and was able to walk freely amongst its streets without drawing too much attention. It is also feasible to suggest that the real killer probably had experienced a negative encounter with a prostitute which fuelled his hatred and anger towards them.

At about the same time that Jack the Ripper was active, Richard von Kraft-Ebing (1840-1902) was working on a contemporary understanding of the concept of sexual deviance. In 1886 he published his most acclaimed work entitled *Psychopathia Sexualis* (*Sexual Psychopathology*). The text went through 12 editions before his death and is still being published today. He coined the term *sadism* after the Marques de Sade (1740-1814), who wrote relentlessly on the relationship between the infliction of pain, humiliation and torture and associated sexual arousal. Kraft-Ebing (1886) believed that sexual homicide offenders are usually males who lie, manipulate, use ligatures to kill their victims, engage in torture and repetitive ritualistic behaviours, and often take souvenirs or trophies from their crime scenes. Although he never proposed an explanation for these behaviours, there is no doubt that the work of Kraft-Ebing has had a lasting influence in fields of forensic psychiatry and psychology. The description he wrote in the 19th century is very similar to contemporary understanding of the serial sexual homicide offender of today. Furthermore, his definition of sadism has strongly influenced the description of sexual sadism in the Diagnostic and

Statistical Manual of Mental Disorders, now in its fifth edition (DSM-V) (Frances & Wollert, 2012).

Numerous other sexual homicide offenders, who remain infamous for the extremely brutal and repetitive nature of their crimes, were at large in the 20th century. Killers such as Peter Kürten (the Vampire of Dusseldorf) who in the 1920s murdered, mutilated and drank the blood of countless victims; Albert De Salvo (the Boston Strangler) in the 1960s, who raped and strangled 13 women over an 18-month period; and Ted Bundy in the 1970s, who tortured and murdered at least 23 young women and children throughout the United States, will be familiar to many. Public fascination in such killers has always been apparent, but it was not until the 1980s that contemporary academic researchers began taking an interest. Possible explanations for this are discussed below.

1.2 The challenge of researching sexual homicide

In comparison to other forms of sexual offending, there is a dearth of research investigating sexual homicide. This is in part due to the extreme rarity of the crime, making ordinary behavioural science research methods difficult to employ (Schlesinger, 2004). Furthermore, there are no national statistics available on the number of sexual homicides committed in the UK. It is generally the case, for example, that when an individual is found guilty of such an offence, only the most serious charge (i.e. murder/manslaughter) appears on the indictment. This means that the sexual offence, which may have been committed before, during or after the homicide, often goes unrecorded. Finally, defining sexual homicide has proved extremely difficult for forensic practitioners and researchers alike. No universal definition is currently available and this makes comparing studies difficult (Greenall, 2012) (see the Introduction section of Chapter 2 for more discussion about the problem of definition).

Not only have different definitions been used, different terms have also been suggested. Terms such as ‘sexual murder’, ‘lust murder’ and ‘serial murder’, are often used interchangeably in the scientific literature, but do not necessarily mean the same thing (Kerr et al., 2013). It is often very difficult to determine the motive for such crimes and, to some extent, the different definitions appear to reflect this. Using the very general term of ‘sexual homicide’, however, makes no assumption about an offender’s state of mind or motivation for the crime (Greenall, 2012); therefore it is this term that the author has chosen to use throughout the thesis.

Although rare, the scientific study of sexual homicide is important. The offender not only destroys the life of the victim, but he/she also destroys the lives of the victim’s family. Furthermore, the repetitive nature of some crimes means that many individuals could be at risk from them, and when they are finally apprehended there is little guidance in the literature as to how to treat them.

Research generally supports the contention that the sexual homicide offender is not significantly different in his treatment needs than the non-homicidal sexual aggressor of women (Beech, Oliver, Fisher & Beckett, 2007; Proulx, 2007). However, given that several different types of sexual homicide offender have been found in a number of studies, it is generally agreed that treatment should be consistent with the particular pathway the offending has taken (Beech et al., 2005; Fisher & Beech, 2007; Proulx, 2007). For those motivated by hate and anger, treatment focused on addressing emotion dysregulation will be seen as a priority; and for those motivated by a sadistic sexual drive, treatment focused on self-management and the acquisition of less harmful sexual interests are more appropriate (Beech et al., 2005).

In the U.K, most of the sexual offender’s treatment needs can be met through the Sex Offender Treatment Programme, and this includes those who kill during the course of their

offence (Carter, Mann & Wakeling, 2007). Variations of the programme are available in the health service for offenders with major mental disorders and learning disabilities (Lockmuller, Beech & Fisher, 2008). Over the last 20 years or so, there has been a shift in the focus of what these therapies target (Mann & Marshall, 2009). For example, instead of challenging cognitive distortions connected with offending, contemporary treatment targets cognition at a deeper level; exploring phenomena such as offence supportive attitudes and schema-related beliefs (Mann & Marshall, 2009). Schemas, or implicit theories, are "causal theories, interacting with personal and interpersonal experiences to form coherent structures that explain and predict our own and others' behaviour" (Ward, Polaschek & Beech, 2006, p. 123). They likely develop early in childhood in response to specific experiences and lie outside an individual's awareness. As Ward, Polaschek and Beech, (2006) put it; "individuals are generally not aware that they think in this way and others may not". Several implicit theories have been identified in sexual offenders, including sexual homicide offenders (Beech, Fisher & Ward, 2005).

As well as the other issues introduced in this section, this thesis aims to explore the treatment of the sexual homicide offender further with the hope of increasing our understanding of this disturbing crime. It does this by using samples from both a mental health and prison-based setting and by using qualitiative and quantitative methodologies.

1.3 Structure and aims of the thesis

The aims of this thesis are three-fold: 1) to explore how the offence of sexual homicide has been defined in the academic literature; 2) to investigate possible motivations for the offence; and 3) to consider the impact of mental disorder on offender motivation and how this might be reflected in the crimes of perpetrators. A more detailed introduction to each chapter is presented below.

1.3.1 Chapter 2: Sexual Homicide: Definition, Motivation and Comparison with other forms of Sexual Offending (Kerr, Beech and Murphy, 2013)

This review paper was published in Aggression and Violent Behavior in 2013 and explores three distinct, though related, areas of sexual homicide that have only recently been addressed in the scientific literature. The first topic concerns how sexual homicide has been defined by academics around the world. It reveals that there have been no less than 13 attempts by various researchers to define sexual homicide. There is little agreement amongst professionals with regard to what constitutes a sexual homicide, with some researchers preferring a very narrow description and others preferring a broader account. No *one* definition is preferred and there is also significant variation in the terminologies that have been used. From 'lust murder' to 'erotophonophilia', many have been used, but they do not necessarily mean the same thing.

The question of motive in cases of sexual homicide is tied very closely with its definition and this is covered in the second part of the review. The literature seems clear in suggesting that there are at least three different types of sexual homicide offender: those motivated by anger or hate, those motivated by a sadistic sexual drive, and those who kill for instrumental purposes (i.e. in order to silence the only witness to an otherwise non-lethal sexual assault). The final section of the review paper explores the question of whether people who commit sexual homicide are clinically different from those who commit other types of non-lethal sexual violence. There is a growing literature in this area and although it is generally considered that sexual homicide offenders share more in common than they do differences with their non-homicidal counterparts, a few distinguishing features are emerging.

1.3.2 Chapter 3: Thematic Analysis of the Motivation behind Sexual Homicide from the Perspective of the Killer

In chapter 3, a qualitative analysis of the motivation behind sexual homicide is presented. This is done with the help of eight men; all of whom were detained in one of the UK's high security hospitals and all had committed at least one sexual homicide. These men were asked to talk about their offences and highlight what they believed to be significant in their motive for the offence. The qualitative technique of thematic analysis as described by Braun and Clarke (2006) was used to analyse extensive interview material from these men. Several themes were eventually extracted from the data; each representing a key feature in their motivation for homicide. Two distinct pathways of offending were found, i.e. those driven by hate and anger, and those driven by sadistic sexual preference. Themes were organised to account for each pathway.

1.3.3 Chapter 4: Case studies

The question of what motivates someone to commit sexual homicide was taken further in chapter 4 in the form of a case study analysis. Three cases were explored in detail; each reflecting a different type of killer described in detail in the review paper by Kerr, Beech and Murphy (2013) contained in Chapter 2. All three cases are from the UK; the first two are drawn from the mental health sample, the third from a prison-based sample.

Each case study is followed by a formulation in both narrative and diagrammatic form and includes hypotheses about the core beliefs associated with each offender, key developmental trajectories, distal and proximal antecedents, and a consideration of possible external factors which made the homicide more likely. In the final section, treatment options are discussed for each type of offender. These options are based on a current understanding of the treatment literature.

1.3.4 Chapter 5: A Comparative Analysis between Sexual Homicide Offenders Detained in a Secure Hospital with those Detained in Prison

In chapter 5, a comparative analysis of offenders deemed legally responsible for their crimes with those deemed not fully responsible is presented. This has not been explored previously. It compares each sample on a number of developmental, pre-crime, crime and post-crime factors, as well as using a number of commonly-used psychometrics to compare clinical profiles. The study finds that both samples of offenders are, for the most part, alike, but there are differences also, and these are discussed with implications for law enforcement and treatment.

1.3.5 Chapter 6: Discussion

In the final chapter of the thesis, the main findings of the research are discussed. The difficulty in defining sexual homicide is re-visited with consideration to the findings of the research. The question of motive, which this thesis has covered to a significant degree, is also re-visited. Other areas include an understanding of the potential impact of mental disorder, re-consideration of whether sexual homicide offenders are different from non-homicidal sex offenders, implications and applications of the work, and suggestions for future research.

Chapter 2

Sexual Homicide: Definition, Motivation and Comparison with other forms of Sexual Offending

(Kevin J. Kerr, Anthony Beech, David Murphy)

in

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Chapter 3

A Thematic Analysis of the Motivation behind Sexual Homicide from the Perspective of the Killer

(Manuscript accepted for publication in the Journal of Interpersonal Violence)

Abstract

Using thematic analysis, this study explores the motivation to commit sexual homicide from the perspective of the perpetrator. In the process it revisits motivational models and offender typologies that have been put forward to explain such offences. From the homicide narratives of eight sexual homicide offenders detained in a high security hospital in the UK, four themes were found which appeared significant in terms of understanding the offences committed. These themes were labelled: 1) avenging sexual abuse, 2) events leading to a catathymic reaction, 3) homicidal impulse, and 4) emotional loneliness. Although these findings are not inconsistent with previous research, it is argued that the current literature fails to capture the complexity associated with these offences. It is also argued that the context or situation in which sexual homicide occurs is a crucial feature of the offence, and one which has not been adequately taken into account by motivational models.

Keywords: catathymia, emotional loneliness, sexual homicide, sexual abuse, thematic analysis

3.1 Introduction

Sexual homicides attract a great deal of attention from the media, the general public, and, more recently, the academic community. Although rare, they are devastating crimes and have the potential for repetition (Greenall, 2013; Ressler, Burgess & Douglas, 1988) if the perpetrator is not apprehended. In comparison to other forms of sexual offending, sexual homicide is still a relatively new area of psychological enquiry. Researchers have only really taken an academic interest in the field in the last 30 years, although a few key papers did exist before this time; most notably those by Brittain (1970) and Kraft-Ebing (1886). Surprisingly, as outlined in chapter 2, there is no universally agreed definition of sexual homicide. However, most scholars seem to agree that there must be evidence of sexual activity at the crime scene by the perpetrator (Douglas et al., 1992; Folino, 2000; Myers, 2002). Sexual activity might occur before, during, or after the killing, or indeed throughout the event (Porter et al., 2003) and could range from masturbation at the crime scene to actual penetration of the victim (oral, anal, or vaginal) with a variety of objects, animate or inanimate. It might also be symbolically expressed, often suffused with anger and curiosity through mutilation of the victim's genitals (Meloy, 2000). However, some authors believe that a sexual homicide need not contain any evidence of sexual activity at all (Revitch, 1965; Schlesinger, 2004). In such cases, the brutal act itself may be a substitute for the sexual act.

It has been estimated that around 4% of homicides committed in England and Wales each year have a definite sexual element (Francis & Soothill, 2000). This figure is consistent with estimates in Canada (Porter et al., 2003), and Finland (Hakkanen-Nyholm et al., 2009). However, given that a sexual homicide need not contain any overt evidence of sexuality, it is highly likely that this is an underestimate. The *true* prevalence of sexual homicide remains unknown. What *is* known about people who commit sexual homicide is that most perpetrators are male and legally sane at the time of their offence(s) (Proulx & Sauvêtre, 2007). Most

sexual homicide victims are women and tend to be of a child-bearing age (Roberts & Grossman, 1993). It is also the case that the majority of sexual homicide offenders do not kill multiple victims and are therefore not serial killers (Schlesinger, 2004, 2007).

3.1.1 Typological studies

There have been at least ten attempts to classify sexual homicide offenders according to motivation (see Chapter 2 for a discussion). Despite variations in the terminologies used and some degree of overlap, all three types of killer seem to present with distinct characteristics. The angry offender, for example, is likely to have average intelligence (Schlesinger, 2004), be married or in a stable relationship (Beauregard, Proulx & St-Yves, 2007) and is not socially isolated (Ressler et al., 1988). Their crime-scenes are likely to be disorganised with evidence of vengeance displaced to a specific victim (Ressler et al., 1988). The sadistic killer is more likely to be highly intelligent (Revitch & Schlesinger, 1981), though socially isolated (Beauregard & Proulx, 2009) with multiple paraphilias (Keppel & Walter, 1999). Their crime scenes are likely to be organised with evidence of sadistic, gratuitous violence, and fantasy enactment (e.g. bizarre rituals carried out over the course of the killing) (Ressler et al., 1988).

3.1.2 Motivational models

There have been at least three motivational models developed independently by researchers to account for the motivation behind sexual homicide (Arrigo & Purcell, 2001; Burgess, Hartmann, Ressler, Douglas & McCormack, 1986; Hickey, 1997, 2002). These models provide a general framework for understanding why an individual may become a sexual homicide offender with an integration of biological, psychological and sociological theories. There is a fair degree of overlap between all three models, but each will be considered in turn.

1. Motivational Model (Burgess, Hartman, Ressler, Douglas, & McCormack, 1986).

From their detailed analysis of interviews with 36 sexual homicide offenders (25 of whom were serial killers) detained in U.S penitentiaries, FBI researchers proposed a motivational model comprising several stages (Burgess et al., 1986). In childhood, the individual experiences an *ineffective early social environment* in which the absence of care and affection leads to a problematic attachment style, characterised by detachment and hostility. *Formative traumatic events*, such as physical, sexual or emotional abuse result in social isolation and foster the emergence of violent sexual fantasies, which compensate for the absence of real-life control. *Patterned responses* then result and can include negative personality traits, such as rebelliousness, hostility, and feelings of entitlement. This emerging interpersonal style interferes with the development of healthy social relationships and the individual learns to cope by retreating further into fantasies of power and revenge. *Actions toward others* then follow and might include damage to property, cruelty to animals and violence. As the individual reaches puberty, violent fantasies become merged with sexual excitement and gratification. *A feedback filter* is the final stage in which the individual comes to view the world in a negative and hostile way. The individual will believe, for example, that people cannot be trusted and that he is entitled to act out his sexually aggressive fantasies.

2. Trauma Control Model (Hickey, 1997, 2002)

Hickey (1997, 2002) focussed specifically on serial sexual homicide in his trauma control model. Consistent in many ways to the Burgess et al., model, Hickey highlighted a number of factors which he believed drive individuals towards serial sexual homicide. Arguably, one of the most important additions to the Hickey model was the role of dissociation. Hickey (1997, 2002) saw *dissociation* as a common mechanism used by the developing adolescent to block out distressing memories, thoughts and feelings. *Trauma reinforcers*, such as failed

relationships, criticism and rejection reactivate childhood trauma with the individual retreating further into his fantasy world. The continued development of *increasingly violent fantasies* and disinhibiting factors such as pornography and alcohol promote a search for deviant activities (Hickey, 2002). This culminates in the commission of *homicidal behaviour* which may generate new images of brutality and, therefore, further fuel the offender's deviant fantasy life. Each subsequent act of violence represents an attempt to completely satisfy the perpetrator's increasingly violent fantasies.

3. Integrative Paraphilic Model (Arrigo & Purcell, 2001)

Arrigo and Purcell (2001) based their model on the Burgess et al., and Hickey models and added a role for paraphilia to account for the motivation of what they term 'lust homicide'. In the Integrative Paraphilic Model (IPM), formative life experiences, low self-esteem and early fantasy development combine to produce paraphilic development. According to Arrigo and Purcell (2001), the paraphilic process is cyclical and consists of paraphilic fantasy and stimuli, facilitators (e.g., alcohol, illicit substances, pornography), and orgasmic conditioning processes, where the individual masturbates in response to his deviant fantasies to the point of orgasm, therefore strengthening the paraphilia. Stressors may be internal or external. They generally act to rekindle negative experiences of childhood and, as suggested by the Trauma Control Model (Hickey, 2002), are thought to precipitate an act of violence. Each behavioural manifestation of the fantasy is thought to feedback into the offender's internal world. In the process, fantasies become increasingly violent in nature, and the paraphilic stimuli also progress in intensity, duration, and frequency (Arrigo & Purcell, 2001).

3.1.3 Evaluation of motivational models

The major strength of these models is that they provide a comprehensive account of an individual's pathway to sexual homicide, taking into consideration developmental, psychological, and, to a lesser extent, situational factors. However, two of the models (Trauma Control Model and the IPM) have never been tested with empirical data. Although the Burgess et al., model was developed on the basis of extensive clinical interviews, most participants within the sample were serial killers, defined as the killing of at least three victims with a significant cooling off period between each murder. Indeed, all three models are restricted in the sense that they only seem to account for one particular type of sexual homicide, i.e. serial sexual homicide. Serial sexual homicide is a particularly rare form of sexual homicide. Such individuals are likely to be motivated by sadism and coercive sexual fantasies. They have a strong likelihood of repeating their crimes, but they are not representative of sexual homicide offenders in general.

3.1.4 The present study

Because the study of sexual homicide is still in its infancy, and due to the fact that researchers still cannot agree on how to define the term, Schlesinger (2004) has argued for a phenomenological-descriptive approach to the study of sexual homicide. A number of quantitative studies have been conducted, but according to Schlesinger (2004, 2007), premature quantification can easily impede rather than enhance understanding. In this paper, we explore the phenomenon of sexual homicide through the eyes of the perpetrator. Our aim was to investigate the motivations behind these crimes using detailed narratives from men who have committed such offences.

3.2 Methods

3.2.1 Selection Criteria

Participants were recruited from one of the UK's high security psychiatric hospitals. They were selected using the criteria formulated by FBI researchers in the 1980s (e.g., Ressler, Burgess & Douglas, 1988). Ressler et al., classify a homicide as 'sexual' if one or more of the following criteria are evident at the crime scene: (a) the victim is found totally or partially naked, (b) the genitals are exposed, (C) the body is found in a sexually explicit position, (d) an object has been inserted into a body cavity (anus, mouth, vagina), (e) there is evidence of sexual contact, (f) there is evidence of substitutive sexual activity (e.g. masturbation and ejaculation at the crime scene), or of sadistic sexual fantasies (e.g. genital mutilation). These criteria have been used in several other studies (e.g., Beauregard & Proulx, 2002; Beauregard & Proulx, 2007; Ressler et al., 1988) as a means of standardising behaviours potentially indicative of sexual homicide.

3.2.2 Participants

In the U.K, it is general practice in in-patient forensic mental health settings for a psychologist to be attached to each clinical team. A letter was sent to all team psychologists introducing the study and included a copy of the FBI criteria listed above. It asked psychologists to consider with their teams whether or not any of their patients' offences matched any of the criteria highlighted above and whether or not they would be deemed suitable to be approached to take part in the study.

A total of fourteen men had been identified by their respective clinical teams as having committed at least one sexual homicide (according to FBI criteria), and all were deemed suitable to be approached to take part (i.e. stable in their mental states and having the necessary capacity to decide whether or not they want to take part). In total, ten patients

agreed to take part, eight of whom agreed to be interviewed at length. The two patients who agreed to take part though refused to be interviewed about their crimes, agreed to complete the battery of psychometric tests only. Information about these two men and their offences was not included as part of the present study but is included as part of a later study (see Chapter 5). Each patient was provided with a copy of a consent form (see Appendix II), which they read and agreed to sign. The main researcher of the study ensured that each participant understood what was expected of them by asking them to summarise in their own words the general procedure. They were also issued with a copy of a Participant Information Sheet, which introduced the study further and addressed any common questions (see Appendix III). Of the four patients who refused to take part, none provided a detailed explanation as to why they declined. Three of the men refused to even enter an interview room with the researcher to discuss the project; another individual agreed to meet with the researcher but reported that he "had [his] own reasons for not wanting to take part".

3.2.3 Participants: Ethical considerations

Given that participants were being asked to talk in detail about potentially traumatic experiences, it is important to be mindful of the ethical implications involved. With over 5 years of clinical experience in the interviewing of forensic clients, the main researcher was mindful of these implications and steps were taken to minimise distress to participants. Participants were asked regularly throughout the interview process how they were feeling and whether or not they needed a break from talking. Participants were made aware that they did not need to continue the interview if they did not want to and they were also informed that a member of the nursing team would always be available should they need to talk about how they were feeling after their interview. An introduction to the research and de-briefs were also provided to nursing staff before and after each interview and a clinical entry was made in

each participant's notes to make their team aware that they had taken part. Anonymity was assured in the research as names would never be used, and any questions were addressed to the best of the researcher's own knowledge. However, a protocol was in place to deal with the possibility of participants disclosing further crimes which were unknown to the police and their clinical team. It was made clear to participants in interview that if this should occur, or if they were to disclose thoughts of harming others or themselves, their clinical teams would need to be informed. All other information and details would be kept confidential.

3.2.4 Participants: Demographics

The average age of the participants at the time of the study was 41 years, with a range from 25 to 63 years. The average age at the time of their first homicide was 24 years, with a range from 17 to 29 years. Three participants described themselves as single at the time of the homicide. Five participants described being in a relationship; however, in four of the cases, the relationship was turbulent, characterised by violence and abuse. All participants were classified as white-British.

All participants had been diagnosed with a mental disorder soon after their apprehension for homicide. This was taken into account at the time of their trial, therefore all had been charged with manslaughter, rather than murder, on grounds of diminished responsibility. Four of the eight participants had a diagnosis of mental illness, notably schizophrenia. Three had a diagnosis of personality disorder - emotionally unstable and dissocial types (ICD-10), and one participant had a dual diagnosis of mental illness (schizophrenia) and personality disorder (dissocial).

Four participants had committed one homicide. Another two participants had committed two homicides each, within succession and at the same crime scene. The remaining two participants had committed three homicides with a significant time lapse

between each, making them serial in nature. All homicides were committed by the offender alone. Thus, a total of 14 sexual homicides had been committed by our sample of 8 participants. Four participants asphyxiated their victims to death, three used a knife, and one used a blunt object. With regards to ethnicity of victim, the majority (10) were white, two were Asian, one was black African-Caribbean and one was Hispanic. And with regards to the relationship of the perpetrator to the victim: four killed an acquaintance, three killed total strangers, and only one had killed a member of his own family (see Table 3.1).

Table 3.1: Participant and victim characteristics

Participant	**Age[1]**	**Ethnicity**	**No of Victims**	**Ethnicity of Victims**	**Victim relationship**	**Killing Method**	**Type of Mental Disorder**
1	24	White	1	White	Acquaintance	Asphyxia	Schizophrenia/ Dissocial PD
2	29	White	3	2 White, 1 Black African	Total strangers	Blunt Object	Schizophrenia
3	17	White	1	White	Family member	Asphyxia	Schizophrenia
4	22	White	1	White	Acquaintance	Knife	Schizophrenia
5	23	White	2	Asian	Acquaintance	Knife	Dissocial/EU PD[2]
6	29	White	2	White	Total strangers	Asphyxia	Dissocial/EU PD
7	25	White	1	Hispanic	Acquaintance	Asphyxia	Dissocial/EU PD
8	27	White	3	White	Total strangers	Knife	Schizophrenia

[1] At time of first homicide [2] Emotionally Unstable Personality Disorder

3.2.5 Procedure

A semi-structured interview based on the interview protocol used by Beech and colleagues in their comparison study of rapists and sexual homicide offenders detained in prison was used (e.g., Beech et al., 2005). The protocol was developed by staff at the Programme Development Section in the prison service with the aim of establishing a functional analysis of a sexual offence. It asked about potential antecedents, such as major life events, relationships, substance misuse, fantasy and planning. It also included a number of prompt questions concerning the offence itself, including, the type of weapon used (if any), how the offender dealt with the victim's resistance, and presence of sexual arousal during the attack. Finally, the protocol asked about the immediate and general post-offence reaction of the offender to his offence. Because it was developed in the prison service, no questions directly asked about the potential role of mental illness in the offence. However, any links between symptoms of the individual's disorder and their offending was explored in detail (see Appendix I).

All participants were interviewed individually in a private room by the first author. The aims and purpose of the interview were explained and informed consent was obtained. Anonymity was assured and participants were encouraged to talk freely. In general, the interviews lasted between two and four hours. The aim was to develop a functional analysis based on what they believed to be the most important factors associated with their offence. The interview protocol was used only as a guide. Participants provided a narrative of their offence in their own words and this was recorded. Seven participants agreed to their interviews being tape-recorded. These were then transcribed and recorded verbatim. One participant refused for his interview to be recorded. He did, however, agree for the interviewer to write down his comments as he spoke. Every effort was made to record details as he spoke.

3.2.6 Data analysis

Transcripts of the interviews were then used to develop themes. This was done using the qualitative technique of thematic analysis, which is a method for identifying, analysing and reporting of patterns (themes) within data (Braun & Clarke, 2006). Thematic analysis looks at data at a latent level which goes beyond the semantic meaning of the data in order to interpret underlying meanings (Braun & Clarke, 2006). It is a flexible approach and has been used in a number of psychological studies, from understanding children's perceptions of obesity (Fielden, Sillence, & Little, 2011) to the identification of grooming techniques used by internet sex offenders (Williams, Elliot, & Beech, 2013). It can be used as an essentialist or realist method involving the reporting of experiences and meanings for participants, or it can be a constructionist method, examining the ways in which events, realities, meanings, experiences and so forth, are the effects of a range of discourses operating within society (Braun & Clarke, 2006). In other words, the essentialist method will look at a person's actions and consequences and generally not go beyond what is reported by people. In contrast, a constructionist approach would go deeper into an individual's interpretation of society's norms and how they have come to believe what they do. Since the present study used interview transcripts with offenders, an essentialist method was adopted.

Although there is little agreement in terms of how to conduct a thematic analysis, the present study used the procedure recommended by Braun and Clarke (2006). This consists of six steps. First, the interview data was transcribed verbatim and the first author of this paper read and re-read transcripts to ensure familiarity with the content. Initial ideas were noted. Second, interesting features of the data were generated in a systematic manner using general codes. Codes identify a feature of the data that appears interesting to the analyst, and refer to "the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon" (Boyatzis, 1998). Third, the first author

reviewed codes and grouped data further into themes. Essentially, this step considers how different codes may combine to form an overarching theme. The fourth step involves reviewing themes. In this step, themes are refined. Some may be discarded, others may collapse into others. In step five, themes are defined and named. In the final step, specific examples from narratives are selected in order to illustrate themes and relate the analysis back to existing literature.

3.2.7 Interrater reliability

Although it is not highlighted anywhere in the Braun and Clarke (2006) recommendations, a second independent researcher was asked to rate a smaller random sample of the data (10% of the total data), which was compared to the first author's coding. This was done in an attempt to ensure consistency in interpretation. Any disagreements were found only to relate to the semantic labelling of codes. For example, the second rater labelled themes such as: "sexual abuse", "deviant fantasy", "anger" and "isolation". These were all themes identified in the present analysis (see results). The second rater also reasoned that substance misuse and dissociation warranted separate themes due to their frequency in the data set. The author agreed that both variables featured strongly in the analysis. With regards to substances, however, no direct causal link to offending could be made. Illicit substances (and alcohol) are probably best viewed as disinhibitors of violence, and their significance for the present analysis is discussed in a later section (see discussion). With regards to dissociation, the author agreed that this was an interesting finding and something that had been coded as an initial theme. However, this was disregarded as it was not implicated as an antecedent to our participants' offending. For the purposes of the present study, we argue that dissociation was best viewed as a post-offence reaction to a traumatic event (i.e. the homicide). This is discussed further in Chapter 4.

3.2.8 Clinical file check

In order to assess the honesty and accuracy of each participant's account of their offending, previous forensic evidence reports of their crimes were checked in their clinical files. Participants provided their informed consent to allow access to file information. In all cases, participants' accounts of their offending largely matched previous accounts given in interviews with the police, psychologists and other mental health professionals.

3.3 Results

From the detailed analysis of all eight interviews, four specific themes were generated. They were selected on the basis that they held direct significance to the commission of the offence (s). The four themes were labelled: 1) avenging sexual abuse; 2) homicidal impulse; 3) events leading to a catathymic reaction; and 4) emotional loneliness (see Table 3.2). Within each theme, a number of sub-themes were also identified. These are discussed in turn following each of the main themes.

Table 3.2: Themes generated within each participant's offence

Participant	Avenging sexual abuse	Homicidal impulse	Events leading to catathymia	Emotional loneliness
1			X	X
2		X	X	
3	X	X		X
4			X	X
5	X	X		
6	X	X	X	X
7	X			X
8	X	X		X

3.3.1 Theme 1: Avenging sexual abuse

Five of the eight participants talked about their experiences of being sexually abused during childhood. In all cases the abuse lasted for several years, and in four out of five cases it involved the use of violence, sometimes torture, and more than one offender. All abusers were reported to be male and were either 'caregivers' or people with some kind of authority over the child (e.g., headmaster). In most cases, salient aspects of the abuse appeared to feature in the homicides of the participants. This could either be in the form of triggers which acted as catalysts to violence by evoking traumatic memories associated with the abuse, or it could be reflected in some way in the choice of victim. Within this theme, two sub-themes were identified: triggers of the abuse and symbolic figure of the victim (see Figure 3.1).

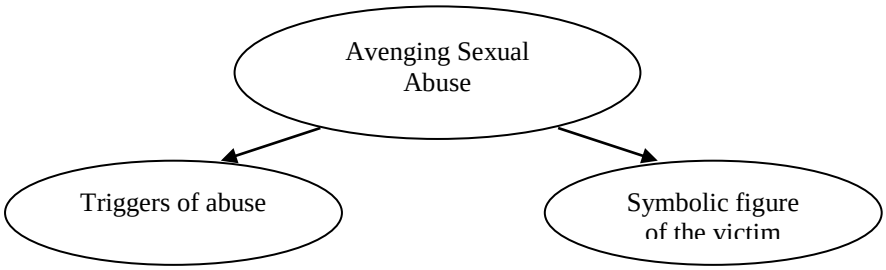


Figure 3.1: Main theme: "avenging sexual abuse", shown with sub-themes

3.3.1.1 Triggers of abuse

In this sub-theme, unexpected sensory and environmental triggers of the abuse appeared to initiate homicidal violence in participants. Such triggers acted as a conscious reminder of the abuse these individuals suffered in childhood. In two cases, the triggers occurred during the commission of a coercive sexual act with homicidal violence following at some point during the sequence. In another two cases the trigger initiated a re-experience of the abuse and associated grievance thinking. In both cases, a killing was carried out a few days later. This sub-theme is illustrated in the following excerpts. The first provides an example of violence

occurring immediately after the trigger, the second provides an example of a more protracted process lasting several days.

One participant talked about his intention to rape a victim only to find that she was menstruating at the time. He said that “the sight of blood reminded me of my own abuse when I was a kid. I was abused by my father, and sometimes as a punishment he’d make me lie in my sister’s bed which had blood stains from when she had been menstruating. When I saw the blood between her [the victim’s] legs I became really angry and killed her. The thought of the blood stayed with me for ages...I could smell it...it was sickening”

Another participant described chronic sexual abuse from both his father and older brother in childhood and a terrified mother who knew of the abuse but was paralysed by fear to do anything about it. A few days before he committed a double sexual homicide he “remembered finding out that the man who abused me when I was a kid [meaning his older brother] was back in prison...he had been doing the same things he did to me to another kid... it reminded me of all the shame and guilt that I went through”.

3.3.1.2 Symbolic figure of the victim

In this sub-theme, the actual victim of the homicide was perceived as representing a salient figure involved in the abuse of the participant. One participant talked of how he had killed an elderly couple in their home. He stabbed the female through the chest upon gaining entry into the apartment. “I remember seeing her [the victim] cowering on the floor after I stabbed her...I could see the fear in her face...I was looking straight into her eyes, but it wasn’t her I was seeing...it was my mother cowering on the floor scared of my father. I remembered thinking to myself see Mum I can protect you, I could have protected you all those years ago if you’d protected me”. After killing both victims in their home, the participant then removed the genitals of both victims and inserted them into their mouths. The participant had suffered

years of sexual abuse from both his father and older brother and, according to him, he killed his two elderly victims because of what his brother and father had done to him. “I killed them off. At that moment in time I had killed my father, mother and brother...and when I walked out of their [the victim’s] flat, I was the calmest I had ever been in my life. I felt clean inside, although empty...but with no more hatred and no more anger”.

3.3.2 Theme 2: Homicidal impulse

Five participants talked about an impulse to commit homicide. Although participants did not describe fantasies to commit *sexual* homicide (i.e. erotophonophilia) they did talk about a drive to kill that had existed within them for many years. In four out of the five cases the actual killing of the victim was preceded by a trigger that reminded participants of the sexual abuse that they had suffered in childhood. In this respect, “homicidal impulse” as a theme is therefore closely related to the theme of “avenging sexual abuse” described above. However, we believe that within our analysis, an impulse to kill was deserving of its own separate theme, as the drive to kill had existed from an early age (usually adolescence) and was a significant feature in its own right.

An impulse to kill is recognised in the work of Schlesinger (2004, 2007), although he describes the phenomenon as a “compulsion” that is “more abstract than fantasy and difficult to explain” (p. 263). The literature also suggests that most sexual homicide offenders who experience this state are aware of it. Brittain (1970) wrote that “given the opportunity, the [sexual] murderer is likely to murder again, and he knows it” (p. 205). “Homicidal impulse” included two sub-themes in our analysis which we labelled as ‘anxiety’ and ‘release of tension state’ (see Figure 3.2).

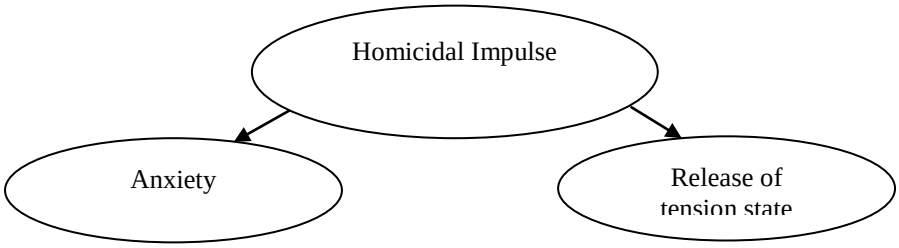


Figure 3.2: Main theme: "homicidal impulse", shown with sub-themes

3.3.2.1 Anxiety

Anxiety was a common emotion reported by all participants in this theme and it seemed directly linked to the resistance of their impulse to kill. In all cases, participants struggled to articulate what the feeling consisted of. One participant appeared to somatise the experience by complaining of headaches and nausea just before the actual killing of a victim. Another participant reflected that "I always knew that I'd kill someone...the feeling inside me was so strong...I knew it would end in murder". Another participant responsible for multiple homicides remarked that "I had to kill...there was a horrible feeling that would rise in me every so often and the only thing that got rid of it was killing...I felt a sense of relief afterwards".

Anxiety is a common response in people who attempt to resist other urges or compulsions to perform particular actions (Schlesinger, 2004). In obsessive compulsive disorder (OCD), for example, a resistance to carry out the compulsion will produce an overwhelming amount of anxiety in the sufferer. Although none of our participants had been formally diagnosed with such a disorder by their current responsible clinician, many described symptoms (e.g. being obsessive about the neatness and tidiness of their rooms) consistent with OCD.

3.3.2.2 Release of tension state

Within this sub-theme participants talked about eventually "giving in" to their urge to carry out homicide after several months or, in some cases, years of resistance. Participants found it very difficult to identify any specific triggers of the release, although three admitted being in an intoxicated state before the killing, which likely served to reduce inhibition. In two cases it seemed apparent that anxiety and tension continued to build until it reached a point where the offender made a conscious decision that he was not going to resist any longer. This process is captured in the following excerpt: "I remember waking up one morning and deciding that I was finally going to give up the fight...the fight of resisting to kill...I always knew that I'd kill someone, it was just a matter of time".

3.3.3 Theme 3: Events leading to a catathymic reaction

Four participants talked about a particular event in their lives to which they attached significance in terms of their motivation for killing. Analysis of the interview material revealed that in all four cases the event had initiated a catathymic reaction. *Catathymia* literally means "according to emotions" and was first used about a hundred years ago by the Swiss psychiatrist Hans Maier to account for the development of the content of delusions that stem from deep-seated emotional conflicts. Schlesinger (2004, 2007), Meloy (2000), and others have used this construct to explain the motivation behind some forms of sexual homicide. According to Schlesinger (2004, 2007), some forms of sexual homicide can be understood as resulting from a breakthrough of underlying sexual conflicts, which have been fused with strong negative emotion. They can be chronic or planned, though not in the sense of avoiding detection, or they can be acute, referring to a sudden release of tension, often precipitated by a seemingly innocuous comment from the victim. The motivation behind these types of homicide, according to Schlesinger (2004, 2007), is to rid the individual of

emotional turmoil associated with the conflict, thus providing some sort of relief. Within this theme, three sub-themes were identified (see Figure 3.3).

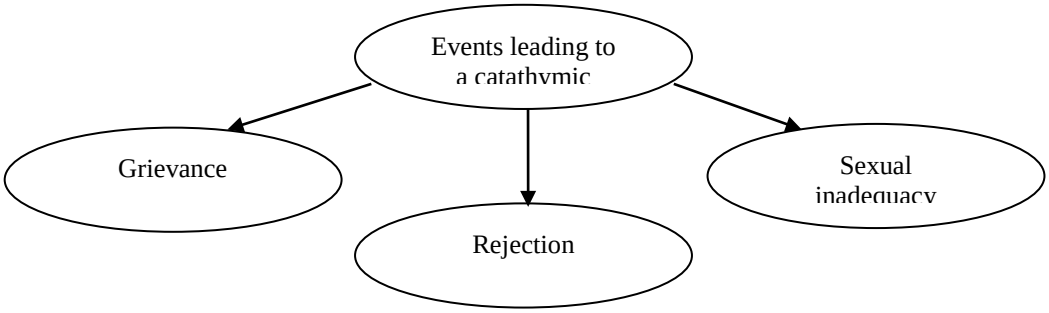


Figure 3.3: Main theme: "events leading to a catathymic reaction", shown with sub-themes

3.3.3.1 Grievance

Grievance, as a motive for sexual homicide, has been highlighted by many researchers. Beech et al., (2005) for example, identified a type of sexual homicide offender motivated by grievance in their cluster analysis of 50 sexual homicide offenders detained in UK prisons. After being mocked by a prostitute for his 'poor sexual performance', one of our participants resorted to serial sexual homicide as a means of avenging the insult. Although there was evidence to suggest that this individual made an active effort to avoid capture by the police, a catathymic reaction to the insult had been initiated and this persisted for many years. The remark made by the prostitute appeared to challenge the participant's sense of integrity and identity of being a 'man'. He described feeling "an intense rage after the whore had insulted me. I couldn't let it go. I had an intense feeling to kill prostitutes and I couldn't control it. After I killed one I felt relief for a while, but it kept coming back".

3.3.3.2 Rejection

A strong sense of rejection was highlighted by one of our participants. He talked about the devastation he felt when his homosexual partner left him for another man. This individual

had killed two male victims he had met in a gay bar and taken back to his apartment. When talking about the immediate antecedents to the homicides in interview he commented “he [the first victim] said something ...I was very drunk and very out of my head, and he said something...like no wonder Dave left you with all your drinking....you weren’t able to satisfy him...and I just snapped and I just grabbed him from behind. I only had him in an arm lock round his throat. I only did it to scare him and the next minute he was dead”. The sense of rejection that this participant was feeling, again, extended to his sense of being a ‘man’ and of being able to satisfy a partner sexually. The catathymic reaction in this case was more sudden and more acute than the chronic case highlighted above.

3.3.3.3 Sexual inadequacy

Sexual inadequacy, or a perception of threat to one’s own sense of sexual identity, was reported by two participants within this theme. In both cases, participants were able to trace the root cause of their sexual inadequacy to a significant event that had happened to them. For example, one participant talked about an inability to become erect during a sexual encounter with his first girlfriend during adolescence. He persisted in his attempts to have sex with the girl which apparently lasted all night. He described this experience as “traumatic” and said that “she [the girlfriend] broke up with me in the end. She said it wasn’t because of that [the impotence] but I knew it was. I hated myself for being so inadequate”. This participant experienced similar problems in subsequent relationships, but only with women he found “extremely attractive”. He described feeling “jinxed” that he would never be able to have the girlfriend of his dreams. It is probably no coincidence that the immediate antecedent to this man’s explosive rage which resulted in homicide during another failed sexual encounter was a comment from the victim to the effect of “just hurry up and get it over with”.

3.3.4 Theme 4: Emotional loneliness

Six individuals reported feeling emotionally lonely from either childhood or early adolescence. Emotional loneliness has been a common finding in the literature on sexual homicide, where it is often referred to as "social isolation" (e.g., Grubin, 1994; Milson, Beech & Webster, 2003). In the present study we chose to label the theme as 'emotional loneliness' because participants talked of feeling a lack of emotional connectedness to those around them, even if they were in an intimate relationship at the time of their offence . Participants described feeling "alone" and "shut off from the rest of society". In the present study, three sub-themes were identified. These were labelled 'social awkwardness', 'retreating into own world' and 'deviant fantasy' (see Figure 3.4).

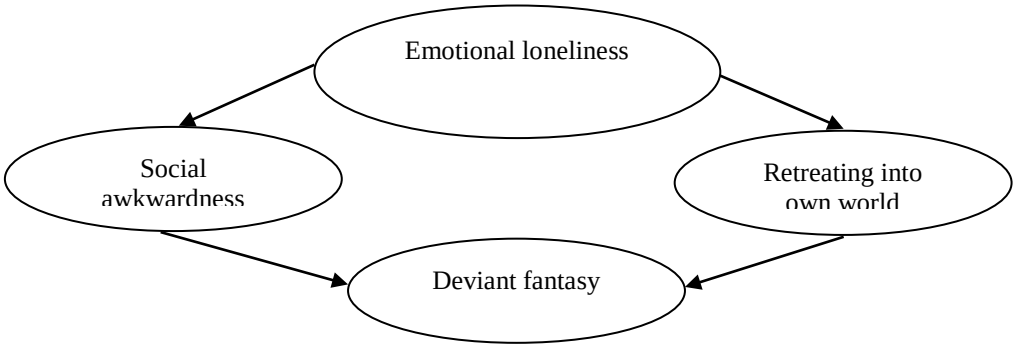


Figure 3.4: Main theme: "emotional loneliness", shown with sub-themes

3.3.4.1 Social awkwardness

In this sub-theme, participants described feeling awkward, clumsy and generally un-skilled in social situations, particularly with people their own age, and especially those they wished to develop an intimate relationship with. One participant described feeling increasingly lonely from the age of around 13 shortly after starting high school. He made frequent attempts to relate to people of his own age but was never successful. "I don't know why, but I began to feel very awkward in social situations and developed a bizarre sense of humour that people

found creepy...I would try and be like the comedians off the TV to make people laugh and win some friends but I could never pull it off... I think they saw me as weird and a bit odd".

3.3.4.2 Retreating into own world

Feeling emotionally detached from the rest of society and lacking the ability and confidence to make new friends, a number of participants described retreating into their own internal world. One participant remarked "because I couldn't make any friends at school I began to shut myself away…I used to like my own space and I needed to be alone. I began taking drugs and not really talking to anyone. I remember that I used to play out happy endings to bad things that had happened to me in my head so I could cope". This participant killed a family member through asphyxiation. Sexual intercourse then took place after the victim was dead. The participant described being raped repeatedly by his headmaster at school, but at the time he felt unable to disclose the abuse to anyone. It was not until the headmaster was dismissed from his post after abusing other children that the participant made his own abuse known.

3.3.4.3 Deviant fantasy

Five participants talked about fantasies involving forcing sex on a partner and, in at least two cases, the fantasies involved highly sadistic elements, such as inflicting pain. One participant commented "I had thoughts of forcing sex on a woman. The thoughts went away while I was in a relationship, but once she [his partner] became pregnant and refused to have sex with me, they came back. The fantasies mainly involved tying girls up and feeling in control of them….particularly girls who had upset me".

The psychological literature on sexual homicide is consistent in suggesting that deviant sexual fantasy plays a significant role in its aetiology. All three motivational models of sexual

homicide include fantasy as a key feature, and typological studies highlight the importance of fantasy in the sadistic offending pathway. According to Ressler et al., (1988) it is sexual homicide offenders' fantasies that motivate them to kill. Furthermore, they suggest that violent thoughts and fantasies in such offenders "are established early and exist in the context of social isolation". For the purposes of the present study, we also argue that deviant sexual fantasy plays a key role in understanding the offence of sexual homicide. In all five cases, it was the participant's deviant fantasy system that brought them into contact with their victim(s) in the first place (i.e. with the intention to rape or sexually assault). However, in all cases, according to our participants, none of their fantasies involved the killing of a victim. It is important to note, however, that in three out of the five cases, an impulse to kill (Theme 2) was also present. Participants described the impulse as more closely related to anger than of sex and no participant described masturbating to their homicide(s) after the event. Thus, no participant in this study matched the descriptions provided by Hickey (1997, 2002) and others of the erotophonophilic, who kills in order to achieve sexual orgasm. Thus, we have chosen to label 'deviant fantasy' as a sub-theme and one arising out of 'emotional loneliness' which, in all cases, preceded its development.

3.4 Discussion

This study identified four key themes in the offence narratives of sexual homicide offenders: 1) avenging sexual abuse, 2) homicidal impulse, 3) events leading to a catathymic reaction, and 4) emotional loneliness. All four themes were highlighted as significant in understanding the motive behind these individuals' crimes. Each theme also carried with it a number of sub-themes. We will now explore each of the main themes in turn with further reference to the psychological literature.

3.4.1 Theme 1: Avenging sexual abuse

This theme was observed in the offence narratives of five participants. We included two sub-themes: triggers of the abuse and symbolic figure of the victim. Childhood sexual abuse as a predisposing factor to sexual offending has been well documented in numerous studies. In Hickey's (2002) model, for example, psychological trauma at such a young age may disrupt normal personal development to a point where the adolescent takes refuge in a fictional fantasy world in which he dominates others. In the present study, by killing in a sexualised context in adulthood, participants seemed to be avenging in some way the sexual abuse they suffered in childhood.

Beauregard and Proulx (2007) observed a similar set of dynamics in their sample of sexual homicide offenders (n=10) who targeted male victims. Indeed, they labelled this type of killer "the avenger". The researchers found that most of the individuals who corresponded to the avenger category of killer were involved in male prostitution. In most cases, it was the type of sexual activity requested by a client in such encounters which seemed to trigger memories of abuse from childhood, leading to homicidal rage. Although, none of our participants were involved in prostitution, a similar dynamic seemed to be apparent in each of our cases. Unexpected triggers of the abuse unleashed the violence and in most cases, the victim held symbolic significance for the perpetrator.

It is true that most childhood victims of sexual abuse do not grow up to be delinquents or criminals, let alone perpetrators of sexual homicide (Widom & Maxfield, 2001). The nature of the abuse, the severity, and the relationship between the victim and the perpetrator, are important factors to take into account when considering its impact on victims later in life (Glasser et al., 2001).

3.4.2 Theme 2: Homicidal impulse

The concept of 'homicidal impulse' is an important feature in Schlesinger's (2004, 2007) understanding of the compulsive murderer. Schlesinger believed the compulsion to be strongly associated with sexual arousal. The compulsive murderer was seen as driven by intense and unrelenting sexual fantasies which ultimately involve the killing, usually by asphyxiation, of another human being.

Although there is no research, as yet, exploring obsessive compulsive disorder (OCD) or obsessive compulsive personality disorder among sexual homicide offenders, participants whose offences corresponded to this theme, described symptoms consistent with the disorder. According to Meloy (2000) there is clinical and forensic evidence to support such a contention. Meloy (2000) notes that self-report patterns of obsessive-compulsive symptoms by serial sexual homicide offenders are evident, and that clinical descriptors of obsessive-compulsive traits among such offenders date back to Kraft-Ebing (1886).

It was unclear in the present analysis exactly what factors contributed to a release of the tension state. However, of the five participants whose offences corresponded to this theme, three highlighted alcohol and illicit substances as a major disinhibitor. The other two participants described the tension state as becoming increasingly difficult to manage and eventually reaching a point where their internal resources could no longer contain it.

In the works of Schlesinger (2004, 2007), Meloy (2000) and others, the impulse to kill in sexual homicide offenders is closely related to sadism and sadistic sexual fantasy. However, none of the participants in the present study described any feeling of sexual arousal associated with their impulse. As predicted by Schlesinger, they did describe very strong urges to take another person's life, characterised by intense feelings of anxiety and worry which made the drive difficult to resist. However, the impulse was more closely related to intense feelings of hatred than of sex. The impulse appeared to serve a means of avenging, in

some way, the abuse that had been encountered in childhood previously. It is interesting that one participant described feeling “clean” and “calm” after he had finally “given up the resistance to kill”, and others talked of a sense of “relief”.

Four out of the five participants who described this phenomenon had killed at least two victims; two of them were serial killers. Three out of the five described asphyxiating their victim to death, one used a knife, and the other used hammer blows. The notion of homicidal impulse has not been highlighted as a specific feature in any of the motivational models on sexual homicide and there is little other research exploring it. Given what Schlesinger has written about the subject and what we have found in the present study, homicidal impulse is more likely to be a feature of the serial sexual homicide offender.

3.4.3 Theme 3: Events leading to a catathymic reaction

This theme was present in four of our participants. All four described a significant event in their lives, sometimes stemming from childhood and other times stemming from young adulthood, which they attached great significance in terms of understanding their homicides. In one case the event centred on grievance, in another rejection, and in two other cases, sexual inadequacy. However, in all cases, an extremely strong negative affect was attached, and at some point during the process, this affect had become fused with a sense of sexuality.

The literature on sexual homicide is consistent in suggesting that many offences are motivated by anger (e.g., Beauregard & Proulx, 2002; Beauregard & Proulx, 2007; Beech et al., 2005; Clark & Carter, 1999). However, few studies have explored in detail the nature or cause of the anger, which we argue is far more important in terms of formulating motive. Anger was an important antecedent in the offences of all participants in this theme, but a feeling of hate was described with more credence by our subjects in the 48 hours preceding their homicide. The experience of hate could be channelled externally (i.e. to a particular

target or victim group) or internally, resulting in low self-esteem and poor relationship skills. However, in all cases participants traced the emotion back to the original event which they could not deal with.

It is interesting to note that what initiated three of these homicides was a comment, often innocuously made by the victim, which just happened to remind the offender of the event or conflict which he had been struggling with. In all cases, the conflict carried with it an intense degree of negative affect (i.e. hate and anger) which appeared to have been unleashed in full force upon the victim. In three cases there was evidence to suggest that the sexual element of the offence was planned, although not in any great detail and certainly not to the degree one would expect from a compulsive killer. Furthermore, in all cases there was evidence of 'over-kill', meaning that the injuries inflicted on the victim far exceeded what would have been necessary to cause death.

Our findings in relation to this theme are partially consistent with the literature on catathymia, and, in particular, the acute catathymic category of sexual homicide described by Schlesinger (2004, 2007). That is, trauma or conflict that has been present in an individual for many months or years becomes fused with intense levels of negative emotion as well as sex. The emotion is then released onto a victim with fatal consequences, although generally has the effect of alleviating the tension. We argue for only partial support because most of our cases contained features of both the catathymic (i.e. anger driven) and compulsive (i.e. sadistically driven) categories of offender.

3.4.4 Theme 4: Emotional loneliness

Emotional loneliness was the most consistent theme in our analysis. It was present in six of our cases. According to the psychological literature, there is little doubt that emotional loneliness is a key feature in the psychology of the sexual homicide offender. McKenzie

(1995) for example, found that over half of the 20 serial sexual homicide offenders he studied were socially isolated, and in a qualitative study by Milsom, Beech and Webster (2003) sexual homicide offenders reported feeling significantly more peer-group loneliness than did rapists in adolescence.

According to Marshall (1989), social isolation can be seen as a form of psychological suffering which can lead to violence. It has been a consistent feature in motivational models of sexual homicide. In the motivational model (Burgess et al., 1986), for example, emotional loneliness was perceived as the result of childhood victimization experiences and as a major precursor for the development of deviant fantasy. This pattern was observed in some of the homicide narratives in the present study, but not all. In some participants, an experience of isolation appeared to have existed since early childhood and in the absence of abuse.

In the absence of any objective developmental evidence, it is difficult to say in the present study why so many of our participants experienced emotional loneliness from such a young age. However, from the descriptions of their experiences, there did seem to be a relatively strong association with sexual victimization, and this is consistent with previous research on sexual homicide offenders (e.g. Burgess et al., 1986).

3.4.5 Linking themes together

We found evidence for the anger and sadistic pathways in our sample, but there was little indication to suggest that participants killed purely for instrumental reasons. This may have something to do with the fact that all of our participants were recruited from a mental health setting and therefore deemed not fully legally responsible for their crimes. It is reasonable to hypothesise that offenders who kill purely for instrumental reasons are more likely to be deemed fully responsible in the eyes of the law, as killing to destroy evidence clearly denotes some degree of rationality and consequential thinking, although this has not been investigated

empirically. More will be said about the possible impact of mental disorder on the offences of our participants below. Here, we make an attempt to link themes together in the hope of developing a more complete understanding of motivation.

Although there were several between-subject inconsistencies, the emergence of a sadistic motivation is captured in theme 1 of our analysis (Avenging sexual abuse). In most cases, extreme physical and sexual abuse suffered from an early age throughout childhood led to the development of emotional loneliness (theme 4). For this type of offender, loneliness led to a retreat into the child's internal world and the use of fantasy serving to regain a sense of mastery and control. As the child developed, fantasies became increasingly aggressive and an impulse to kill (theme 2) slowly emerged. This theme was particularly common in those with multiple victims. In such cases, the impulse did not seem connected to the offender's own deviant fantasy system as the literature would predict (e.g. Schlesinger, 2004; 2007), but more a feature of their intent to avenge, in some way, the sexual abuse/torture that they suffered in childhood. This pathway and the sequences which emerged in our analysis are highly consistent with previous motivational models of sexual homicide.

Offences that appeared consistent with the anger pathway were preceded by an event that led to a catathymic reaction (theme 3). In most cases, the event challenged the individual's sense of identity, including sexual identity, or transgressed how they believed others should behave (e.g. women should not sell their body for sex). In the anger pathway too, emotional loneliness (theme 4) emerged out of an inability to cope with intense negative emotion, but its effect on the individual was different to the sadist. Instead of the individual retreating into their own world and fantasising how they wanted things to be, the angry individual became detached from the rest of society and was generally thought of by others as 'odd'. Whether or not a homicidal impulse occurs in this type of offender may depend on how the catathymic reaction is processed. If the offender is aware of such emotions and

attributes a cause to their origin, then he may develop an impulse to kill. This could manifest in a specific target or group of targets in the case of the serial killer (e.g. prostitutes). If the individual is unaware of the catathymic dynamic then the trigger for the homicide will likely occur as a feature of the interaction between the offender and the victim; for example, the victim mentioning something which just happens to unleash pent-up negative emotion connected with the conflict. Diagrammatic representations of how themes might fit together are often referred to as "mind maps" in the technique of thematic analysis (Braun & Clarke, 2006). See figures 3.5 and 3.6 for the representations described above.

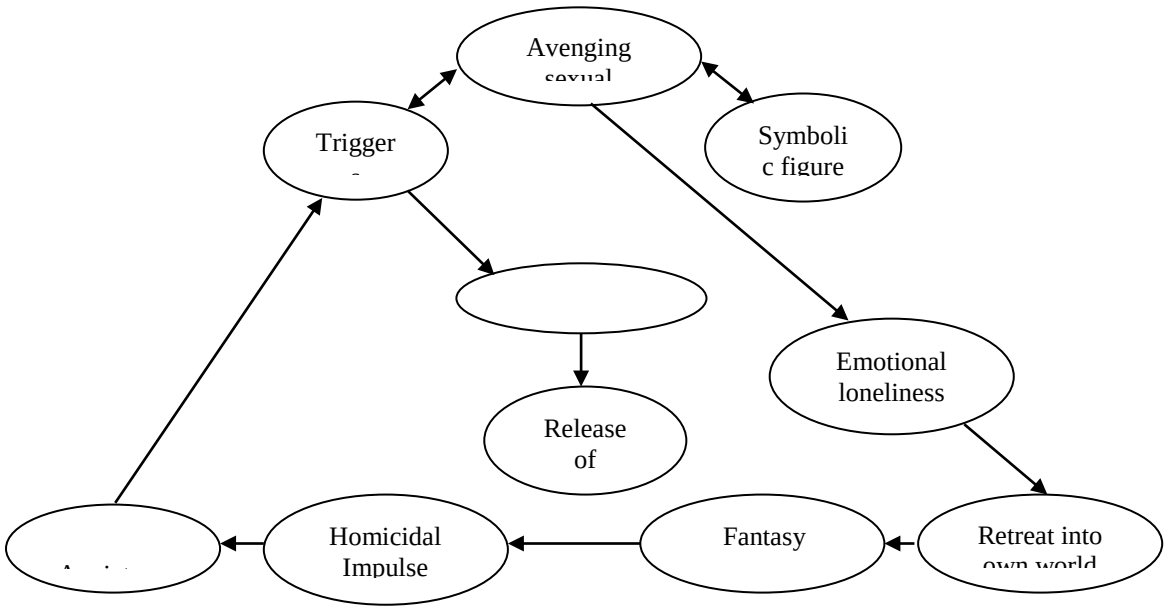


Figure 3.5: Sadistic pathway mind map

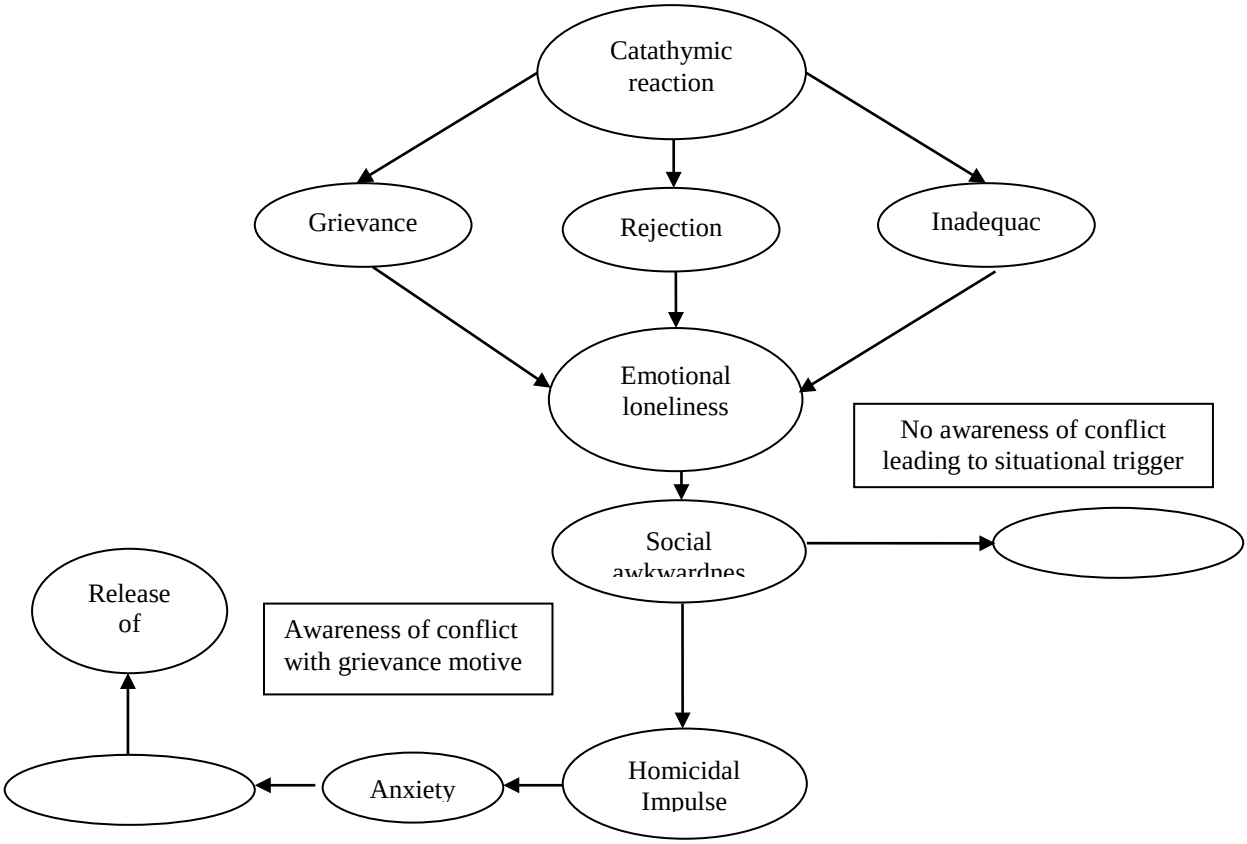


Figure 3.6: Anger pathway mind map

3.4.6 Impact of mental disorder

To what extent mental disorder had on the outcome of our participants' offences remains unclear. Four participants had a diagnosis of schizophrenia, which is quite rare in cases of sexual homicide (e.g., Firestone et al., 1998). Positive symptoms (i.e. command hallucinations) were thought to play a role in one serial case as the participant complained of hearing voices instructing him to kill shortly after his apprehension. There is some doubt, however, as to the veracity of his claim, as accounts of the participant's story have not been consistent. In other cases, mental illness appeared to play a minor role in the offences of our participants; perhaps acting as a disinhibitor to violence, rather than having any direct influence per se.

3.4.7 Limitations of the present study and suggestions for future research

A major weakness of this study concerned the small sample size used. In addition, the sample consisted of serial killers, single and double homicide perpetrators, and an individual who offended against male victims. Sexual homicide offenders are a rare breed of sex offender, and those with major mental disorders or personality disorders to the severity that their culpability for the offence is reduced, are even rarer. Therefore the generalisation of results to other groups of sexual offenders or indeed other groups of sexual homicide offenders is very limited.

Another weakness relates to the fact that not all participants allowed for their interviews to be tape-recorded. It is impossible to record exactly all of the words verbatim in a lengthy interview without the use of a tape-recorder. Thus, inevitably, some bias from the interviewer is likely to be present. In addition, the study was limited in confining its sample to a high security psychiatric hospital. Because all of our participants were found to be suffering with a mental disorder at the time of their crime, none were held fully legally responsible for their actions. Although previous studies have found that most sexual homicide offenders are not in fact mentally ill at the time of their offending, they do suggest that most suffer from some kind of personality pathology, even those deemed to be fully legally responsible. There have been no studies to date exploring the differences, if any, between psychiatric and non-psychiatric samples of sexual homicide offenders. If both samples are indeed found to be similar, then it would be interesting to learn what factors courts take into account when making decisions about culpability.

3.5 Conclusion

The results of this study indicate that the motivation which lies behind sexual homicide is far more complex than previous research suggests. Our study provides partial support for

motivational models of sexual homicide, as well as typological studies and the catathymic process described by Schlesinger and others (e.g. Schlesinger, 2004, 2007; Meloy, 2000). However, none of our participants were found to fall convincingly into one pathway or another. We argue that motivational models underestimate the power of the situation in cases of sexual homicide, and although sadism and anger are important antecedents to such crimes, they do not usually account for why a victim ends up being killed. Themes of sexual abuse and other traumatic events, as well as social isolation, and an impulse to kill are all important factors when attempting to understand why an individual ends up killing in sexual circumstances. They will not be present in all cases of sexual homicide, and how they fit together in the formulation of an offence will depend very much on the uniqueness of the offender and the interaction with his victim.

Chapter 4

Case Studies

4.1 Introduction: types of sexual homicide offender

What motivates an individual to commit sexual homicide is an important, though highly complex question, which science is only beginning to understand. Knowing why an individual has killed a particular victim in a certain way is critical in the context of risk assessment and crucial if any therapeutic intervention is to be effective. There have been a number of attempts to classify sexual homicide offenders based upon their apparent motivation for the offence. The literature seems to suggest three distinct types, although in reality most cases involve some degree of overlap. All three categories have attracted several different labels depending upon researcher preference. For the purposes of this chapter, however, they have been labelled: 1) sadistic fantasy-driven sexual homicide (SH) offender; 2) anger-driven sexual homicide (SH) offender; and 3) sexually-driven sexual homicide (SH) offender. Each type of sexual homicide offender is summarised below. For a more detailed review see Kerr, Beech and Murphy (2013) (Chapter 2).

4.1.1 Sadistic fantasy-driven SH offender

The sadistic fantasy-driven sexual homicide (SH) offender is driven to offend in response to sadism and sadistic sexual fantasy. Sometimes referred to as a ‘compulsive murderer’ (Revitch & Schlesinger, 1981) an ‘organised murderer’ (Ressler, Burgess & Douglas, 1988) or a ‘calculated pain infliction murderer’ (Beech, Fisher, Oliver, & Beckett, 2005), the sadistic fantasy-driven (SH) offender has an insatiable sexual drive characterised by a need to take control and cause pain and humiliation to a non-consenting person. Although a small number may kill directly in response to fantasy involving murder (i.e. erotophonophilia) the

majority of offenders seem to kill for multiple reasons and may not derive any extra pleasure from taking another person's life (Keppel & Walter, 1999; Kerr, Beech & Murphy, 2013). As Keppel and Walter (1999) write "the luxury of sadism is found in the art and process of killing, not the death" (p. 431). In this group of offenders, there is often a high level of sexual mutilation. Strangulation is often used as the method of killing and the victim is not usually known to the offender beforehand. The offender's behaviour can be considered ritualistic and interference with the victim's body after death often occurs. This type of offender is likely to move the body from the crime scene, perhaps in line with his fantasy, but also in an attempt to cover-up his crime. He is unlikely to confess his killing to the police.

4.1.2 Anger-driven SH offender

The anger-driven SH offender is driven to kill primarily by grievance and resentment towards women. Revitch and Schlesinger (1981) and later Meloy (2000) prefer the term 'catathymic murderer', Ressler et al., (1988) use the term 'disorganised murderer', Keppel and Walter (1999) opt for the term 'anger-retaliatory rape murderer', Clarke and Carter (1999) prefer the term 'aggressive dyscontrol murderer', Kocsis (1999) opts for 'fury murderer', whereas Beech et al., (2005) prefer 'grievance murderer'. In this group of offenders, the victim is most often known to the killer beforehand and selected on the basis of the killer's daily activities. The killing itself is characterised by high levels of emotional and expressive violence with evidence of 'overkill' (e.g. multiple stab wounds far in excess of what would be needed to kill). In a recent study by Radojević et al., (2013) a significant correlation was found between the number of stab wounds on a victim and a sexual motive for the killing. In 83% of cases that involved over 21 stab wounds, a sexual motive was ascribed to the offence, regardless of the victim's gender. It should be added, however, that this study did not adequately define the term 'sex-related homicide'. The authors chose to include motives such as "jealousy" and

"cheating" in their analysis, which probably would not conform to any of the definitions highlighted in the literature (see Kerr, Beech & Murphy, 2013).

Several authors have proposed that many offenders who fall into this category are over-controlled with regards to their temper (Grubin, 1994; Schlesinger, 2004; 2007). The killing is often preceded by the victim's words or actions which activate the offender's rage. Minimal restraint is used, and although postmortem sexual acts and mutilation may occur, it is less common than the sadistic-fantasy driven SH offender. There is most often a feeling of relief after the homicide and the corpse of the victim is usually left at the crime scene. This type of offender is more likely to confess his crime to the police.

4.1.3 Sexually-driven SH offender

The sexually-driven SH offender has only featured in a few typologies. Sometimes referred to as 'aggressive control murderer' (Clarke & Carter, 1999) or the 'motivation to sexually offend murderer' (Beech et al., 2005), the sexually-driven SH offender kills in order to either make sure his victim is not around to identify him after the offence, or his victim dies as a result of their injuries (perhaps due to frailty in the case of elderly victims). Therefore, in this type of offender, the killing of the victim is purely instrumental i.e. serving the function of eliminating the only witness to a sexual assault which was intended, or applying excessive force to control a vulnerable victim. According to Beech et al. (2005), in many ways the sexually-driven SH offender is very much like the archetypal sex offender in the sense that he believes he is entitled to have sex, experiences (non-sadistic) sexual fantasies which drive the offence, and plans the crime in some detail. In most situations, sexual offenders who take this course of action do not end up killing their victim, and for those that do there is very little evidence to suggest that such individuals are any different from non-homicidal rapists.

However, for those offenders who decide to kill in order to eliminate their only witness, it is reasonable to hypothesise that such people may exhibit an increased level of psychopathy.

4.1.4 Motivational models of sexual homicide

There have been at least three motivational models developed independently by researchers to account for the motivation behind sexual homicide (Arrigo & Purcell, 2001; Burgess, Hartmann, Ressler, Douglas & McCormack, 1986; Hickey, 1997, 2002). These models provide a general framework for understanding why an individual may become a sexual homicide offender with an integration of biological, psychological and sociological theories (see section 3.1.2 on page 36 for more details about the models).

4.1.5 Case studies

Three case studies are presented below. The first two were taken from extensive interviews that the author conducted with mentally disordered offenders detained within a high security hospital. The first presents the case of Mr. J; a young man whose offence broadly matches the description highlighted above of the anger-driven SH offender. The case of Mr. R is presented next. Mr. R's offence broadly matches the description of the sadistic fantasy-driven SH offender. The final study is taken from an interview that took place as part of the STEP 4 project. It describes an individual whose offence broadly matches the description of the sexually-driven SH offender. Each case study is followed by a formulation of the offence. Each formulation includes key developmental trajectories which create vulnerability in the individual to commit homicide. Based upon cognitive behavioural principles, the formulations indentify core beliefs as well as significant consequences of those beliefs in terms of understanding the homicide. External factors are considered separately but linked to internal drive in an attempt to produce a more complete understanding of the offence. It is

interesting to note that no offender in the mental health sample from which this research was taken (N = 10) broadly matched the description of the sexually-driven SH offender. Possible reasons why this might be the case are explored in Chapter 5. At the end of this chapter, consideration is given to possible evidence-based treatment approaches for the three types of sexual homicide offender explored in detail. All three participants have provided their informed consent for their cases to be used.

4.2 The case of Mr. J

(An Anger-Driven SH Offender)

4.2.1 Summary

At the time of assessment Mr. J was 24 years old. He had committed his index offence of manslaughter 18 months previously with a suspected sexual element. Although there was no evidence of any overt sexual assault, both he and his 25-year-old female victim were found naked in the victim's house by investigating officers. He was admitted to an accident and emergency department immediately following the killing having sustained multiple stab wounds which he inflicted upon himself as the police came to investigate. From there he was admitted to a high secure hospital. At his trial he was found guilty of manslaughter on grounds of diminished responsibility and placed on a criminal section (37) of the Mental Health Act (1983). What follows is a brief background of Mr. J's psychosexual and personality development along with an account of circumstances that led up to the homicide. A forensic clinical case formulation is then presented using all evidence available. It provides an opinion as to whether the homicide committed by Mr. J could be labelled as 'anger-driven' in its motive. Certain names and details have been altered for reasons of confidentiality.

4.2.2 General background

Mr. J is the eldest of four siblings. His Mother looked after the family home and his father worked as a school teacher. According to Mr. J he had a reasonably happy childhood. He described his mother as "loving" and his father as "strict but fair, most of the time". He attended a private secondary school and achieved an excellent academic record. He said that he thought of himself, as did his family, as "gifted" intellectually and was always destined to achieve great success. He remarked that there was great pressure from his family to be the best he could possibly be. His grades at school eventually helped him to secure a place at a

prestigious University where he began a course in English Literature before he committed his index offence.

4.2.3 Personality and psychosexual development

Mr. J said that his first sexual experience occurred at boarding school when he was aged fifteen. He said that he had no recollection of who initiated the idea, but he agreed to perform oral sex on a boy around his age in the school toilets. He remembered it happening on a mid-week afternoon when the building was mostly empty after the two of them had been reading pornographic magazines. He described the experience as "kind of cool and exciting", but said that he never masturbated to any thoughts about it later. He repeated the activity some months later with the same boy and soon after this Mr. J noticed "an epidemic [of fellatio] in his boarding house".

At the age of sixteen, Mr. J committed a sexual assault on a younger boy for which he was never charged; however, he was asked to leave the boarding house. He reported that he became very drunk one evening and decided to place a boy's penis inside his mouth as the boy lay asleep in bed. He said that he believed the boy was homosexual because he behaved in a very "camp" manner and was sure that he would enjoy the experience. The boy awoke during the act and filed a complaint with the school authorities. Mr. J believed that he would have been expelled from the school if his father had not been a master there. Instead, Mr. J became a "day boy", which means that he lived at home with his parents. He said that this was a very unusual circumstance to occur but it allowed him to explore nightclubs and bars in the evenings. He believed that he "got off lightly".

Later in that same academic year Mr. J met his first girlfriend, Donna, in a nightclub. Initially he said that he was interested in Donna's friend, as she was "slim and very beautiful", but since she was displaying little interest in him, he "made do" with Donna. Mr. J

described Donna as “fat” and having a low opinion of herself. The two of them kissed and exchanged telephone numbers and after four weeks of dating they engaged in full penetrative sex. He described feeling like a “cool guy” after having sex for the first time but after just three months their relationship came to a close. Mr. J said that it was Donna who chose to end the relationship and he never really understood why. After several failed attempts to rekindle their relationship, Mr. J described feeling “deeply depressed”.

The depression continued until Mr. J met Phoebe. They met at a friend’s birthday party. Mr. J had little confidence at this point with other people so it was Phoebe who made the initial contact. They began talking and exchanged telephone numbers. Mr. J described Phoebe as “very attractive” and that she had even done some modelling whilst at college. During one evening in Phoebe’s apartment Mr. J decided to make sexual advances towards her. He said that he removed her hair clips and suggested they “go to bed”. However, at no point during this encounter was Mr. J able to become erect. He described talking to himself in the adjacent bathroom mirror for over twenty minutes, willing himself to become erect and have intercourse with his girlfriend, but to no avail. He said that he lay awake most of the night wondering why he could not have sex with a girl whom he found very attractive, but came up with no answers. Mr. J said that Phoebe asked him to leave her apartment the following morning and said that she phoned him that same day to say that she didn’t want to continue dating him. Mr. J asked Phoebe if her reason for breaking up with him had anything to do with the fact that he failed to become erect; she said that it wasn’t, but Mr. J was convinced that it was. Interestingly, Mr. J did not describe feeling depressed after the breakup; instead he described feeling very angry. The anger was directed towards himself as he began feeling that there was “something wrong” with him. He gradually became more uncomfortable with his body image and made an effort to go to a gym to become bigger and stronger; however, he did not persist with this.

Mr. J completed his secondary schooling and achieved excellent grades, though perhaps not as good as his parents would have liked. An unsuccessful attempt in his application to University to read English meant that he needed to wait another year before he could apply again. During this year out from study, Mr. J worked at a summer school where he met several girls whom he described as either “fat” or “dumpy”. He had brief relationships with at least two of these girls and was able to have full penetrative sex with both. He described feeling “in love” with one girl but was uncertain if this feeling was reciprocated. He made an effort to share his feelings, but felt punished as both girls ended their relationship with him after only a few months of dating. Again, Mr. J was left feeling devastated and wondering why.

Towards the middle of the following year, with Mr. J now aged 19, a second application to University was made. This time he was successful and he began his course in the autumn of that year. Although he described achieving a place at University as very special and important to him, he found the beginning of his course very difficult. He found it impossible to concentrate and at one point he remembered “collapsing through misery” because he was hiding so much “emotional baggage” from the failed relationships of recent. At this point Mr. J described himself as “withdrawn and emotionally distant from others”.

Mr. J managed to pass his first year exams and gained entry into the second year of his course, but by this time he described feeling “deeply depressed”. He began “hanging out” with a group of friends who consumed drugs. It was not long before Mr. J was also taking drugs. These included cannabis, amphetamines and cocaine. During the summer he began dating Catherine who was part of his new circle of friends. He said that he found Catherine very attractive but throughout their short time together he had difficulties maintaining an erection. However, on one evening during another attempt to have intercourse, Mr. J became very aroused and had the idea of penetrating Catherine’s anus. He said that he got this idea

from reading various websites depicting sadomasochistic sexual practices. Another idea he wanted to try was to tie a partner up. According to Mr. J, Catherine consented to being blindfolded and being tied to the bed with a belt, but she did not consent to anal intercourse. She began screaming as Mr. J penetrated her from behind and Mr. J immediately untied her. After this incident, Catherine decided not to date Mr. J again but did not file any charges. The relationship lasted only a few months and, again, Mr. J described feeling "devastated".

Throughout the second year at University, Mr. J's mental state continued to decline. He was consuming large quantities of alcohol at this stage as well as illicit substances. He described his mind as being in "chaos". He described feeling "jinxed" because he had only managed to have sex with "overweight women", whom he did not like. He dreamed of having the "perfect relationship" where he could be the breadwinner and support his partner. The two of them would live in an idyllic home in the country, have children and be happy. However, Mr. J said that he began feeling more and more ineffectual at talking with women he found attractive. He did not have the confidence and came across as "weird". His typical way of "chatting up" girls would be to "show off with a piece of acting" from a play that he was familiar with and hope that she would recognise his "talent". This strategy never seemed to work however, and his attempts to be funny "like the comedians off the TV" were not well received.

Not having any success with girls of a similar age, Mr. J then decided to go to a massage parlour for sex. After paying his money he was "shown to a room where a large black woman was waiting". She attempted to perform oral sex on Mr. J but he was not able to become erect. They ended up talking about a character from a TV show for the rest of the time. Mr. J remembered this to be incredibly upsetting for him. He said that he was very sexually frustrated at the time and that he "needed sex", even though he did not find the sex worker very attractive. He said that he cried all the way home. Later in that same year Mr. J

also attempted to have oral sex with one of his male friends with whom he took drugs. Again however, Mr. J was unable to become erect.

4.2.4 Emotional turmoil and delusional thinking

Mr. J's mental state probably began to deteriorate long before he began his course at university and long before he began taking illicit substances and consuming alcohol. In one interview Mr. J described being in a state of "emotional turmoil" which he thought was particularly evident during the twelve months before the index offence. He acknowledged that consuming illegal substances as well as alcohol was probably a means of self-medicating against this turmoil.

Although psychosis was not a direct feature of his index offence, Mr. J described some psychotic beliefs in the year leading up to the homicide. Interestingly, he described one set of beliefs involving cats. Not being able to correctly read or understand emotions in others, Mr. J came to believe that cats had the power to mimic the emotions of women. This could be, for example, witnessing a display of affection in a cat which would indicate to him that a certain girl was experiencing that same emotion at that same time. In addition, he also believed that he had special powers because of his "high level of intellect", and that he was in-training to become a government agent like James Bond. These beliefs lasted for several months and were probably a consequence of consuming large amounts of hallucinogenic drugs at the time. Mr. J said that he found these beliefs unsettling and that they dissipated once he stopped consuming drugs.

However, during his second year at university, Mr. J's mental health deteriorated further. He became increasingly withdrawn and restricted in his affect. Both his family and his tutors at University became very concerned. He was advised by the Dean to take a year out of study in order to recuperate, but Mr. J objected strongly to this and convinced the

department authorities to allow him to continue. He attended an appointment with his GP who placed him on antidepressant medication. However, he discontinued his use because he believed the drug was having a further detrimental effect on his ability to become erect.

About six months before the index offence, Mr. J described another belief that reached delusional proportion. He described an urge to kill one of his male friends. This was the same friend with whom he had taken drugs and had attempted to have sexual relations with. In interview, he described his friend as successful, charming, and very confident with women. He said that he admired him and longed to be like him. In interview Mr. J could not explain why he wanted to kill his friend, but he described two disorganised attempts to do so. On one occasion he went round to his friend's house with a knife but could not pick the lock, so he decided to go home. It did not occur to him to knock on the door or gain access to the house in any other way. On another occasion he went round to his house with a chainsaw, but seeing his friend's father in the vicinity he decided not to go ahead with the plan because he "would also have to kill [his] friend's father as well".

4.2.5 Mr. J's account of the index offence

After failing all of his examinations of the second year of study, Mr. J was forced to re-sit assessments before being accepted into the final year. These were scheduled to take place in around mid-September. Mr. J described feeling an incredible amount of pressure at this time. He did not have the concentration necessary to prepare for the re-sits and he had become completely detached from the rest of society, spending all of his time in his bed room playing video games, watching movies and fantasising.

One of his fantasies involved a young female, Lynda, aged around 25 who lived in the same street as he. Despite living very close to each other, Mr. J said that he never really knew Lynda. He described her as "very attractive, but reclusive". As Lynda was a fashion student,

Mr. J imagined that she spent the majority of her time in her room working on her designs. The only contact that Mr. J had with Lynda was the occasional opportunity to say "hello" when passing. However, Mr. J described a detailed and elaborate fantasy involving Lynda. In the fantasy, Mr. J was perceived as a "hero" who "rescued" Lynda from "the boredom and monotony of her reclusive existence". The two of them would elope to a big city where Mr. J would work for a successful internet company and Lynda would be successful in running her own fashion business. It became apparent in interview that there were no features of sadism or any coercive sexual practices in Mr. J's fantasies of Lynda. The relationship within the fantasy was described as "perfect".

The homicide occurred only a few days before Mr. J was due to re-sit his exams. On the night in question, Mr. J decided to take round to Lynda's house a kitten from a litter that his family cat had recently given birth to. According to Mr. J, he no longer believed that cats had the power to mimic the emotions of women, but he believed the kitten to be the perfect gift and an ideal way to initiate a relationship with the girl of his dreams. However, Lynda politely refused the gift, stating that "he [the kitten] was cute", but her parents (who were out at this point) probably would not allow it in their home. According to Mr. J, Lynda's refusal of the kitten did not anger or infuriate him, but he was able to use the situation to enter her house by "talking [his] way in". He remembered exploring the family home for a short while before being asked to leave. He did not remember exactly what was said at this point, but he did recall Lynda persistently referring to him as Robert (Mr. J's younger brother).

Mr. J refused to leave when asked, and after a while the two of them ended up in the kitchen area. Mr. J said that he decided to "make a move" on Lynda by kissing her. He said that "because she did not resist too much, [he thought] she was enjoying it". Mr. J then proceeded to remove his clothes as well as Lynda's. Any struggling from Lynda at this point was interpreted by Mr. J as Lynda enjoying the experience. Mr. J's intention was to have

penetrative sex with Lynda, but at no point during the encounter was he able to become erect. He reported feeling intensely angry about this. Meanwhile, realising that Mr. J intended to rape her, Lynda became increasingly worried for her safety and made a comment to the effect of “stop hesitating – get it over with and just do it”. According to Mr. J, Lynda’s comment infuriated him. He took a bread knife out of the dish washer nearby and began stabbing her.

Once he realised that Lynda was dead, Mr. J said that he then made an attempt to “get rid of the body”. He believed that a near-by lake was the best opportunity for disposal and began looking for something to dissect the body. He managed to find a saw and a pair of secateurs from the garage. He made an attempt to saw the body in half and attempted to cut the fingers off with the secateurs. However, this proved much more difficult than he bargained for so he chose a different option; taking his own life. He found some paracetemol, which he took, but shortly after the police arrived. A neighbour had phoned for the police as she heard screaming from next door. Although the neighbour could not see clearly what was going on through the kitchen windows, she did notice “a naked man walking around with his groin area soaked with blood”. In her witness statement she described it as “like seeing someone go through their period”. As soon as Mr. J saw the first police officer peer through the kitchen window he began stabbing himself in the chest with the same knife he used to kill Lynda. The next thing that Mr. J remembered was waking up in a local accident and emergency department.

Evidence contained in the depositions of the offence seem to indicate that Mr. J may have attempted to have sex with the victim post mortem due to the amount of blood that was located across his groin area. Mr. J denied this in interview. Mr. J recounted the index offence in a very cold and detached manner. At one point he said that “it didn’t feel real...as if it had happened to somebody else”. He said that he felt “terribly guilty” for taking someone’s life but he was not able to empathise with the victim. He said that he felt “dead inside”.

4.2.6 Forensic case formulation

A forensic case formulation of Mr. J's homicide revealed several predisposing factors. Firstly, he had a very strict background with an incredible amount of pressure placed upon him to achieve academically. Immersing himself in academia prevented Mr. J from establishing a healthy social network with people his own age. Enmeshed in a world of fantasy filled with ideas of perfection and omnipotence, Mr. J spent the majority of his time alone, dreaming of the perfect partner. In his later adolescent years, this pattern of behaviour contributed to the development of a borderline and narcissistic personality style. Others began to see him as strange and socially awkward. He was never accepted into a peer group of his choice and he struggled to find a sense of identity he was comfortable with.

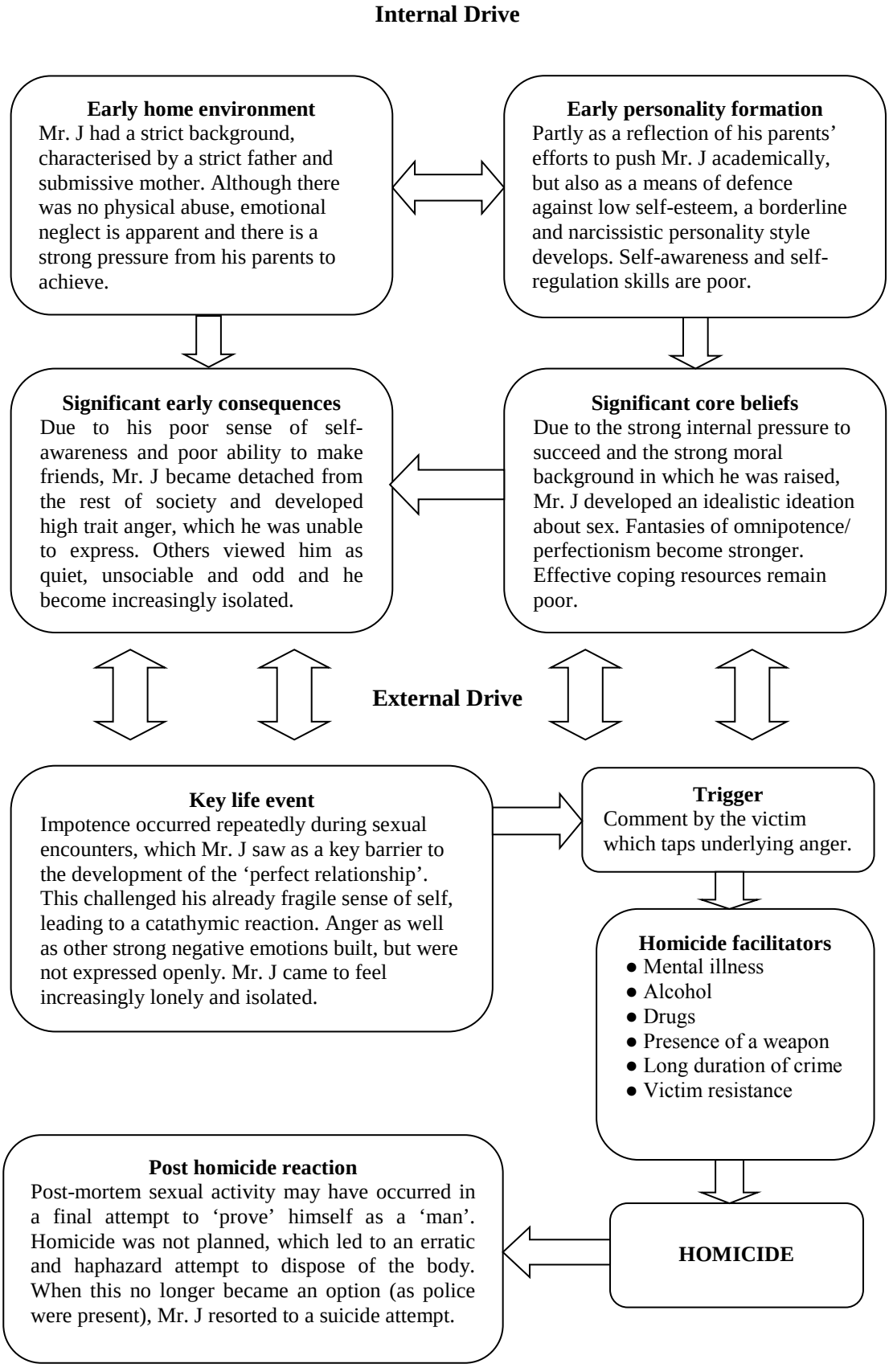
Mr. J described an intense feeling of rage at the time of the index offence which was released when the victim told him to "get on with it" (presumably meaning the rape). He talked about an intense affect that had been building in him for several years ever since the episode of erectile dysfunction with his first girlfriend. This feeling was compounded by several similar experiences. He described the anger as being directed towards himself rather than anybody else, due to a persistent feeling of sexual inadequacy, particularly with women he found very attractive. He said that he found it very difficult to express his emotions, especially anger, and results from the STAXI II supported this, indicating that he was significantly over-controlled with regards temper.

Mr. J did not describe any sadistic fantasies at any point before the homicide, and a recent penile plethysmograph assessment supports the contention that he was not sadistic. Looking at pornographic material on the internet had "given [him] the idea of tying a woman up". He tried this during a sexual encounter with one partner, but when he noticed her discomfort, he quickly released her. In interview, Mr. J spoke of very rich idealistic fantasies

involving the perfect partner and perfect relationship. His sense of entitlement and superior self-image left him feeling “jinxed” that he was not able to find his dream.

The homicide occurred just weeks before Mr. J was due to re-sit his examinations for year two of his course, and having completed no revision or reading for these he was likely to be feeling very distressed indeed. It is unlikely that substances played any direct role in the commission of Mr. J’s violence as he had not taken any substances for three months prior to the index offence. However, substances may have played an indirect role in contributing to the development of an emerging psychosis which impacted on Mr. J’s ability to organise his thinking. Similarly, it is difficult to say to what extent the psychosis impacted on the course of events leading up to the homicide. Mr. J did not describe any psychotic beliefs relating to the victim before the attack and he was not suffering from any command auditory hallucinations instructing him to rape or kill. Thus, it is likely that the psychosis resulting in a disorganisation of his thinking acted as a disinhibitor to violence rather than playing a direct cause (see Figure 4.1).

Figure 4.1: Diagrammatic Formulation of Mr. J's Offence



4.3 The case of Mr. R

(A Sadistic Fantasy-Driven SH Offender)

4.3.1 Summary

At the time of assessment, Mr. R was 43 years of age. He committed his index offence of double manslaughter in August 1994, aged 29. Mr. R is homosexual and killed two men who he invited back to his flat after a night of drinking at a local gay bar. The first victim was a 44 year-old-man named John. He was described by his landlord as "a very quiet man who kept himself to himself and caused no trouble in the house". The second victim was 28 years old and named James; he lived with his partner, Martin. He was described by Martin as a "friendly, non-violent man, who was rather extravert". Both victims were strangers to Mr. R and strangers to each other before the night of the homicides. After having sex with both victims, Mr. R killed both men within succession of each other in the living room of his flat and positioned their bodies in line with fantasies which dominated his life. At his trial he was found guilty of manslaughter on grounds of diminished responsibility and placed on a criminal section (37) of the Mental Health Act (1983). He currently resides in one of the UK's high security hospitals. What follows is a brief background of Mr. R's psychosexual history and personality development along with an account of circumstances that led up to the homicide**s**. A forensic case formulation is then presented using all clinical and forensic evidence available. Certain names and details have been altered for reasons of confidentiality.

4.3.2 General background

Mr. R described his upbringing as "traumatic". Both he and his elder half-brother were abandoned by their mother from a very early age. Mr. R went to live with a foster family when he was aged 4, and his older brother, aged 6, lived in a children's home. Mr. R never saw his natural mother again after being placed with his foster family and has never met his

natural father. He had irregular contact with his brother who, at the time of writing, is serving a prison sentence. He currently resides in one of the UK's high security prisons after having been convicted of street robbery and murder.

Mr. R suffered physical, sexual and emotional abuse at the hands of his foster family. His foster family were an older couple in their fifties, who reportedly could not have children of their own. The main perpetrator of the abuse was his foster father. He forced Mr. R from a very early age (around seven) into having sex with him. In interview, Mr. R described his foster father as "sadistic"; he would often punish Mr. R for no reason by locking him in a dark cupboard for long periods of time. In order to deal with the trauma, Mr. R said that he would often allow his mind to "wander into a better place", for example, being on holiday in Bournemouth under a warm sun. According to Mr. R, his foster mother was aware of the abuse, but did nothing to prevent it. As Mr. R grew older he said that the beatings from his step father became much worse and he would often attend school with black eyes and bruising all over his body. He defended his foster father as a child by explaining his injuries to teachers and friends as being the result of getting into fights with other children. At the age of 13, Mr. R ran away from home. He was later taken into care and spent the rest of his youth in a children's home. He never saw his foster family again, and they were never prosecuted for the abuse of Mr. R.

4.3.3 Personality and psychosexual development

Mr. R left school at the age of 16 without achieving any formal qualifications. He described his school years as "difficult" and recalled being expelled a number of times after fighting with other children. Mr. R denied being the instigator in any of his fights. He described being rebellious at school, refusing to comply with requests from teachers and feeling that he "did not fit in with the other children".

In interview, Mr. R said that he realised that he was homosexual from around 13 years of age. His first sexual encounter was with another boy at the children's home. This was with an older boy of around 16 years of age who forced Mr. R into performing oral sex on him. Mr. R said that such practice was a regular occurrence at the home. Older boys would bully younger boys and some of the bullying would be of a sexual nature. According to Mr. R, the carers at the home knew what was going on but did nothing to prevent it from happening. Mr. R said that as he grew bigger and stronger he followed the pattern of bullying boys who were younger than he. He would force boys as young as 9 into sexual activity. He said that he would threaten and intimidate them into performing the practices he enjoyed.

Throughout his adolescence, Mr. R appeared to have developed an appetite for aggressive forms of sex. He said that he enjoyed "experimenting" and preferred to play the dominant role with partners. He said that he preferred older partners and "making them do what [he] wanted them to do". If they resisted then this only served to further Mr. R's excitement. In a police report it is stated that Mr. R "was very overt and aggressive in respect of his homosexuality. He shaved his head and had favoured clothing of Doctor Martin boots, army-style camouflage trousers, and a string vest or T-shirt". In interview, Mr. R said that this was his preferred attire. Although he acknowledged feeling comfortable with his sexuality, his intention was to portray a "tough guy image" and "someone not to be messed with". Mr. R also developed a taste for alcohol during his adolescent years. He said that he could consume up to three bottles of vodka in one drinking session. According to Mr. R this helped him to "drown" the pain of the abuse he suffered in childhood. In his late teen years he began to experiment with illegal drugs (cannabis, ecstasy, magic mushrooms and cocaine).

In his early to mid-twenties Mr. R described two long-term relationships with male partners, each lasting over a period of three years. In a police report it is stated that "both relationships were epitomised by Mr. R becoming jealous, possessive, and ultimately violent

towards his partners". In interview, Mr. R said that he was faithful to both partners, but depositions of witness statements suggest that he was sexually promiscuous. Mr. R talked of one relationship with a partner named Dave whom he "loved very much". From his account of the relationship it seemed apparent that Mr. R was very much attached to this man in a preoccupied sense and when the partner finally left him for another man, Mr. R felt "devastated". He spent much effort attempting to rekindle the relationship to no avail, and at some point later he decided to change his surname by deed poll to match that of his former partner.

Mr. R has spent most of his life unemployed. However, he had a few short-term jobs; mainly factory work. His most recent job before the index offence was as a care assistant in an AIDS hospice. Mr. R said that he enjoyed this job. He said that it was interesting to see how the disease progressed in victims. Despite this experience and witnessing many sufferers die in the hospice, Mr. R chose not to practice safe-sex. He said that, at the time, he felt "immune" to the illness as he selected his partners very carefully. Mr. R was relieved of his duties at the hospice as he was persistently late for his shifts.

In addition to the double manslaughter for which he received a hospital order, Mr. R has been convicted of numerous other offences. These include a string of acquisitive offences in his late teen years and early 20s, several incidents of credit card fraud, possession of illegal substances, and actual bodily harm. These offences were dealt with by the criminal justice system by a series of fines and, in the case of the ABH, community service. Interestingly, Mr. R has never been charged with a sexual offence, despite a number of former partners claiming to have been raped by him. This information only became known after the index offence as various witnesses who knew Mr. R were interviewed. None of Mr. R's former sexual partners ever filed charges against him.

4.3.4 Deviant fantasies

In interview, Mr. R revealed a very fertile and imaginative fantasy life. Fantasy was very important for Mr. R. He had used fantasy initially as a means of coping with the trauma of the abuse he suffered as a child. However, as he grew older, his fantasies became more aggressive with elements of revenge (mostly against his step-father) and gratuitous forms of violence. As Mr. R reached adolescence, his fantasies became sexual. He began to try out some of his fantasies on the younger boys in the children's home. Mr. R described his initial experiences as "exciting", and being in control of someone more vulnerable than he provided a powerful sexual return. His aggressive fantasy life, now fused with his developing sexuality, became increasingly violent. By his late teens/early twenties, his fantasies involved sadism, torture and degradation of male partners.

In February 1994 (6 months prior to the index offence) Mr. R contacted a homosexual magazine and offered to supply them with stories of his fantasies. One of these fantasies involved asphyxiating a victim in a bath tub and bringing him close to death. Mr. R described this fantasy as involving an "intense feeling of being in absolute control over another human being". In interview, Mr. R said that he was unsure as to where the idea about the bath tub came from. However, he said that he used to read a lot of aggressive forms of pornography and so the idea likely came from this. He described this particular fantasy as being one of his favourites. It is important to add that none of Mr. R's fantasies were ever accepted for publication.

One former lover spoke about Mr. R's preference for 'S & M' and bondage. Such actions involved handcuffing of sexual partners to radiators and water pipes around his flat and inflicting sadistic and gratuitous forms of violence. Police photographs of Mr. R's bedroom revealed a leather body harness with a penis ring, studded leather belts, a nipple torturer, and numerous pairs of handcuffs. Another former lover and witness for the

prosecution spoke about Mr. R's preference for locking his partners in a cupboard. This particular fantasy involved keeping a partner as a "slave" with a neck collar and leash attached. When police searched Mr. R's flat they also found a number of books, magazines and videos depicting various acts of sadistic sexual violence. In one book entitled "Hold Tight", a passage describing the tightening of a neck tie around a man's neck was book marked.

4.3.5 Mr. R's account of the index offence

Mr. R was single and unemployed at the time of the index offence. In interview he reported a significant history of illicit drug taking and chronic alcohol abuse. He said that he drank on a daily basis often to the point where he would become unconscious. On the day of the index offence, Mr. R spent all afternoon and early evening at his local public house. He said that he had drunk 15 pints of beer together with some spirits from 12 noon to 7pm and that he was "pissed...absolutely and utterly pissed". On the night before he said that he had taken a cocktail of drugs, including cannabis, ecstasy and cocaine but, according to Mr. R, such drugs did not make him violent towards others. From the pub he decided to go home, take a shower and change his clothes. He decided to contact his former partner Dave to "hang out" at a local gay night club. Mr. R had made several attempts to rekindle his relationship with this man whom he said he loved very much. However, as was the case previously, Dave rejected his advances. This made Mr. R very angry. He returned to the pub where he continued drinking until closing-time, which was 11pm. Mr. R then decided to go to the gay club alone, which was a short walk from his local pub. Mr. R was seen in the bar performing oral sex on one man and engaged in a "passionate embrace" with another. He met both victims in the club and invited them round to his flat for sex.

Once at his flat, Mr. R said that he engaged both of his victims in oral sex and convinced his younger victim, James, to wear handcuffs. In the police report it was highlighted that both the victims' wrists were severely bruised, "which would not have occurred unless the handcuffs had been applied with excessive force". Mr. R said that he then had anal intercourse with his older victim, John. Mr. R said that John resisted the intercourse as he "was not man enough to take it". The post-mortem report revealed that John had blood around his anus, emanating from splits in the lining of the anal canal. Mr. R perceived his victim's pain as pleasurable as he felt in total control. At this point, Mr. R described feeling "out of it", meaning that he was very intoxicated after consuming copious amounts of alcohol throughout the day. Mr. R said that after he had ejaculated he placed John in a "head-lock in order to scare him". In interview he boasted of how strong he was at the time due to attending his local gym regularly. Mr. R said that he was uncertain as to how long he had his victim in a head-lock but he remembered that he put up a violent struggle. He said that he did not intend to kill him. The post-mortem report revealed that John had two deep lacerations on his forehead and cuts and grazes over his body.

Mr. R said that he had very little memory of killing his second victim, James. The post-mortem report also suggests that James died from compression of the neck. There was a bruise to his right lower jaw and some haemorrhaging around the eyes and forehead. Mr. R said that once he had killed the second victim he panicked and fled the scene. He booked into a bed & breakfast and stayed there for two days before the police discovered his location. Mr. R said that he was not thinking clearly at the time and was considering turning himself in to the police. Hearing the noise in Mr. R's flat a neighbour called the police. Interestingly, when the flat was searched, the police found the first victim, John, naked in the bath tub, and the second victim, James, in a cupboard. Mr. R said that he did not remember placing either victim in these locations; however, it is probably no coincidence that these elements featured

strongly in Mr. R's fantasies. Mr. R said that he did not intend to kill either victim and did not derive any pleasure from the act of taking another person's life.

It is fair to say that when questioned by the police, Mr. R was not fully co-operative. Although he may have been telling the truth when he claimed to have experienced lapses in memory for certain events, this may not be the case. In an interview for the present study, Mr. R said that he "always knew that [he] would end up killing someone". He described what appeared to be an impulse to kill, but, according to him, this was not in line with his sexual fantasies. Despite there being clear links between Mr R's sadistic fantasies and the manner in which he killed his victims, Mr. R said that he derived no pleasure from actually killing them. He said that he "panicked and left the flat in a hurry" making no attempts to dispose of the bodies. Although he chose not to inform the police, Mr. R said that he was convinced that one of his neighbours would have done this for him and that he would eventually be caught.

It is very difficult to discern whether or not Mr. R was telling the truth during his account of the homicides. However, at the time of writing this study, he had been informed by consecutive home secretaries that he would never leave the confines of high security. Therefore, it is difficult to see what value lying would serve for Mr. R given that he was unlikely to ever leave institutional care.

4.3.6 Forensic case formulation

There are several predisposing factors in Mr. R's history which contribute to an understanding of his violence. Firstly, the separation from his natural mother at an early age left Mr. R feeling confused and guilty as to why she walked out on both him and his older brother. The reason for her leaving was never explained to Mr. R. Secondly, the abuse which then occurred in the foster home is significant. The abuse was chronic, violent and of a sexually sadistic nature. Not only was Mr. R traumatised by his experiences, but the manner

in which he dealt with the aftermath is important. Mr. R described using fantasy to cope with such trauma by allowing his mind to "wander to a better place". Throughout his later childhood, fantasies became more aggressive, with elements of revenge. Abuse continued in the children's home with Mr. R being sexually violated by at least one of the older boys on a repeated basis. With the onset of adolescence Mr. R's fantasy life began to incorporate more sexual themes. His developing sexuality became fused with the aggression that already dominated his internal world. Fantasies of control and dominance become reinforced with behavioural try outs on victims whilst still at the children's home.

Throughout his teen years and early twenties, Mr. R became increasingly rebellious in his attitude towards others and society in general. His chronic sense of abandonment from his natural parents left him with a tendency to develop strong, pre-occupied, attachments with partners whom he abused and behaved aggressively towards in response to his fantasies. Mr. R's lack of success in establishing an intimate relationship added to his sense of feeling increasingly isolated from the rest of society. Again, he turned to fantasy as a means of coping with this. This only served to strengthen and reinforce them. At one point they provided him with such self-esteem and such pleasure, that he wanted to share them with others by attempting to publish them in a magazine.

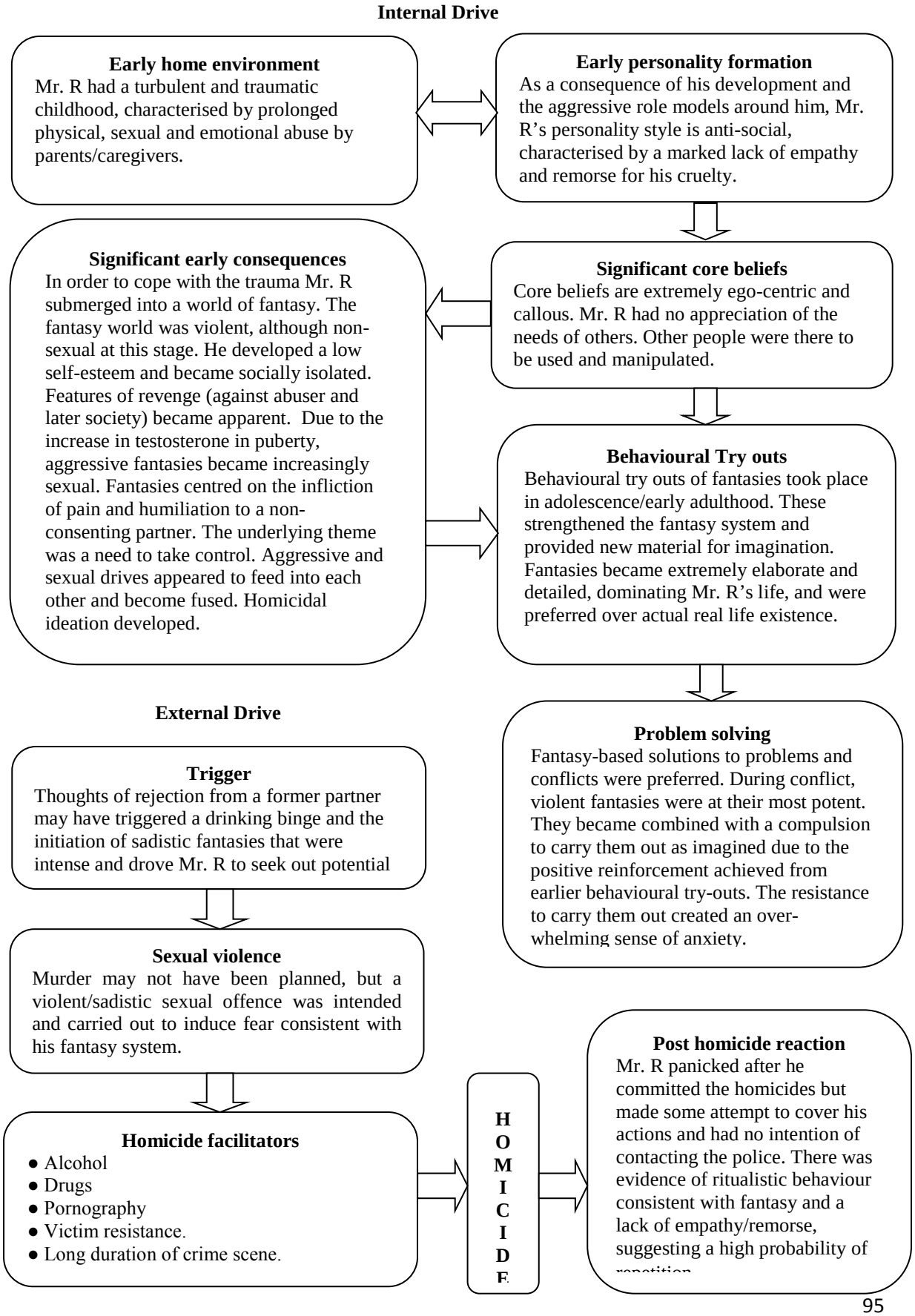
It is unclear at what age Mr. R developed an impulse to kill. In interview he found this difficult to describe but said that he had always had a feeling that one day he would end up killing someone. According to Mr. R, the impulse did not carry with it any sexual feeling and it was not directed at anyone in particular. It is likely the case that a drive to kill emerged very early in Mr. R's life within the context of revenge fantasies, first against his step-father, and then against society in general.

Mr. R's full-scale PCL-R score was 34, which is indicative of severe psychopathy. On a more symptom-specific level, he presented in interview as superficially charming,

grandiose, manipulative and possessed very little empathy or remorse for his victims. Further confirmation of this could be found in his clinical profile on the MCMI III. He produced clinically elevated scores on the Antisocial, Sadistic, Borderline and Histrionic personality disorder sub-scales. In addition, a penile plethysmograph confirmed a very strong sexual drive with arousal to non-consenting and sadistic scenes involving male homosexual activities.

It is clearly the case that the index offence of double manslaughter occurred within a sexual context. According to Mr. R, the index offence was not planned, but committed within the context of him wanting to scare the first victim. However, after he had killed him Mr. R said that he panicked and killed the second victim soon after. It is very difficult to be certain what actually happened on the night of the homicides. Mr. R complained of lapses in memory with regards to any other possible immediate antecedents and could not explain why he chose to kill the second victim as well. However, forensic evidence does suggest that the two homicides were committed within the context of a sadistic sexual act involving the infliction of pain to the victims beforehand. It is probably not a coincidence that the two victims' bodies were discovered by police in line with Mr. R's sexual fantasies. His chronic consumption of alcohol preceding the homicides and the rejection from a former partner likely acted as catalysts, which ended in the killing of two innocent victims (see Figure 4.2).

Figure 4.2: Diagrammatic Formulation of Mr. R's Offence



4.4 The case of Mr. B

(A Sexually-Driven SH Offender)

The following case was taken with permission from the main author of the STEP 4 project, which evaluated the efficacy of the Sex Offender Treatment Programme for sexual homicide offenders and non-homicidal sexual aggressors in a number of UK prisons. The following description attempts to capture the main motivation for the offence (i.e. intention to have intercourse) and why the victim died. It is interesting to note that no homicide committed in the mental health sample (see Chapter 5) conformed to this particular type of killer.

4.4.1 Summary of events leading up to the index offence

At the time of the assessment, Mr. B was 58 years old and serving a life sentence for murder. He killed his victim – an 80-year-old woman – in her own home when he was aged just 26. Mr. B lived with his partner at the time of the index offence. His partner was seven months pregnant with their first child. Mr. B was unemployed at the time of the index offence and had been for many months, having worked for only short periods on building sites and other forms of manual labour. During the pregnancy, Mr. B's partner became uninterested in sex and had refused physical intimacy with Mr. B for several weeks. He seemingly respected her decision, never forcing sex upon her, but his partner nevertheless described him as controlling and dominant at times and someone who liked to get his own way. After an argument with his partner one early afternoon, Mr. B decided to spend the rest of the afternoon and evening drinking in a local pub. A female acquaintance with whom he had been drinking, said that when Mr. B left the pub he appeared "quite happy and not very drunk".

Later that same evening, three elderly women neighbours were disturbed by a man knocking at their front doors asking if they knew where someone lived. The area which Mr. B chose to target was close to the pub and reasonably familiar to him, but he did not know of anyone who lived there. The victim's body was found the following morning. Mr. B had ransacked her home and left her body in a bedroom dressed in a nightgown and cardigan, which had been pulled up around her neck. A pillow and cushion were covering her head. A stocking and a piece of red material had been used to tie the victim's wrists together in front of her. Her handbag was found empty on a table. A packet of butter was also found stuck to the side of her cardigan. There was bruising around her groin area and on the breasts, shoulders, legs, lower lip and tongue. There was also abrasions and bruising to the walls of the vagina and the anus. Post-mortem examination revealed that the external genitals were greasy. The cause of death was asphyxia due to suffocation.

Leaving a crime scene that was highly disorganised, there were a number of clues linking Mr. B to the homicide. He was apprehended quickly due to him leaving finger prints within the victim's house and being seen in the local area by numerous witnesses immediately before the attack. Upon questioning, Mr. B initially denied involvement, but eventually admitted to the crime. He said that he had intended the sexual assault, but had not intended to kill her. He admitted his attempt to have intercourse with the victim and that he got some butter, but he said that he did not recall what he did with it. He said that he had his hand over her mouth to stop her screaming and that after he had had intercourse with her, he lay by the side of her and went to sleep. When he awoke, he realised that she was not breathing and left the house in a panic and "feeling scared". On arrest Mr. B stated "I'm terribly sorry" and wrote on the charge form 'I'm terribly sorry I have committed this crime and also wish to say that I am sorry to any family Mrs **** has'. There was no evidence of

mental illness on psychiatric examination. At his trial, Mr. B was deemed fully legally responsible for his actions and given a life prison sentence.

4.4.2 Psychometric assessment

Mr. B completed a battery of psychometric assessments whilst in prison. His full scale score on the Wechsler Adult Intelligence Scales (WAIS IV) was 92, placing him in the "average range" compared to peers. He produced a very flat profile on the MCMI-III. The only significantly elevated subscale was the Social Desirability scale suggesting that Mr. B was keen to present himself in a favourable light. The Obsessive Compulsive and Narcissistic personality disorder scales showed some elevation, but neither was above trait significance. On the Memories of Childhood Scales he described an overprotective though rejecting father with little warmth and a rejecting mother.

The Multiphasic Sex Inventory (MSI) revealed no sexual deviance but consistent with the MCMI III, the social sexual desirability scale was significantly elevated, again suggesting that Mr. B wanted to be seen in a favourable light. The Burt Rape Myth Scale suggested that Mr. B had a stereotypical view of the sexes; believing, for example, that men should be seen as the dominant bread winner of the family, whilst a woman's place was in the home, taking care of the children and house hold chores. Mr. B was also assessed for the presence of offence-related implicit theories (IT). The only IT detected from interview was the 'Male sex drive is uncontrollable' IT. A full-scale PCL-R was not available from prison file records, but there was no evidence to suggest that Mr. B suffered from a personality disorder and he had never been diagnosed with any mental disorder at any point in his life.

4.4.3 Previous offence history and response to treatment

Mr. B had a history of previous offending, though not sexual offending. He had a string of acquisitive offences including burglary and theft of a bicycle, and had several convictions for common assault and one episode of actual bodily harm. In prison he successfully completed the Sex Offender Treatment Programme. Facilitators reported good engagement with the material and there was a positive shift observed in a number of post-assessment measures. Furthermore, Mr. B's risk profile on both the SARN and the HCR-20 improved.

4.4.4 Forensic case formulation

With little information about Mr. B's early life history, personality development or the content of his fantasies, the following is a tentative formulation based on information that is currently available.

Evidence from the Memories of Childhood Scale suggests that Mr. B's father was both aggressive and controlling of his family and that his mother was rejecting and had little time for him. It is unclear whether Mr. B had witnessed any sexual violence between his parents, but it is likely that his personality and attitude towards women were shaped by his early experiences at home. Mr. B's personality development is characterised by narcissism, dominance, and poor emotion regulation skills. No evidence of sexual deviance was found in his MSI profile but the Burt scale revealed a strong stereotypical view of the sexes and this is supported by presence of the implicit theory 'Male sex drive is uncontrollable'.

At the time of the murder, Mr. B had a relatively stable relationship with a woman he had been living with for over a year. Her refusal to have sex with him towards the latter stages of her pregnancy is significant. This clearly frustrated Mr. B but not to the extent where he would vent his anger in a physical way upon his partner. However, after the

argument with her on the afternoon before the index offence, Mr. B was likely feeling undermined, rejected and increasingly sexually frustrated.

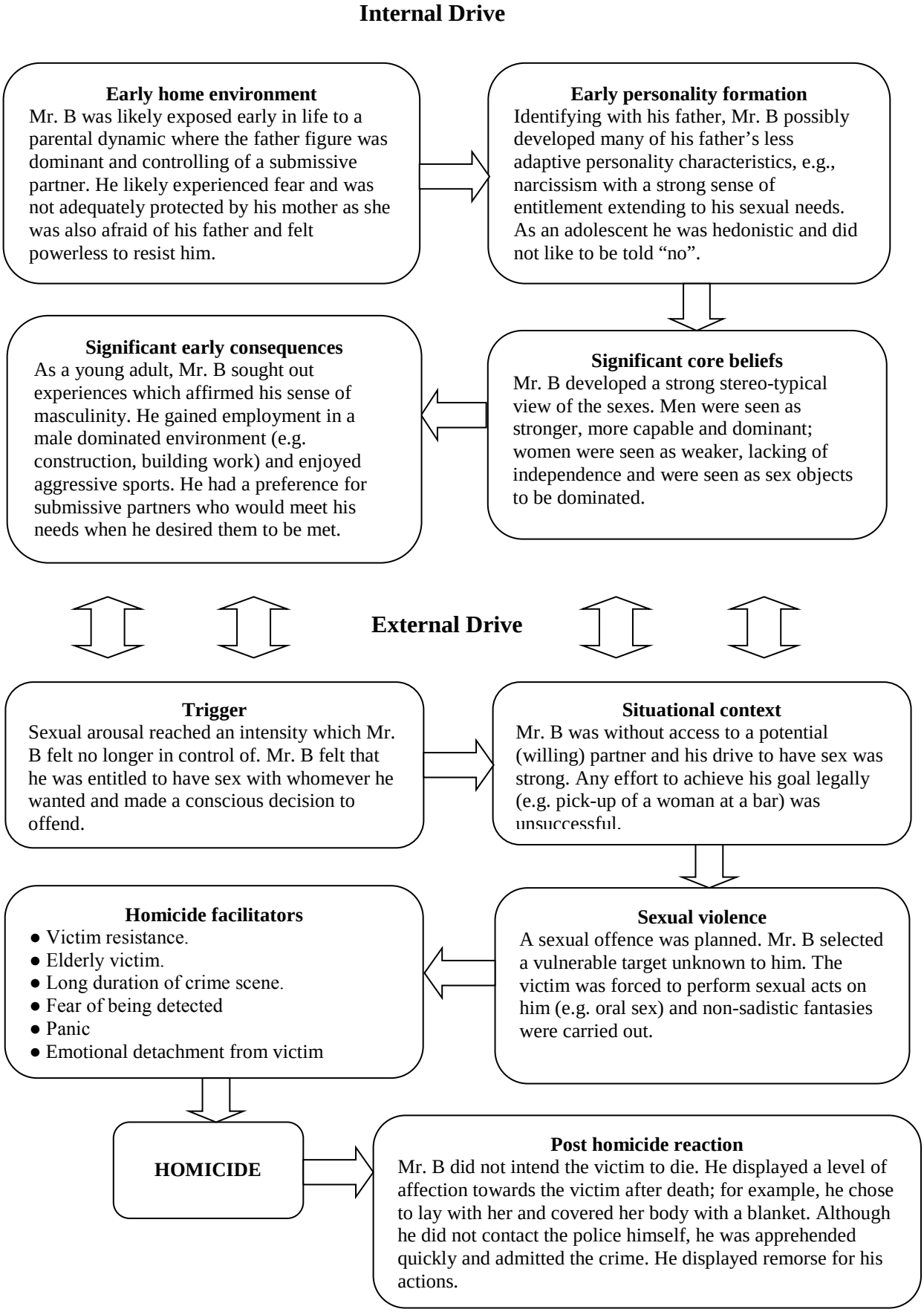
In interview, Mr. B admitted to drinking alcohol to excess regularly, but insisted that he never consumed illicit substances. Along with the resentment he was feeling towards his partner and the strong sense of sexual frustration, it is likely that the alcohol he consumed facilitated his initial action of knocking randomly on people's front doors looking for a potential victim. Mr. B's choice of victim probably does not indicate a sexual preference for older women (Gerontophilia) but more likely reflects his intention of selecting a person who was vulnerable. Although he had a string of previous violent offences, none of them were sexual. Thus, Mr. B was not following any mental template of a sexual offence script (as the serial killer might). The disorganised nature of the crime scene reflects this. The crime he committed was impulsive and largely unplanned.

Forensic evidence is also consistent with Mr. B's contention that he did not intend to kill his victim. Due to his panic and the fact that his victim was elderly, it is not surprising that she died from her injuries. When questioned by the police, Mr. B admitted rather quickly that he was the perpetrator of the homicide. He expressed remorse for his actions and wanted to apologise to his victim's family. This sets him apart from the sadistic killer who experiences little empathy for his victim. Although Mr. B's pride was hurt by his partner's decision not to have sex with him and by the argument that took place between them on the day of murder, he was not angry towards women. He was not fuelled by hate as the anger-driven killer is, but driven by the need to have sex whatever the cost.

Beech et al.'s (2005) description of the sexually-driven SH offender appears to match Mr. B. According to these authors, sexually driven offenders have many characteristics that set them apart from their sadistic and angry counterparts. For example, these killers are more socially integrated and have fewer substance abuse problems, are less impulsive, have high

impression management skills, are more narcissistic, have lower levels of anger, are more likely to acknowledge fantasising and planning, and are more likely to be motivated to work on their problems. The nature of the aggression used by the sexually-driven SH offender is purely instrumental and designed to overcome the victim's resistance (i.e. in Mr. B's case), or in the case of more psychopathic offenders, designed to eliminate the only witness to their sexual attack (see Figure 4.3).

Figure 4.3: Diagrammatic Formulation of Mr. B's Offence



4.5 Comment and critique of the case studies and links to previous research

The case studies presented in this chapter attempt to cover all three phases of the crime-commission process for the three types of sexual homicide offender discussed in the literature, i.e. pre-crime, crime and post-crime reaction (e.g. Beauregard, Stone, Proulx, & Michaud, 2008). Along with an explanation for the development of an internal drive, they also propose that situational factors are crucial in the understanding of the offence in all categories. This has been largely neglected in previous motivational models of sexual homicide.

In effect, each case study and formulation presents a vulnerability to sexually offend in a particular way depending on the situation, and critical external forces that are likely to precipitate sexual violence that becomes lethal. It is impossible to generalise from these cases to achieve an understanding of other offenders, but it is anticipated that few offenders will conform absolutely to one type of killer. It may be more common for individuals to evidence features of all three categories, but on the basis of previous research (e.g. Beech, Oliver, Fisher & Beckett, 2005; Proulx, 2007) and the author's clinical opinion, it is likely that an individual's offence and psycho-sexual development will be reflected in one type more than any other.

Some links can be made between the cases presented in the current chapter and the motivational models presented in Chapter 3. As already mentioned in Chapter 3, the models are very similar in their design and content and the case which most closely resembles them is that of Mr. R (the sadistic fantasy-driven SH offender) who appeared to kill in response to a deviant fantasy system. Mr. R's developmental history was a reasonably good match to that predicted in the models. For example, physical and sexual abuse during childhood, the development of critical anti-social personality traits and a deviant fantasy system (paraphilia) which ultimately led him to offend. In addition, the high probability of Mr. R repeating his

offences is also consistent with motivational models of sexual homicide. This is not surprising, however, given that all three models only really apply to the serial sadistic sexual homicide offender which, as we saw in Chapter 3, is a particularly rare type of offender.

It is difficult at this stage to say where mental health difficulties may fit in a given case. It is proposed that such phenomena act as disinhibitors to action, instead of playing any direct role, but this may not be the case with other offenders. A more thorough understanding of the mechanism for repetition of an offence is also unclear at this stage. The literature is consistent in suggesting that the so-called sadistic fantasy-driven SH offender is most at risk of repeating his crimes (e.g. Proulx, 2007, Schlesinger, 2004, 2007). However, it was highlighted in Chapter 3 that there may be a mechanism for the anger-driven offender to repeat his offences if he is aware of the source of the hate that drives him, and his post-offence reaction facilitates the expression of another attack. It is anticipated that this reaction, however, is extremely rare, and such an individual may share other components with the sadistic offender which better explains his propensity for repetition. Similarly, there may also be a mechanism for repetition for a particular type of sexually-driven offender who deliberately kills his victim in an effort to silence the only witness to his crime. Such an offender is likely to be more psychopathic than the offender who kills out of panic or perhaps accidently by applying too much force to a vulnerable victim.

There are no models currently available in the literature, which explore the anger-driven or the sexually-driven SH offender, but it is anticipated that much of the material presented in this chapter will be consistent with other cases which conform to these categories. It is also hoped that the material in this chapter will provide clinicians with some base to structure formulations of their own cases and inform on relevant treatment. For the remainder of this chapter, attention will now focus on the assessment and treatment of the sexual homicide offender.

4.6 Assessment

The assessment of sexual homicide offenders or of those charged with a homicide with a suspected sexual element, needs to be comprehensive and should include the use of collateral information, different modalities of assessment, and the testing of hypotheses throughout (Perkins, 2007). The literature is replete with cases of sexual homicide in which the perpetrator has tried just about anything to rid them of responsibility. US serial killer Kenneth Bianchi, for example, managed to fool several experienced clinicians into believing that he had a split personality before he was eventually caught out, and another serial offender, John Wayne Gacy, deflected his guilt for years post apprehension by blaming other people for his crimes despite irrefutable evidence right up to his execution. Because many sexual homicide offenders have a tendency to lie or withhold key details that they feel might incriminate them, it is essential that other sources of information are sought (e.g., information from school reports, work colleagues, friends, relatives, victim statements). Once a sexual element has been established in a case, the long process of formulating how significant that element was in terms of understanding risk and treatment, as well as other factors that might contribute to the offence, can progress.

For the most part, sexual homicide offenders do not differ significantly from sexual aggressors of women who do not kill their victims (Beech, Oliver, Fisher & Beckett, 2005; Proulx, Beauregard, Cusson & Nicole, 2007). However, when assessing such offenders, actuarial risk assessment approaches are of limited utility, given the rarity of such cases in development samples (Kingston & Yates, 2008). Nevertheless, structured professional judgement tools such as the Risk of Sexual Violence Protocol (Hart et al., 2003) help to create a useful structure.

4.6.1 Specific areas of assessment

There are many specific clinical variables that are important in the assessment of sexual homicide offenders. In order to reach a comprehensive, detailed and useful formulation of the offence, it is of course important to consider how each factor may link with others. Specific areas of focus in an assessment include: psychosocial development; psychopathology; paraphilic disorder, especially in relation to deviant fantasy; anger and other negative emotions; implicit theories; intellectual functioning; neurological functioning; and chromosomal analysis. All of these areas have been detailed elsewhere (see Chapter 2), but there is room in this section to consider two general areas in more detail: 1) the assessment of motive, and 2) consideration of the situation at the time of the homicide.

4.6.2 Assessment of motive

Crucial in the assessment of the sexual homicide offender is to establish the motive for the killing. This is important because it has implications for risk as well as for future treatment needs. However, the motive for the killing is rarely obvious and the client may be unwilling or unable to assist, either because of a genuine dissociative reaction at the time of the killing or because of a deep seated conflict he is unaware of. He may also lie in his attempt to deflect responsibility or lie in an attempt to hide a fantasy component that was present at the time. When clients are reluctant or unable to provide information, it may be useful to present them with a number of possible scenarios for their offending with the aim of helping them to remember and explain (Perkins, 2007). Key questions the assessor might ask him or herself include: a) was the killing due to a mistake of applying too much force to the victim in response to her resistance?; b) was the killing designed to silence the only witness to the offender's sexual assault?; or c) was the killing used to serve a specific psychological need in the form of a grievance towards women or to satisfy a sadistic sexual drive?

Crime scene photographs can be helpful in determining the function of a killing by investigating the location of stab wounds, for example, in a victim killed with a knife. Many stab wounds inflicted in a frenzied manner about the victim's body before, during or after sex, likely indicates an anger-driven motive. Knife wounds inflicted more purposefully and located around the genital region of a victim might indicate a sexual motive connected with sadism. If there are more bizarre elements, for example, the victim posed in an unusual position or body parts have been dissected, it could be evidence of a psychotic process.

4.6.3 Consideration of situational factors

In the author's experience, sexual homicide offenders rarely set out with a motive to kill, although some do, and a few may actually derive pleasure from the kill itself. However, by all accounts, situational factors at the time of the offence can provide vital clues as to why a victim ends up being killed. Research from Chene and Cusson (2007) suggest that factors such as the presence of a weapon and especially verbal or physical resistance from a victim are useful in predicting the outcome in a sexually violent crime. If such variables are present, then homicide is more likely. The author also advises that an exploration of the interaction between perpetrator and victim immediately before the homicide can be incredibly useful in many cases. Specific comments made by the victim to the offender that appear seemingly innocuous at first, may provide clues of a repressed conflict which the client is little aware of.

Alternatively, something may have happened to the offender in the days leading up to the homicide. This is particularly significant in sadistic offenders. In 1970 Brittain wrote, "The sadist who has been laughed at by a woman or mocked by his acquaintances, particularly in his sexual contacts, or who has been demoted or discharged from his employment is likely to be at his most dangerous" (p. 199). Factors that may reduce an offender's inhibition in the pre-crime phase of the offence are also important to consider.

Heavy alcohol and illicit substance misuse are fairly common in cases of sexual homicide, and pornography depicting violence is another common disinhibitor (Hill et al., 2007; Firestone et al., 1998).

4.7 Treatment approaches

On a clinical level, many sexual homicide offenders, particularly those that fall into the sadistic category, present deeply anchored, very primitive psychological problems (Tardif et al., 2007). To reduce the detrimental impact of long-term incarceration, Carter, Mann and Wakeling (2007) suggest intervening from the beginning of the sentence/hospital admission. Tardif et al., (2007) propose that therapeutic interventions targeting the sexual nature of the killing should not be proposed at the start of a sexual homicide offender's treatment. It is advised that other treatment programmes addressing related other criminogenic needs are delivered first (e.g. treatments for social skills deficits, substance misuse, and anger). This is to equip the offender with the skills necessary in order to present an un-distorted account of his offence. Furthermore, in order to increase his readiness to engage in treatment, Hart (2007) suggests intervening in varied ways to reduce major sources of stress, such as untreated mental illness and death threats from other prisoners/patients.

In the UK prison service and within NHS and private secure mental health units, the programme of choice for people who have killed victims in sexual circumstances is the Sex Offender Treatment Programme (SOTP: Beech, Oliver, Fisher & Beckett, 2005). The main targets of change of the programme are to increase offenders' motivations to avoid re-offending and to develop the self-management skills necessary to achieve this. The programme places treatment as a collaborative effort, with cognitive restructuring, modelling and positive reinforcement at the centre of treatment. The average dose of treatment is 180 hours (Beech & Mann, 2002) and the recommended number of times that groups meet is

between two and five sessions per week (Beech et al., 2005). Although the SOTP was not developed with sexual homicide offenders in mind, it has been used and evaluated with such clients since 1991. It has been modified by various institutions for use in mental health settings and has been adapted for use with offenders with learning disability. Let us now look in more detail at the evidence-base suggested for the three types of sexual homicide offender covered in this chapter.

4.7.1 Treatment approaches for the anger-driven SH offender

The author suggests that sexual homicide offenders may present with anger problems in one of two different ways: 1) in an under-controlled way in which anger, and other negative emotions, are under-regulated and result in frequent and impulsive outbursts; or 2) over-controlled, where the offender fails to acknowledge that he is angry, choosing to inhibit rather than exhibit any display of emotion. Traditional anger-management approaches, such as the CALM programme, are effective at treating anger problems in offenders in the first category by teaching them to inhibit and control their anger using a variety of skills and techniques. However, such programme may be contraindicated for the over-controlled offender, such as Mr. J, who has learned to inhibit negative emotions at all costs. What the 'type two' angry-driven SH offender needs is an intervention focussed on understanding the purpose and value of anger in everyday life. To a large extent, the RESOLVE programme, which currently runs within the UK prison service, does this. Using a combination of individual and group-based sessions, it helps participants to develop insight and awareness of their individualised and often complex motivations for aggressive and violent behaviours, as well as develop the skills to manage these. It could be particularly useful for Mr. J and the marker for change could be framed as his acceptance of anger as a natural emotion. He would need to examine

underlying cognitions that result in anger and develop assertiveness skills to minimise angry/aggressive responses.

The anger-driven SH offender needs to manage situations better in which he suffers narcissistic insult (Tardif et al., 2007). This can be a problem for both the over-controlled and under-controlled anger offender and a major goal in treatment is to help him to foster a self-esteem that is more stable and less sexualised. Furthermore, it has been found that all types of sexual homicide offender evidence the same offence-related implicit theories as rapists (Beech, Fisher & Ward, 2005). Five implicit theories have been identified in such offenders and they all reflect key targets for interventions. In the anger-driven SH offender, the 'Dangerous world' implicit theory appears to be the primary underlying higher order cognition in terms of how the offender views the world, with thoughts about punishment and control central to the offence (Beech, Fisher & Ward, 2005).

In the UK, the most recent evaluation of the SOTP (STEP 4: Beech et al., 2005) suggests that the anger-driven SH offender should be referred for the Cognitive Self-Change Programme (now referred to as the Self-Change Programme) as well as the Extended Programme of the Core SOTP to meet his criminogenic needs. In practice, however, there appears to be little value in an offender completing both these programmes. The former is designed to reduce violence in high-risk adult male offenders, whose repetitive use of violence is part of a general pattern. The Extended Programme of the SOTP aims to help participants to develop an awareness of unhelpful thinking patterns and deeper level offence-related attitudes whilst replacing these with more adaptive, healthier patterns. It also helps participants to manage their emotions more effectively, develop an awareness of dysfunctional attachment styles and develop skills for fostering healthy intimacy. In addition, it helps participants to understand the role of offence-related sexual interests in their offending and encourages them to find better ways to cope with life's problems, recognise

risk factors and generate strategies for living happier, more successful lives in the future without offending (A. Carter. Personal Communication, May, 2015). Of the two programmes, it is more advisable to refer the anger-driven SH offender, including Mr. J, for the Extended Programme only, as most of his criminogenic needs can be captured here.

Another suggested form of therapy that may be useful for such offenders is mindfulness therapy. With its roots in Buddhist philosophical traditions, mindfulness has been defined by Bishop et al., (2004) as involving self-regulation of attention in the present moment whilst maintaining a curious attitude of openness towards thoughts, feelings and emotional experiences, as and when they arise. Although this form of therapy has yet to be formally evaluated for use with sexual offenders, there is some evidence for its use with anger problems (Borders, Earleywine & Jajodia, 2010) and it may be particularly useful for Mr. J and other offenders who are less likely to acknowledge their emotions (i.e. those who are over-controlled).

In addition, for those who are over-controlled in their anger expression and perhaps struggling with deep-seated conflicts such as Mr. J, psychodynamic forms of therapy may be appropriate. Schlesinger (2004) recommends such treatment for catathymic-type reactions to life events that contain some sexual element (e.g. inferiority complex). However, there is no evidence to suggest that such treatments are any more effective than the CBT approaches described above, and the long-term duration of such therapy means that it would be less readily available in the prison service and in the NHS.

In the author's experience, the responsivity of the anger-driven SH offender to treatment can be variable, and will ultimately depend on his capacity and willingness to resolve the issue(s) connected with his anger. In the case of Mr. J, treatment for his psychosis will need to take precedence before any collaborative exploration of his offending can take place. He will also need to formally address his use of illicit substances at some point later in

his treatment. His high IQ, especially in the area of verbal comprehension, is likely to make it easier for him to access talking therapies, but the schizoid/avoidant elements to his personality are likely to make engagement difficult. Finally, helping him to continue his studies when he becomes more stable in his mental state is likely to increase his self-esteem and foster new hope for the future.

4.7.2 Treatment approaches for the sadistic fantasy-driven SH offender

With the sadistic-fantasy driven SH offender, the entry point for treatment remains the analysis of the modus operandi (Tardif et al., 2007). The killer's active, concrete role in the crime is more readily explored than his inner world, which is less readily consciously accessible (Tardif et al., 2007). For the sadistic offender, implicit theories in need of targeting include 'Entitlement', 'Male sex drive is uncontrollable' and 'Dangerous world' (Beech, Fisher and Ward, 2005). Such individuals are also likely to evidence at least moderate levels of (PCL-R) psychopathy in their characters and are therefore less prone to be honest in assessment/ treatment. Contrary to what they might say in therapy, the tendency for some sadistic sexual offenders to keep their deviant sexual imagery life active is an important obstacle in treatment and a good example of this (Tardif et al., 2007). It is also important to assess for what might appear to be bizarre fantasy content reflective of an underlying psychotic process. In these situations, the modus operandi usually appears less controlled, more disorganised, and more chaotic (Tardif et al., 2007).

Another major difficulty with the sadistic fantasy-driven SH offender is his self-absorbed tendency to avoid experiencing reality and acquiring new experiences (Tardif et al., 2007). He should be encouraged to engage in educational and recreational activities to foster openness with others, develop a realistic perception of himself and find socially appropriate solutions to everyday problems. Other aspects of his personality and interests should be

explored in order to develop self-esteem less oriented towards omnipotence (Tardif et al., 2007). A major objective of therapy with the sadistic offender is to make him aware of his rejection of his real world and his underlying desire for control, dominance and omnipotence. Thus, throughout the course of therapy, the principal indicator of progress becomes the offender's interaction with the real world.

For sadistic fantasy-driven SH offenders detained in the UK, Beech et al., (2005) suggest that the Extended SOTP is indicated as the treatment of choice. Although recent research seems to support the continued use of victim empathy work in such programmes (e.g., Mann & Marshal, 2009) it is probably not wise to include such a component when working with sadistic offenders, given that they are more likely to experience such phenomena as pleasurable.

Because no variant of the SOTP is designed to target deviant fantasy, the Healthy Sexual Functioning programme (HSF) is recommended as an adjunct therapy for sadistic offenders, including those who kill their victims. HSF is a 16-session programme delivered on an individual basis and is geared towards enhancing appropriate fantasy and modifying deviant fantasy based on aversive reconditioning techniques. At the time of writing, however, HSF has not been subject to any formal evaluation.

A more constructive way for offenders to think about their deviant fantasies in the context of their offending is to apply the Good Lives Model (Ward). The Good Lives Model (GLM) is now becoming popular in many offending behaviour programmes, particularly in the relapse prevention stage of treatment. The model suggests that there are a number of needs, or "goods" (e.g., need for autonomy, need for recreation etc...), that all people strive for throughout their lives. The weight a particular person places upon each need will vary, and people will also vary in terms of how they go about meeting their needs. The model advocates that there is nothing fundamentally wrong with the needs themselves; the problem

for offenders is how they choose to meet their needs. In therapy, an individual who meets his need for sexual expression by offending, for example, would be encouraged to re-think how he could meet the need without putting others (or himself) at risk.

According to Carter, Mann and Wakeling (2007), psychological treatment alone is not sufficient to meet the needs of sadistic sexual homicide offenders. Pharmacological treatment has the advantage of treating several paraphilias at once (Bradford, 2007). Bradford (2007) recommends the use of cyproterone acetate which causes a "complete suppression of gonadatropin secretion and a drastic reduction of plasma testosterone levels" (p. 15). Such treatments are delivered via injection, making compliance easier to manage, and in the case of sadistic sexual SH offenders, they should be delivered at maximum intensity (Proulx, 2007).

Research is consistent in suggesting that the prognosis of the sadistic sexual homicide offender is less favourable than the other two types of killer explored in this chapter (Beech et al., 2005; Proulx, 2007). In the author's experience, no other type of offender evokes quite the same level of fear and anxiety in the mental health professional when it comes to the end of his prison sentence or the end of his treatment in hospital. The offences of Mr. R, for example, were felt by the Home Office to be of a nature where he could never be released back into society again. Mr. R had been diagnosed with several personality disorders as well as sexual sadism and was rated as being psychopathic on the PCL-R. Not only are these conditions incredibly difficult to treat successfully, the prospect of him never moving on from the confines of secure care would likely impact negatively on his motivation to engage.

4.7.3 Treatment approaches for the sexually-driven SH offender

According to Beech et al., (2005) the sexually driven SH offender is, in many ways, like the archetypal sex offender in the sense that he plans his offence, is driven by fantasies, and uses

instrumental aggression to force compliance from his victim, i.e. offending behaviours traditionally targeted by sex-offender treatments such as SOTP. Relative to the anger-driven and sadistic-fantasy driven SH offenders, the sexually-driven offender is more often motivated to work on his problems.

The implicit theory most strongly related to the sexually-driven offender is 'Male sex drive is uncontrollable' (Fisher & Beech, 2007). This explains his motivation for the sexual offence whatever the cost to the victim. Other related key criminogenic needs include stereotypical views about the sexes, attitudes which support rape, deficits in victim empathy, and poor self-regulation skills. According to the most recent evaluation of SOTP (Beech et al., 2005) treatment is effective in all key areas except the offender's core belief about women.

One option to address the sexually-driven SH offender's core belief relating to women is schema therapy. Schema therapy is generally thought to be a long-term therapy aimed to address an individual's dysfunctional higher-order cognitions or implicit theories about themselves, the world and the people in it. It is effective but expensive and probably would not be readily available within a criminal justice system. Schemas are notoriously difficult to change in shorter-term therapies (e.g. traditional forms of CBT; Rafaeli, Bernstein & Young, 2011) but they are important because they act as filters that dictate what an individual is likely to pay attention to with regards to incoming information.

Of all three cases presented in this chapter, the case of Mr. B appears to be the most amenable to treatment. Effective treatment (i.e. in the form of SOTP) is available and he was motivated to engage. He was not sexually sadistic, not psychopathic and there was little evidence of any personality disorder. Furthermore, he demonstrated few difficulties in terms of regulating his emotions and his post-offence reaction of shame and increased level of openness with the police during interview bodes well for future risk assessment. Thus, Mr.

B's prognosis is likely to be good. It has previously been highlighted, however, that in some cases, sexually-driven SH offenders do intend to kill their victims and thus likely evidence significant psychopathic traits. This was not true of Mr. B, but in such cases the treatment and risk management of these people are likely to be more complicated. There is very little currently available in the treatment literature to suggest that psychopathy is treatable.

However, the prison service in the U.K is currently piloting a treatment programme designed for offenders who present with high levels of psychopathy. Adopting a GLM philosophy, the CHROMIS programme is an intense therapy involving individual and group-based sessions and is largely focused on managing instrumental forms of violence. At the time of writing, it is currently undergoing an evaluation (Tew & Atkinson, 2013).

4.8 Concluding comments

It has to be said that treating sexual homicide offenders in either a prison or a mental health setting is often a difficult and very long process, involving multiple interventions and appropriate sequencing to maximise strengths and facilitate change. There are many obstacles to consider when treating such offenders, including stigma, poor motivation and the possibility of multiple life sentences. It may also be the case for some offenders that they are never released from custody. Some may receive life sentences without the possibility of parole, and others, like Mr. R (described above), may be detained under the Mental Health Act indefinitely. The individual's perceived level of dangerousness is not the only significant factor here, as some high profile cases may be detained indefinitely for political reasons, and over many years of incarceration the impact of institutionalisation may make it very difficult for an individual to move on. With very little prospect of ever being released, is it ethical to even offer treatment to such individuals? Is it worth asking such people, for example, who may already be traumatised by their offending, to re-visit their trauma over, what could be,

many years' worth of therapy? In such cases, health care professionals will need to consider very carefully where to channel valuable resources that may be already stretched. Similarly, for those offenders who do go through a pathway of treatment, the relatively small number of such offenders, the low rate of release, and the stringent monitoring that these men receive in the community, makes investigating efficacy of such treatments difficult in the long-term. It should also be recognised that the therapist is the object of several types of external and internal pressure. Their concern to avoid further victims and fulfil their duty to protect society influences their attitude to offering treatment and evaluating its effectiveness (Tardif et al., 2007). The media also contributes to such pressure due to their detailed coverage of sexually violent crimes.

Chapter 5

A Comparative Analysis between Sexual Homicide Offenders detained in a Secure Hospital with those detained in Prison

Abstract

There is little available literature on sexual homicide offenders detained in secure mental health services. In addition, what studies exit seem to suggest that perpetrators detained in hospital are not all that different to those detained in prison. However, no study to date has formally set out to compare sexual homicide offenders given hospital orders with those given prison sentences. This was the focus of the present study. A sample of male participants who had committed sexual homicide and received state hospital orders for their offence(s) was compared with a sample detained in prison. The two groups were very similar in their demographic profiles, their prior histories of violent and sexual offending and their self-reported experiences of physical/sexual abuse in childhood. Differences were observed in the frequencies of personality disorder and sexual deviance, with participants in hospital presenting as more pathological. Sexual homicide offenders detained in hospital were also more likely to target older victims, people that they knew, kill in a disorganised manner, and were more likely to mutilate their victims after death. Implications for law enforcement and treatment are discussed.

5.1 Introduction

There is currently no universally accepted definition of the term ‘sexual homicide’ (Greenall, 2012; Kerr, Beech & Murphy, 2013). Some authors prefer a very broad description, e.g. ‘a homicide in which there is a sexual element, motivation, relationship, or perversion involved, such as rape, molestation, prostitution, intimacy, battery, and sexual jealousy’ (Flowers, 2001, p. 3). Others prefer a more refined version, e.g. ‘a breakthrough of underlying sexual conflicts or where the killing itself is sexually gratifying’ (Schlesinger, 2004, p. 1). Without a clear definition of the term, investigating sexual homicide is difficult. It is not defined by English law and it is not defined clinically by the Diagnostic and Statistical Manual of Mental Disorders (DSM-V; American Psychiatric Association, 2013) or the International Classification of Disease (ICD-10; World Health Organisation, 1992).

In 1988, FBI researchers published a set of guidelines primarily for use by law enforcement agencies investigating homicide with a suspected sexual motive. Ressler, Burgess and Douglas (1988) suggest that a homicide needs to include at least one of the following to be considered ‘sexual’: a) victim’s attire or lack of attire; b) exposure of the sexual parts of a victim’s body; c) sexual positioning of the victim’s body; d) insertion of a foreign object into the victim’s body cavity; e) evidence of sexual intercourse (oral, vaginal, anal); or, f) evidence of substitute sexual activity, interest, or sadistic fantasy, such as mutilation of the genitals. These guidelines are not without problems. For example, it would be very easy for an offender to remove the clothing of a victim to make the homicide appear ‘sexual’. At the same time, however, the guidelines offer at least some attempt to operationalise the term and have been used by numerous studies in the scientific literature (e.g., Beauregard & Proulx, 2007; Beauregard, Stone, Proulx & Michaud, 2008; Chan, Heide & Beauregard, 2011).

Despite the lack of an agreed definition, studies are consistent in reporting that the prevalence of sexual homicide varies between 1% and 4% of the overall homicide rate in the United States, Canada, Finland and Great Britain. Most perpetrators are men, most victims are adult women of a childbearing age, and most sexual homicide offenders do not kill multiple victims and are therefore not serial killers – defined as killing three victims or more with a significant 'cooling off period' between each killing (Francis & Soothill, 2000; Hakkanen-Nyholm et al., 2009; Porter et al., 2003; Ressler et al., 1988).

5.1.1 Sexual homicide and mental disorder

The apparent senseless nature, sheer brutality and sometimes torture in cases of sexual homicide lead many to believe that its perpetrators are disturbed (Carabellese, Vinci & Catanesi, 2008). In fact, until the pioneering work by Ressler and colleagues from the FBI (e.g., Ressler et al., 1988) many authors assumed that many, if not most, sexual homicide offenders were psychotic (Rada, 1978; Revitch, 1965). However, this does not seem to be supported by empirical evidence. In a study by Firestone, Bradford, Greenberg and Larose (1998), for example, 48 sexual homicide offenders were assessed over a 10-year period in a medium secure psychiatric facility from 1982-1992 on a number of commonly used psychological inventories, criminal histories and clinical diagnoses according to DSM-IV. Only seven (14.6%) of the sexual homicide offenders had a diagnosis of a psychotic disorder, only one (2.1%) had a diagnosis of a mood disorder, and only one (2.1%) had an anxiety disorder. Proulx and Sauvètre (2007) investigated the prevalence of psychopathology in 30 sexual homicide offenders detained in a Canadian penitentiary. Only 6.6% had a diagnosis of a psychotic disorder and none were diagnosed with mood, anxiety or dissociative disorders, according to DSV-IV criteria. In a study of 166 psychiatric court reports of sexual homicide offenders by Hill, Habermann, Berner and Briken (2007) it was found that only 3% met

formal DSM-IV criteria for schizophrenia or another psychotic disorder. Only 9.6% met criteria for a mood disorder and only 4.8% were diagnosed with an anxiety disorder.

The clinical picture is different when personality disorders, substance misuse disorders and disorders of deviant sexual preference (paraphilias) are considered. In the Firestone et al., study, 79.2% of participants were diagnosed with a paraphilia, 52.1% had been diagnosed with a personality disorder, and 39.6% diagnosed with a substance misuse disorder. In the Proulx and Sauvètre (2007) study, personality disorders were also frequently diagnosed, with antisocial (35.7%), borderline (28.6%) and narcissistic (25%) disorders being most evident. In the Hill et al., (2007) study, half the sample (50%) met diagnostic criteria for a substance misuse disorder, and 51.8% were found to meet criteria for a paraphilia (sexual sadism being the most common, 36.7%), and the majority of the sample (78.3%) displayed at least one personality disorder, with cluster B as well as schizoid and avoidant diagnoses being the most common. Psychopathy, according to European standards, was present in 18.1% of the sample (PCL-R total score ≥ 25), but only 6% reached the North American cut off (PCL-R total score ≥ 30).

5.1.2 Motivation

It appears that the clinical literature is clear in suggesting that the majority of offenders who commit sexual homicide evidence at least some degree of psychopathology, although most in fact may not be mentally ill at the time of their offence(s). The classification literature is also clear in suggesting that there are broadly three different types of sexual homicide offender based upon their apparent motive for the crime. Several typologies are in agreement that some perpetrators kill to satisfy a sadistic sexual drive, some kill out of intense anger and an entrenched grievance towards women, and others kill purely for instrumental reasons, for example, in order to silence the only witness to a rape/sexual assault or unintentionally due to

excessive force applied to a vulnerable victim (Beauregard & Proulx, 2007; Beech, Oliver, Fisher & Beckett, 2005; Clarke & Carter, 1999; Schlesinger, 2004, 2007). It is possible that each of the proposed categories is associated with a specific psychopathological dimension which is yet to be investigated (Proulx &Sauvêtre, 2007).

5.1.3 Murder or manslaughter

Under English law, an individual who has been found guilty of committing a homicide will be convicted of either murder or manslaughter. Although the *actus reus* (guilty act) is the same (i.e. the unlawful killing of another human-in-being) the distinguishing feature relates to the offender's state of mind, or *mens rea* (guilty mind), at the material time (Smith & Hogan, 2013). The *mens rea* of murder has traditionally been described as "malice aforethought" and is applied to cases where there has been an intention to kill or cause grievous bodily harm, without any mitigating circumstances.

Manslaughter is a legal term and there are two broad types. Involuntary manslaughter is committed without intent to kill or cause grievous bodily harm and therefore does not carry the mens rea for murder. It is an unlawful act resulting from gross negligence where an individual has failed to take reasonable care. The second type of manslaughter is voluntary manslaughter. In such cases, the accused has committed the crime with the mens rea for murder (i.e. he or she intended to kill the victim) but mitigating circumstances in the form of provocation, suicide pact or diminished responsibility, reduce the charge to manslaughter.

As a defence, diminished responsibility is the most relevant to cases of sexual homicide. Diminished responsibility can be accepted if the accused can prove on the balance of probability that when the homicide occurred they were "suffering from such abnormality of mind (whether arising from a condition of arrested or retarded development of mind or any inherent causes or induced by disease or injury) as substantially impaired his mental

responsibility for his acts...” Diminished responsibility was introduced as a partial defence in Section 2 of the Homicide Act 1957 for mentally disordered offenders who fell outside the narrow legal definition of insanity (Fennell, 2008). If successful, it can reduce the homicide offence from murder with the mandatory life sentence to manslaughter, where the sentence is within the judge’s discretion, although it does not necessarily mean that a hospital order will be imposed (Fennell, 2008).

In R *v* Byrne (1960) a young woman was strangled to death in a YWCA and then her corpse mutilated. The killer, Patrick Byrne, was described as a “sexual psychopath” who experienced violent sexual urges which he found “irresistible”. At his trial, all three medical professionals who gave evidence agreed that Byrne was not insane under the McNaughton Rules for insanity (Smith & Hogan, 2013), but suffering from an irresistible impulse which ultimately drove him to kill. Although the trial judge did not allow the defence of diminished responsibility to go to the jury, Byrne’s appeal was allowed and a verdict of manslaughter on grounds of diminished responsibility was accepted. The appellate judge, Lord Parker CJ, defined abnormality of mind as “a state of mind so different from that of ordinary human beings that the reasonable man would term it abnormal”. However, this did not affect his life sentence and Byrne remained in prison [(1960) *All England Reports*, 1] (Fennell, 2008).

Thus, given that most people who commit sexual homicide suffer from personality disorder and/or paraphilia, it appears that a substantial number of offenders are eligible to rely on the defence of diminished responsibility according to the ruling by Byrne. Even if successful, however, this does not mean that they will be subject to a hospital order. From the limited information we have available, it appears that sexual homicide offenders detained in prison are very similar to those detained in secure psychiatric units (Firestone et al., 1998), at least in the USA and Canada. In English law, up until 2007 and the amendments made to the Mental Health Act (1983), a person suffering from a personality disorder needed to be

considered *treatable* in order to be admitted to hospital. The 2007 amendment abolished the treatability dimension, stating instead that treatment must simply be *available*.

5.1.4 The present study

Although most offenders who commit sexual homicide, including those detained in prison, appear to suffer from some sort of mental disorder, most do not appear to suffer from a mental illness (e.g. schizophrenia, depression, bipolar disorder). This is the case even in secure psychiatric settings (Firestone et al., 1998) suggesting that the two populations may be very similar. However, there has been no study to date which compares directly sexual homicide offenders given a hospital order with those given a prison sentence. This is what the present study set out to do using a range of demographic, crime scene and clinical variables.

5.2 Methods

To qualify for the present study, participants had to meet at least one criterion of the definition of sexual homicide provided by Ressler et al., (1988). All participants were detained in either a high security psychiatric hospital or a prison that specialised in the psychological treatment of sexual offenders.

5.2.1 The psychiatric sample

Participants were recruited from one of the UKs high security psychiatric hospitals. At the time of the study, 14 men detained in the hospital under the Mental Health Act (1983; amended 2007) had committed at least one homicide that contained at least one criterion suggested by Ressler et al., (1988) in their description of the offence. With consent from clinical teams, all 14 men were approached with a request to take part in the study. Participation involved a detailed functional analysis interview of their homicide(s), a review

of all clinical reports containing information relevant to developmental, clinical, and offence-related information, a review of any available depositions in order to further establish motive, and completion of a brief battery of psychometric testing. Ten patients agreed to take part in the study and gave their informed consent for their files to be reviewed, although only eight agreed to be interviewed at length about their crimes. As mentioned in Chapter 3, of the four patients who refused to take part, three decided not to meet with the interviewer and one reported having his "own reasons not to take part" but would not provide any further details. The psychiatric sample had killed 32 victims in total. Twenty-five were female, seven were male. They had an average IQ of 102. 40% of the sample was single at the time of their first homicide and an equal percentage was in a relationship. The average age at the time of the assessment was 42, although at the time of their first homicide the average age was 25. Half the sample reported physical abuse before the age of 18 and 40% reported sexual abuse before 18. The majority of the sample (90%) was white-British with only 1 participant from a mixed race background (see Table 5.1). All participants who took part had been given Section 37/41 hospital orders from the crown court.

Table 5.1: Demographic characteristics

Characteristic	Psychiatric sample n=10	Prison-based sample n=26 -58 [1]	*P* Value
Mean age at time of assessment (SD)	42 (8.3)	39.3 (10.5)	n/s
Mean age at time of first homicide (SD)	25 (6.8)	24.2 (7.1)	n/s
Total length of time in prison	1 (0-4)	Not available	--------
Total length of time in hospital	15 (5-27)	Not available	--------
Mean IQ (SD)[2]	102.8 (12.1)	99.4 (13.9)	n/s
Occupational status at time of homicide			

Unemployed	60%	Information	
Full-time employment	30%	not available	
Full-time student	10%		
Ethnicity			
Caucasian	90%	93%	n/s
African-Caribbean	0%	7%	n/s
Mixed race	10%	0%	n/s
History of alcohol dependency	40%	20%	0.22
History of drug abuse	50%	70%	0.28
Previous history of non-sexual violence	60%	49.8%	0.73
Previous history of sexual violence	50%	33.9%	0.31
Physical abuse before age 18	50%	68.4%	0.28
Sexual abuse before age 18	40%	65.4%	0.18
Sexual orientation			
Heterosexual	60%	82.7%	0.20
Bisexual	30%	15.4%	0.35
Homosexual	10%	1.9%	0.31
Relationship status at time of first homicide			
Single	40%	38%	n/s
Married/Partner	40%	35%	n/s
Recent relationship breakdown	10%	15%	n/s
Casual partners only	10%	11%	n/s

[1] Prison-based sample sizes vary considerably due to the research team's ability to obtain relevant information from case file, which, in turn, was effected by variations in information recording practices between prison establishments.

[2]WAIS-R equivalents for the prison-based sample derived from Shipley Institute of Living Scale. Information was only available for those individuals who agreed to be interviewed.

5.2.2 The prison-based sample

A sample of 58 participants was recruited from a number of prisons in the UK that specialise in the treatment and management of sexual offenders. All participants had completed the Sex Offender Treatment Programme (SOTP). Each participant was identified as a sexual homicide offender due to the fact that they had killed at least one victim in a sexual context i.e. a selection strategy very similar to the one used to recruit the mental health sample described above. The prison-based sample was collected by Beech, Oliver, Fisher and Beckett (2005) as part of the Sexual Offender Treatment Programme Evaluation Project (STEP) between 1998 and 2002. Information was obtained from a combination of interview and case file review. It is important to note that, at the time of recruitment, offenders scoring 25 or more on the PCL-R were generally excluded from the SOTP. This means that the sample collected from the prison service did not include psychopaths as described by Hare. The majority of offenders (95%) in the prison sample were white. 55 (95%) had killed women, three (5%) had killed men. They had an average IQ of 99.4. Mean age at time of assessment was 39. Mean age at the time of the offence was 24. 38% of the prison sample reported not being in a relationship at the time of their offence and 15% reported a recent relationship break-up. 68% reported physical abuse during childhood and 65% sexual abuse, and in the majority of cases (61%) the abuse involved a male perpetrator. Average age of the victim was 34 and around half were strangers, where no reported conversation or interaction between victim and killer had taken place. 9 (16%) individuals had offended against a woman over the age of 65 and over three quarters had consumed alcohol or drugs prior to their offence(s) (see Table 5.1).

5.2.3 Procedure

A semi-structured interview with the aim of generating a functional analysis of the offence was administered as part of the procedure (see Appendix 1). The same interview protocol was used with both samples and asked about potential antecedents, such as major life events, relationships, substance misuse, fantasy and planning. It also asked direct questions about the offence itself. This included any use of weapons, disguises, victim resistance and how this was dealt with, and the presence of sexual arousal during the course of the attack and subsequently afterwards. This information was used to generate an understanding of whether or not the crime could be classified as organised or disorganised according to FBI criteria. If 6 or more features from either category were present at the time of the offence, then the appropriate label was applied (see Table 5.2). In general, the interviews lasted between two and four hours. Anonymity was assured and participants were encouraged to talk freely.

Table 5.2: Organised and Disorganised indicators

Organised	**Disorganised**
Planned	Spontaneous
Victim stranger	Victim known
Control of victim	Little control
Body hidden	Body not hidden
Evidence hidden or removed e.g. weapon removed from crime scene	Not attempt to hide or remove evidence e.g. weapon left at crime scene
More than average intelligence	Less than average intelligence
Controls own behaviour	Uncontrolled behaviour
Socially competent	Socially incompetent
Follows murder on news	Does not follow news
Limited change in behaviour	Major change in behaviour

Source: Ressler et al., 1988

As part of the assessment procedure, a number of psychometric tests were also administered. These were chosen in order to gain a better understanding of clinical presentation, sexual deviancy, childhood abuse and anger. Note that data relating to the STAXI-II and PCL-R were only available in the mental health sample. A brief description of each psychometric is presented below.

5.2.4 Measures used

Multiphasic Sex Inventory (Nichols & Molinder, 1984)

The MSI is a True/False self-report inventory consisting of 300 items and is designed specifically for use with sex offenders. It consists of 20 scales, six of which are validity scales designed to assess the respondent's attitude at the time of assessment. The remaining other 14 scales include a number of sexual deviancy measures, a sexual knowledge and belief measure, a measure of sexual dysfunction, and a motivation to engage in treatment scale.

Memories of Childhood (Perris et al., 1980)

This instrument is a self-report measure of an individual's perception of their parents' behaviour towards them as they were growing up. The questionnaire was developed in Sweden and prompts the respondent to rate on a four-point Likert scale, ranging from 'No, never to 'Yes, most of the time. Three sub-categories are included in this measure: (1) over-protectiveness, (2) warmth, and (3) perception of rejection. Separate scores are produced for both Mother and Father.

Millon Clinical Multi-axial Inventory III (Millon, 1994)

The MCMI III is a 175 item self-report psycho-diagnostic assessment that was developed in line with DSM-IV. It assesses for a range of psychopathology, including a number of clinical

syndromes (e.g. anxiety, major depression, bipolar disorder) as well as personality disorder. Base-rate scores are indicative of level of pathology. Scores of over 75 indicate presence of traits associated with a syndrome; scores of over 85 indicate clinical presence of a disorder. The assessment is sensitive to an individual's tendency to exaggerate or minimise their difficulties. Millon (1994) has reported test- retest reliability coefficients between 0.80 and 0.90 over a short retest interval.

State Trait Anger Expression Inventory II (Spielberger, 1998)

The STAXI-II is a 57-item self-report questionnaire designed to measure the experience and expression of anger in respondents. The STAXI-II State Anger scale assesses the intensity of anger as an emotional state at a particular time. The Trait Anger scale measures how often angry feelings are experienced over time. The Anger Expression and Anger Control scales assess four relatively independent anger-related traits: (a) expression of anger toward other persons or objects in the environment (Anger Expression-Out); (b) holding in or suppressing angry feelings (Anger Expression-In); (c) controlling angry feelings by preventing the expression of anger toward other persons or objects in the environment (Anger Control-Out); and (d) controlling suppressed angry feelings by calming down or cooling off (Anger Control-In).

Psychopathy Checklist-Revised (PCL-R; Hare, 2003)

The PCL-R is a 20-item clinical checklist of interpersonal (e.g. glibness/superficial charm, grandiose sense of self-worth), affective (e.g. shallow affect, callous lack of empathy) and behavioural (e.g. impulsivity, poor behavioural controls) features associated with the syndrome. Valid PCL-R ratings can be made on the basis of high quality archival information

(Harris, Rice & Quinsey, 1994; Quinsey, Rice & Harris, 1995). The main author who completed each rating is trained in the use of the tool.

5.3 Results†

5.3.1 Victim characteristics and pre-crime variables

Table 5.3 compares a select number of pre-crime variables and victim characteristics for both samples. It can be seen that the victims of the psychiatric sample tended to be older than those detained in prison. The majority of offenders detained in prison had taken a single life (73.7%), whereas half of those detained in hospital had killed at least 2 victims, with a third conforming to the FBI description of serial killer (i.e. having killed at least 3 victims with a significant cooling off period in between each homicide).

The samples were similar in predominately killing adult females only (i.e. women over the age of 16), with significantly more of the prison-based sample doing so. Although not significant, a greater proportion of participants detained in prison had killed strangers, which is unusual in non-serial forms of homicide, including sexual homicide. Consumption of drugs and alcohol was common in both samples in the 48 hours preceding their crimes, as was use of pornography and a feeling of isolation in the psychiatric sample.

†Note that due to low numbers within the psychiatric sample, it was not possible to employ the use of parametric statistical tests to analyse date. Where appropriate, Fisher's Exact Test and the Mann Whitney U test of independent samples have been used.

All participants in the psychiatric sample killed alone compared to a small number of individuals in prison who killed with an accomplice. Most victims of those detained in hospital were white-British and killed by means of stabbing or asphyxiation either manually (by using their hands), or by use of a rope or similar weapon (e.g. neck tie).

In half of cases within the psychiatric sample mutilations were carried out on the victim postmortem. In most cases, mutilations were extensive, ranging from body dissection to total evisceration and cannibalism. In one case, body parts and clothing were removed from the crime scene. According to FBI description, significantly more crime scenes of the psychiatric sample were labelled as disorganised (see Table 5.3).

Table 5.3: Differences in victim and crime-scene situational characteristics

Victim characteristics	Psychiatric	Prison-based	*P*
Mean age of victims	46.3	34.2	0.05*
Age of youngest victim	4	7	--------
Age of oldest victim	96	86	--------
Total number of victims	32	83	--------
Killed once	50%	73.7%	0.15
Killed twice	20%	17.5%	1
Serial killers	30%	8.8%	0.09
Offended against males only	10%	5.2%	0.49
Offended against females only	70%	94.8%	0.04*
Offended against adults only (> 16yrs old)	90%	82.8%	1
Offended against children only <16yrs old)	10%	15.5%	1
Offended against adults and children	0%	1.7%	1
Offended against older adults (> 65 yrs old)	30%	15.8%	0.37
Wife/Partner	0%	12.1%	0.58
Other family member	20%	5.2%	0.16

Acquaintance	40%	36.2%	1
Stranger	30%	44.8%	0.49
Co-defendant	0%	7%	1
Prostitute	10%	1.7%	0.28
Disorganised crime scene	90%	30%	0.01**
Drugs consumed 24 hours before homicide	20%	23.4%	1
Alcohol consumed 24 hours before homicide	40%	72.3%	0.08
Pornography used 24 hours before homicide	30%	Information not available	
A feeling of isolation	80%		
Race			
White British	87.5%		
White European	3.1%		
Black	3.1%		
Asian	6.3%		
Use of a weapon			
Blunt object	10%		
Knife	30%		
Rope/Neck tie /Sweater sleeve/Pillow	40%		
Manual strangulation	20%		
Vaginal penetration	30%		
Anal penetration	10%		
Penetration with an object	10%		
Mutilation carried out	50%		

* $p < 0.05$ ** $p < 0.01$

5.3.2 Psychiatric diagnoses

Somewhat inconsistent with the literature, there is evidence to suggest that half the psychiatric sample was psychotic (i.e., diagnosed with a form of Schizophrenia) at the time of the index offence, and over half (n=6) had a diagnosis of at least one personality disorder, with Antisocial being the most common and many being co-morbid with other personality disorders. The majority of the psychiatric sample (n=7) had been diagnosed with at least one paraphilia – sexual sadism and voyeurism being the most common. 50% of the sample talked of experiencing deviant and coercive fantasies in the 48 hours before their homicides, but no participant described experiencing sexual pleasure from actually killing their victim. None had diagnoses of either affective disorders or anxiety disorders (see Table 5.4). 31.3% of the prison sample had a diagnosis of a mental illness at the time of assessment for research and 17% had a diagnosis of personality disorder. Unfortunately, information regarding their diagnoses was not available, and research data was not clear in terms of whether participants were suffering at the time of their arrest or whether they became ill whilst in prison. However, two thirds (68%) of the sample had some sort of psychiatric assessment or intervention at some point in their lives before committing homicide. This ranged from being referred to a psychiatrist as a child due to conduct problems, for example, to periods of admission to a psychiatric institution in adulthood.

Table 5.4: Diagnostic status of the psychiatric sample

DSM diagnoses	Psychiatric sample (n = 10)
Schizophrenia	5
Affective disorders	0
Anxiety disorders	0
Personality disorders (overall)	6
Antisocial	5
Borderline	2
Avoidant	1
Autistic spectrum disorders	1
Paraphilias (overall)	7
Fetish	2
Transvestism	1
Sexual sadism	6
Zoophilia	2
Voyeurism	3
Telephone scatalogia	1
Substance abuse	8

5.3.3 Psychometric data

MCMI III (Millon, 1994)

Due to the small sample sizes used, a comparative analysis of Millon scores was carried out using Fisher's Exact Test. In terms of response style, it is perhaps not surprising to note that the psychiatric sample was significantly more disclosing of psychopathology ($p = .03$). The samples were similar in terms of desirability (wanting to be seen in a favourable light) and debasement (faking bad). In terms of self-reported personality pathology and other clinical

syndromes, the two samples produced similar profiles on the MCMI III. For example, both groups displayed some evidence of the schizoid/avoidant personality disorder style first highlighted by Brittain in the 1970s. Both groups also shared relatively high rates of anxiety as well as somatoform disorders. There is a significantly higher incidence of dependent ($p = .007$), antisocial ($p = .05$) and narcissistic personality disorders ($p = .005$) in the psychiatric sample as well as a higher incidence of alcohol dependency ($p = .01$). All other sub-scales remain very similar and comparatively low (see Table 5.5).

Table 5.5: Percentage of sexual homicide offenders with base rate scores over 74 and over 84 on the personality and clinical syndrome scales of the MCMI III

MCMI III Scale	Psychiatric (%) (N = 10) BR score		Prison-based (%) (N = 44) BR score		*P* Value
	75-84	> 84	75-84	> 84	
Disclosure	10	30	2.3	9.1	0.03*
Desirability	30	0	20	11.4	1
Debasement	30	0	0	4.5	1
Schizoid	10	10	6.8	0.0	0.23
Avoidant	20	30	20.5	2.3	0.69
Depressive	40	0	25	9.1	1
Dependent	60	10	11.4	11.4	0.007**
Histrionic	0	0	4.5	0.0	1
Narcissistic	0	40	2.3	0.0	0.005**
Antisocial	20	40	15.9	6.8	0.05*
Sadistic	0	0	4.5	0.0	1
Compulsive	20	0	6.8	0.0	0.23

Negativistic (passive-aggressive)	0	0	6.8	6.8	0.58
Masochistic (self-defeating)	10	0	15.9	6.8	0.18
Schizotypal	0	0	0.0	2.3	0.09
Borderline	20	0	4.5	4.5	0.31
Paranoid	0	0	0.0	4.5	1
Anxiety	30	50	36.4	18.2	0.17
Somatoform	0	0	0.0	2.3	1
Bipolar: manic	0	0	0.0	2.3	1
Dysthymia	0	0	18.2	0.0	0.33
Alcohol dependence	20	50	15.9	9.1	0.01*
Drug dependence	40	0	13.6	2.3	0.19
Post-traumatic stress disorder	10	0	9.1	2.3	1
Thought disorder	10	20	0.0	2.3	1
Major depression	0	0	2.3	2.3	1
Delusional disorder	0	0	0.0	2.3	1

* $p < 0.05$; ** $p < 0.01$

Multiphasic Sex Inventory (MSI; Nichols & Molinder, 1984)

On the MSI, participants in the psychiatric sample rated themselves as significantly more sexually deviant than those in prison and significantly more when compared to a sample of pre-treated rapists (see MSI manual, Nichols & Molinder, 1984). Psychiatric inpatients also rated themselves as experiencing a significantly higher level of sexual dysfunction, sexual obsession and cognitive distortion. Both samples rated similarly on measures of treatment attitude (2.13/3.9) and Justification for offending (2.78/1.8) indicating that most participants took some responsibility for their crime and were motivated to engage in treatment (see Table 5.6).

Table 5.6: MSI data and comparative data from rapists and college students

	Prison sample	Psychiatric sample	*P*	Rapists†	
	M SD	M SD		M	SD
Rape Scale[1]	7.43 (5.3)	9.6 (9.9)	0.44	10.517	7.655
Paraphilias[2]	2.68 (3.0)	9.7 (6.8)	0.00**	4.179	4.520
Cognitive Distortion	4.45 (2.75)	7.5 (1.84)	0.01**	6.34	2.416
Sex Knowledge & Beliefs	17.63 (3.7)	15.7 (4.3)	0.74	17.071	3.173
Sex Dysfunction[3]	2.43 (2.8)	8.9 (2.7)	0.02*	1.833	3.275
Social Sexual Desirability	23.4 (8.0)	26.1 (8.6)	0.81	10.433	2.985
Sex Obsessions	2.9 (4.4)	5.3 (2.5)	0.04*	3.607	3.447

[1] Combined scales of Deviant Arousal, Pre-Assault, Sexual Assault, Aggravated Assault, Intra-familial type

[2] Combined scales of Fetish, Voyeurism, Obscene Phone Calls, Bondage & Discipline, Sado-Masochism

[3] Combined scales of Sexual Inadequacies, Premature Ejaculation, Physical Disabilities & Impotence

† Comparative sample mean data taken from the manual of the MSI (Nichols & Molinder, 1984)

* $p < 0.05$; ** $p < 0.01$

Memories of Childhood (Perris et al., 1980)

The two groups appeared to differ in their perception of their parents' behaviour towards them as they were growing up. The prison-based sample rated both parents as significantly more over-protective than the psychiatric sample. The prison-based sample also endorsed significantly more items descriptive of warmth by their parents towards them. The prisoners also rated their parents as more rejecting, but this latter finding was not statistically significant. See Table 5.7.

Table 5.7: Memories of Childhood scores

Mother	Psychiatric[1]	Prison[2]	*P*	Father	Psychiatric[1]	Prison[2]	*P*
Over-protective	9.3 (3.8)	19.5 (4.5)	0.00**	Over-protective	11.8	19.5 (3.7)	0.01**
Warmth	5.5 (2.7)	15.5 (3.8)	0.00**	Warmth	3.5	13.9 (4.6)	0.00**
Rejecting	6.4 (2.7)	10.7 (3.1)	0.21	Rejecting	9.6	12.1 (4.6)	0.33

[1]N = 10; [2]N = 21 -39 dependent on information available

** $p < 0.01$

5.3.4 Anger

In terms of anger, results from the psychiatric sample on the STAXI II indicated that participants believed their general state and trait anger to be low compared to a standardised (North American) hospital sample of male in-patients. However, significantly elevated scores were observed on both the Anger Control Out and Anger Control In subscales. This indicates that the hospital-based sexual homicide offenders as a whole were likely to spend a great deal of energy trying to prevent any outward expression of anger and, therefore, could be seen as being 'over-controlled' in their tempers. See Table 5.8.

Table 5.8: Summary of STAXI II scores (Spielberger, 1998) (psychiatric sample only)

Subscale	Mean/SD SHO[1]	Mean/SD† Comparison	Subscale	Mean/SD SHO[1]	Mean/SD† Comparison
State anger	16 (0.85)	22.71 (8.49)	Trait anger	13.6 (0.92)	20.14 (5.86)
Feeling angry	5 (2.13)	9.16 (3.97)	Angry temperament	4.6 (1.92)	6.88 (2.92)
Expressing verbally	5.6 (2.70)	7.73 (3.55)	Angry reaction	6.8 (2.30)	9.61 (3.17) [2]
Anger physically	5.4 (3.10)	5.96 (2.09)	Anger control out	29.8 (3.10)	21.06 (0.23) [2]
Anger expression out	12.4 (3.73)	15.68 (4.16)	Anger expression in	13 (2.63)	18.26 (4.68) [2]
Anger control in	29.4[2] (12.2)	21.39 (6.13)	Anger expression index	14.2 (3.29)	39.58 (13.96) [2]

† Based on a sample of male psychiatric patients aged 18 years and over

[1] SHO = Sexual Homicide Offender (psychiatric sample only)

[2] Indicates elevated or reduced scores as compared to psychiatric population

5.3.5 Psychopathy Checklist-Revised (Hare, 2003) (Psychiatric sample only)

All participants in the psychiatric sample were rated for the presence of psychopathy using the PCL-R. Assessments had been completed by qualified and trained assessors and were available from participants' files. The mean total score for the 10 participants was 24.8. For Factor 1 (interpersonal/affective) the mean score was 10.8 and for Factor 2 (Antisocial lifestyle) it was 11.1. This is comparable with previous North American studies that investigated the prevalence of psychopathy in prison-based samples (mean score of 26.5; Porter et al., 2003) and secure psychiatric hospitals (mean score of 26.6; Firestone et al.,

1998). 60% of the sample was rated as having total scores of 25 or over, indicating that just over half of participants met the UK accepted cut-off score for a diagnosis of psychopathy. A comparative analysis is not available from the prison-based sample due to a requirement of the group programme they had been referred to which did not accept individuals who scored over 25 on the measure.

5.4 Discussion

5.4.1 Demographics, victim and crime variable differences

This is the first reported study to compare sexual homicide offenders given a hospital order for their crime with those given a prison sentence against a number of psychological, psychiatric and crime-scene variables. In terms of demographics, the two groups were remarkably similar. For example, both groups were around their mid-twenties when they committed their first homicide, both groups reported similar frequencies of previous violent and sexually violent offences, and both groups reported similar frequencies of physical and sexual abuse during childhood.

In terms of victim and crime-scene variables, a number of differences were found. Victims tended to be older in the psychiatric sample, and if not known to their killer, they were at least acquainted. This is consistent with the literature which suggests that people with a mental illness who kill are far more likely to do so against someone they know (National Confidential Enquiry into Suicide and Homicide by people with Mental Illness, Annual Report, 2014). This was not the case for those with multiple victims (i.e. serial killers). The three serial killers in the sample killed strangers. This is also consistent with the literature (e.g., Ressler et al., 1986). Almost all crime scenes of participants in the psychiatric sample were disorganised according to FBI criteria, compared to only 30% of those detained in prison. Fifty percent of the psychiatric sample performed acts of mutilation on the bodies of

their victims after they had killed them. This included acts of gratuitous violence, body part dismemberment and, in one case, cannibalism. It is unfortunate that no comparative data is available from the prison sample. However, only a minority of individuals in prison were identified as being sadistic (Beech et al., 2005). One word of caution however, given the strong association between psychopathy and gratuitous forms of violence in sexual homicide offenders (Porter et al., 2003), the fact that the prison sample did not include individuals who had scored over 25 on the PCL-R may be significant.

5.4.2 Differences in experiences of up-bringing

Participants differed in their perceptions of their parents' behaviour towards them growing up. For example, participants in the prison sample rated both parents as significantly more overprotective and warm than those in the psychiatric sample. Given that both samples reported relatively high frequencies of both physical and sexual abuse during childhood, it is difficult to explain such a finding. However, more research is needed to provide an understanding of attachment styles in sexual homicide offenders.

5.4.3 Differences in types and prevalence of mental disorder

The literature is consistent in reporting that few sexual homicide offenders are psychotic at the time of their homicides. This is the case even in medium secure psychiatric services where only 15% of offenders are mentally ill (Firestone et al., 1998). However, the present research investigating the crime in a high security psychiatric institution found that at least half of the participants who took part in the study were psychotic at the time of their index offence. None had diagnoses of mood disorders or anxiety disorders. However, over half had a diagnosis of personality disorder and 70% had a diagnosis of at least one paraphilia. This is consistent with the literature. In comparison, only 31.3% of the prison sample had a diagnosis

of a major mental illness at the time of their assessment and only 17% had a diagnosis of personality disorder. This is reflected further in a comparison of the MCMI III profiles of the two samples. There was a higher incidence of antisocial, narcissistic and dependant personality disorders as well as higher levels of alcohol dependency and drug abuse in participants detained in the psychiatric setting. On the MSI, participants in hospital rated themselves as more sexually deviant and as experiencing higher levels of sexual dysfunction and sexual obsession. They also rated themselves as more cognitively distorted than the prison sample. This could be a reflection of a psychotic process during the commission of the offence which impacted on their mental processing of events, or it could be a reflection of shame. Alternatively, it could be the result of a difference in post-offence reaction not fully assessed for in the present study. For example, some offenders in the psychiatric sample talked of experiencing a dissociative-like reaction after their crime, which may have impacted on their memory of events. It is unfortunate that such detail was not available in the prison sample.

5.4.4 Impact of mental disorder on offending

Although in some cases, psychosis may play a direct and causative role in sexual offending through, for example, command auditory hallucinations or sexual delusions (Jones 1992), it is more likely that the effects of mental illness for our psychiatric sample acted as a potentiator for violence in the context of other variables (such as deviant fantasy, antisocial behaviour, drug and alcohol abuse). It is also possible that the impact of the illness had a disinhibitory effect on behaviour by distorting cognitions about sex or victims. Most participants in the psychiatric sample, including those with psychosis, had committed acts of violence, including sexual violence, before they committed their index offence of homicide. Furthermore, participants reported high levels of deviant sexual preference, sexual dysfunction and

obsession with sex at the time of assessment when presumably positive symptoms of their psychosis were controlled by medication. Thus, although two participants with paranoid schizophrenia in our sample complained of hearing command hallucinations instructing them to kill, we agree with Phillips et al., (1999) and Jones (1992) in suggesting that psychosis alone is not sufficient to explain the mechanisms by which mentally ill sex offenders offend.

Despite the fact that 60% of the psychiatric sample had been diagnosed with sexual sadism, the crime scenes of most participants in the sample were highly disorganised and bizarre in the sense that no clear evidence of ritual was present and all crimes bar one were poorly planned. This is probably reflective of severe mental illness and of a thinking pattern that was chaotic and in dyscontrol. This was the case even for those with multiple victims. Deviant fantasy was a feature of at least 50% of the sample. Most fantasies revolved around coercive sex with an adult female. However, none described a sexual fantasy of wanting to kill another human being. Therefore, no participant in the sample conformed to the clinical description of erotophonophilia, where the thought of taking another life provides a sexual return for the individual.

5.4.5 Motivation

Two out of the three types of sexual homicide offender identified in the literature were clearly evident in the psychiatric sample – i.e. those motivated by anger and those motivated by sadism. Forty percent of the sample appeared to kill out of either a sudden loss of self-control or a more protracted dynamic fuelled by a hatred of women. These participants scored very highly on the control subscales of the STAXI II, suggesting that they were over-controlled in terms of their anger. Allowing such pent-up negative emotion to build and then be unleashed upon an individual is a dangerous way to deal with anger and is reflective of the term ‘over-kill’. For example, one of our participants stabbed a victim over 50 times after a

perceived negative comment was made by the victim. Interestingly, there is recent evidence to suggest that the more stab wounds inflicted upon a victim, the more likely it is that a sexual motive exists for the killing (Radojević et al., 2013).

Although sexual sadism was a feature of over half the sample and severe mutilations were carried out by 50% of participants, this was not done in the controlled, methodical way in which it is purported that a sadist usually operates. However, combined with high traits of psychopathy and/or the disabling impact of a psychotic illness, an individual may end up killing during a forced sexual encounter.

It is interesting to note that none of the offences committed by participants in the psychiatric sample conformed to the sexually-motivated type of offender. This type of sexual homicide offender kills in order to silence the only witness to his sex crime or perhaps accidentally in response to the struggles of his victim. Not finding evidence for this type of killer in a hospital setting is not surprising, however. An offending dynamic such as this denotes an offender who is clearly in control of his behaviour and who is acting with deliberation and intent. Although possibly psychopathic in his presentation, there is little rationale for a psychiatric treatment order in such cases. Thus, it is hardly surprising that such an offender was not present in our sample.

5.4.6 Major findings and value of the study

This study has found that sexual homicide offenders given hospital orders and those given prison sentences are very similar with respect to demographics, prior offence record and reported history of abuse. However, in the psychiatric sample offences appeared to be more disorganised, expressive and more deviant in the sense that they contained acts of mutilation and, in one case, cannibalism. Such a finding could potentially be useful to law enforcement officers tasked with the duty of investigating suspected cases of sexual homicide. If such

findings are present in the context of a disorganised crime scene it could be an indicator of a psychotic process or a severe personality disorder that has impacted significantly on the individual's ability to plan and organise their thinking. It was also found in the study that offenders from the psychiatric sample were significantly more likely to target older victims.

The findings of the study also have implications for the assessment and treatment of mentally disordered offenders who commit sexual homicide. We found in our sample that offences were less likely to be driven by psychosis than deviant fantasy and anger, and since these areas are addressed in the SOTP then such treatment is indicated. However, some adaptations could be made, including an appreciation of how an individual's psychosis may have impacted on their cognitive functioning as well as existing deviant fantasies at the time of the offending. To the author's knowledge, there are currently no standard recommendations made to programmes facilitated in mental health units at the time of writing. However, it is advised that each case is explored using a detailed formulation-driven account of the offence to account for a hypothesised relationship between disorder and offence. This should be shared with the client first and discussed within the group to achieve a better understanding. Finally, given that a number of participants described feelings of dissociation following the offence, additional work around the possibility of trauma might be worth considering.

5.4.7 Limitations of the study and suggestions for future research

A significant limitation of the present study concerns the small sample sizes used. This is a common problem for researchers exploring the offence of sexual homicide, with sample sizes very rarely exceeding 30. In order to improve the strength of generalisation within the field, this needs to be addressed in larger scale, multi-site projects. Furthermore, because the prison-based sample was drawn from a treatment project that precluded men who scored

highly on the PCL-R, many individuals whose offences may have been more sadistic were absent.

Samples were also biased in the sense that all participants who took part in the study had completed at least some kind of therapy during the course of their detention. This is true of participants at both sites and is likely to include interventions aimed at targeting offence-related variables (e.g., anger, implicit theories, and management of deviant arousal). As a consequence, participants were generally able to present a reasonably clear and un-distorted narrative of their crime. It is feasible to suggest that offenders less engaged with their treatment pathway and perhaps in denial of its sexual nature would be less likely to take part in the study. Equally, those that did take part may have actually enjoyed talking about their offences. Although no participant admitted to masturbating over thoughts of their offences, offenders do have a tendency to lie, and six out of the 10 that agreed to take part had a diagnosis of sexual sadism. Similarly, the measures used to assess psychological functioning were done so at a time when offenders were relatively stable in their mental states and, in most cases, years after the offence had occurred. It is difficult to imagine that offenders would have presented in this way at the time of their offences. In addition, no standard measure of reliability (e.g., Paulhus Deception Scales) was used beforehand to establish the likelihood of participants answering truthfully in their responses to the psychometrics.

Using larger sample sizes, it would be interesting to explore further potential differences in crime scene variables between sexual homicide offenders deemed mentally ill and those deemed legally responsible at the time of the homicide. Drawing on from what was highlighted above, this would aide law enforcement officers with an understanding as to the possible presence of mental illness in a killer at the time of their offence.

It would also be interesting to conduct research into the success or otherwise of various psychological treatments offered to sexual homicide offenders in both hospital and in prison.

There has been some research in the UK on the efficacy of the Sex Offender Treatment Programme for use with such offenders. This has shown a mild to moderate reduction in offender risk. However, there have been no further studies relating to treatment, particularly in a mental health setting. Therefore, mental health units tend to devise their own adaptations on the basis of clinical opinion only. In addition, half of the psychiatric sample was thought to be psychotic at the time of their index offence and this is likely to have been taken into account in the sentencing stage of the offender. However, from the available evidence it was more difficult to determine what the courts were taking into account when deciding on the culpability and suitable placement for those with personality disorder. At the time of conducting the study, the English MHA 1983 stated that for a hospital order to be issued, the offender's mental disorder (in this case personality disorder) must be treatable. This is no longer the case in the 2007 amended version which merely states that treatment must be available. Presumably, the severity of the disorder in terms of its impact on the offender's thinking and disruption to their emotional well-being, combined with multiple paraphilias and significant level of disorganisation at the time of the crime, were sufficient enough for courts to decide on treatment in hospital rather than punishment in prison. However, the decision-making process of the courts needs to be investigated further using larger sample sizes and regression analysis.

5.5 Conclusion

Samples of prison-based and hospital-based sexual homicide offenders were compared in this study and found to be very similar in terms of their demographics, prior offence records and experiences of early abuse. There were also some differences. The crimes of the mentally disordered sample were more disorganised than those detained in prison. The violence inflicted upon victims was highly expressive, deviant, and involved extensive mutilation and,

in one case, cannibalism. It is feasible to suggest that the offender's mental state as a result of their diagnosis contributed significantly to the disorganisation apparent at the crime scene. If this is the case, the findings have implications for law enforcement agencies when faced with similar crime-scene evidence. We also suggest that offenders who commit homicidal acts of sexual violence in the context of a mental illness need to have an understanding of the relationship between their disorder and other important criminogenic features. Sex offender treatment programmes delivered in mental health settings need to adapt their interventions to take account of this. However, given that both samples consisted of small numbers of participants, it is difficult to generalise from the findings.

Chapter 6

Discussion

In this final section of the thesis, key findings are presented. The research is then discussed with a number of key areas being re-visited. These include the definition of sexual homicide, understanding of motive connected with the offence, impact of mental disorder, and a consideration of whether people who commit acts of sexual homicide are any different from sex offenders who do not kill their victim. Finally, applications and limitations of the research are presented.

6.1 Key findings of the thesis

1) The psychological characteristics of sexual homicide offenders with severe and debilitating forms of mental disorder may not be significantly different from men who commit such acts of violence without such disorders.
2) Level of deviancy, however, is likely to be more extreme in those detained in secure hospitals. This is likely to include, severity of mental disorder (e.g. personality disorder impacting more detrimentally on social functioning), and sexual deviance as well as increase in frequency of major mental disorders (e.g. schizophrenia).
3) Experiencing the symptoms of a major mental illness was not a primary motivating factor in the offences of any of the participants who took part in the study. Such illnesses likely impacted negatively on the way offenders were thinking at the time of their offence, but no offender committed his crimes either through offence-related delusion or hallucination.

4) Severe forms of mental disorder are likely to be reflected in the crime-scenes of sexual homicide offenders (SHO) with such conditions. Crime-scenes are likely to be highly disorganised with expressive violence.
5) The sexually-motivated SHO may be less frequently found in a forensic hospital setting, possibly due to a less disorganised, instrumental function to the killing (e.g. in order to prevent a victim from revealing their identity).
6) The situational context is crucial to understanding why a sexual homicide takes place in many, if not, most offences. This can only be understood fully by constructing a psychological formulation, which links the offender's mental state and motivational drives with the course of events that unfold. Several examples have been included as part of this thesis to illustrate how this might be done.
7) Avenging sexual abuse and pent-up negative emotion that is linked to the individual's sense of sexual identity (i.e. catathymia) are likely to be key motivational drives in many SHO. They may also parallel what is apparent in the offending pathways of the sadistic and anger-driven SHO respectively.
8) Anger difficulties may present differently in SHO in that some are under-controlled and others are over-controlled. It is hypothesised that those who are under-controlled and perceive the cause of their anger to lie within a particular group of people in society (e.g. prostitutes) are likely to be more at risk of repeating their crimes.
9) Specific treatments for each type of SHO have been explored in detail with reflection of the author's experience of working with such clients. It is recommended that SOTP as it is run in mental health settings take into account the offender's mental disorder on an individual formulation-driven basis, as this is likely to impact on an individual's offending in different ways. On the basis of the findings in the present work, psychosis is more likely to play an indirect role (e.g. disinhibiting) in the offence as

opposed to a direct one (e.g. command hallucinations instructing someone to kill) and therefore key motivational offence variables, such as sexual deviancy, offence-supportive cognitions, and emotion dysregulation, which are present in prison populations are also likely to be present in SHO detained in secure hospitals.

6.2 Revisiting the definition of sexual homicide

Thirty-five years on from the first academic text on the subject, we are still without an agreed definition of the term 'sexual homicide'. Given what we now know about the different types of sexual homicide offender, one possible definition might be..."any homicide committed in the context of sadistic sexual violence, a homicide committed in the context of anger or hatred that has been expressed at the crime scene in a sexual manner, or a homicide designed to eliminate the only witness to sexual assault or rape". This attempt at a definition of the crime takes recent research into account, but it fails to capture the complexity of the offence. Most offenders do not fall neatly into one category or another, and there are likely to be some sexual homicides that do not contain any overt evidence of sexual activity whatsoever.

In order to understand sexual homicide and thus create a formulation that will be useful to the offender as well as others working with them, three important elements must be included: 1) the sexual element connected to the killing, be it in the form of rape, assault or conscious fantasy at the time of the offence; 2) the motive for the killing, be it sadism, anger, instrumental etc..; and 3) the situational context that the victim and perpetrator are subject to. For some researchers, most notably Schlesinger (2004; 2007), the situational context is largely discounted, and the killing, together with some sort of arousal that is either overtly or covertly sexually motivated are very closely linked in time. Only in these circumstances, according to Schlesinger (2004; 2007), should a homicide be labelled 'sexual'. The so-called

'sexually motivated homicide offender', who kills purely for instrumental reasons, would not be regarded as a sexual homicide offender, according to Schlesinger, as the killing does not serve a sexual purpose. In a sense, the function of the homicide is no different from a robber who decides to kill his victim because his identity has been revealed. Schlesinger (2004; 2007) is not alone in his view; Folino (2000) and Grubin (1994) also believe that the term 'sexual homicide' should only apply to specific cases where sexual arousal is closely linked with violence. It was argued in Chapter 2, however, that even in homicides arising from unquestionable levels of sadistic violence, the motive for the killing may serve no additional sexual pleasure for the perpetrator and therefore fall out of the Schlesinger description. After researching the field for several years, the author of this thesis cannot agree with such a narrow description. A much broader account of the offence is preferred, which includes a consideration of the impact of situational triggers.

Instead of using just one label to define all cases of sexual homicide, is it time that researchers employed several different labels depending on the motive for the killing? Several authors seem to have done this over the years, but in many texts and academic papers written on the subject, labels are often used interchangeably. The term 'lust murder', for example, has often been used to describe homicides where the killing itself provides a sexual return for the perpetrator or where there is a significant sadistic motive for the crime. However, using a variety of labels to describe particular sets of dynamics associated with the offence is probably not helpful to researchers and mental health professionals. Labels, like definitions, which make an assumption about the motivational state of the offender, carry with them a great deal of bias (Greenall, 2012). As the term 'sexual homicide' carries with it no assumption about the motivational state of the offender, the author recommends that this term should be used to describe cases. As for the question of definition, is an attempt even necessary given how complex and how dynamic the offence can be? If an aspect of the

offender's sexuality is highlighted as being significant in the formulation of his homicide, then the killing may be labelled a 'sexual homicide'. It may not necessarily be a sexually motivated homicide (i.e. where the killing itself serves a degree of sexual pleasure) but it will highlight to clinicians involved in the offender's care of a treatment need related to his sexuality.

6.3 The motivation behind sexual homicide

Consistent with the literature, this thesis supports the finding that there are at least three different types of sexual homicide offender, but the complexity of each case, power of the situation and competing motivational drives throughout the offence mean that there is a significant degree of overlap. Identifying a number of themes associated with the offence from the perspective of the killer enabled a clearer understanding of the crime, particularly in terms of initial contact between victim and offender. For example, several offenders talked about avenging, in some way, sexual abuse that had happened to them during childhood. Several also admitted to an impulse to kill from an early age that became increasingly difficult to resist. This was particularly apparent in those with multiple victims where the killing seemed to initiate relief from a tension state. It would be interesting to explore this phenomenon further and perhaps use it as the base to understand the differences between those who kill on one occasion with those who kill multiple times. It was possible to link all four themes identified to create a more coherent understanding of the offence, and this was taken further in the form of case study analysis.

In an attempt to present detailed case history examples of all three types of killer, the nature of the sample used in the study (i.e. a high secure psychiatric hospital) presented a problem. None of the ten participants who took part in the study conformed to the sexually motivated type of killer identified in the literature (e.g. Beech et al., 2005). This type of

sexual homicide offender commits his offence with a high degree of deliberation, planning, control and forethought, and there is often a clear function behind the decision to kill i.e. to silence the only witness to a planned sexual assault/rape. With this in mind it is perhaps not surprising that *he* was not found in a mental health setting. A sexually motivated offender was selected from the prison-based STEP data to complete the case study analysis.

Formulations were developed in line with a cognitive behavioural framework which drew links between early life experiences, personality development, significant core beliefs and behavioural consequences of holding such beliefs. In addition, consideration was given to external factors which, to a large extent, previous motivational models of sexual homicide have neglected. Given findings from the thematic analysis and more detailed analysis of the cases presented in Chapter 3, this thesis argues that external factors are crucial in understanding sexual homicide. These range from critical life events which impact on the individual's self esteem, interpersonal dynamics with the victim and so-called facilitators (e.g. alcohol, drugs and pornography). Furthermore, although not explored in any detail, the offender's post-reaction to the homicide may be important in predicting whether or not a similar event will occur in the future. Serial offenders who took part in the study, for example, described a sense of relief from tension and anxiety after having killed a victim.

The formulations presented in chapter 3 were designed to illustrate how complex the offence of sexual homicide can be, and readers with an overview of what features are likely to be significant when working with a particular type of offender. Key areas of assessment and different treatment pathways were explored for each type of offender.

6.4 Consideration of the impact of mental disorder

A large focus of this thesis has explored the impact of mental disorder on cases of sexual homicide. The literature is consistent in suggesting that a large number of sexual homicide

offenders, including those detained in prison, evidence at least some degree of psychopathology at the time of their offence(s) and this is likely to be reflected in their crime(s). For example, an individual with Antisocial Personality Disorder may feel that he is entitled to have sex with whomever he chooses and care very little about the wishes of his victim. Another example might be an individual with paraphilia, who engages in coercive sexual practices to meet his sexual needs. Because the research was carried out in a secure psychiatric hospital, it would be expected that all participants who took part suffered from at least some kind of mental disorder. This is part of the essential criteria necessary for a hospital disposal. The literature on sexual homicide suggests, however, that even in such settings, mental illness (e.g. schizophrenia, major mood disorders) is rare. This was not found in the present study. Half the sample was thought to be psychotic at the time of their offence(s). What impact this may have had on their offences, however, is difficult to formulate, and although participants were interviewed about this in detail, mental illness was not assessed systematically in the interview protocol.

It is unlikely that psychosis played any direct part in initiating an offence. One serial offender complained of experiencing command auditory hallucinations at the time of his offences, but there was some doubt to his claim as he had presented an alternative account previously. It was also the case that the majority of psychotic offenders had committed acts of violence, including sexual violence, before the onset of their illness, suggesting that positive symptoms did not act as a primary motivator. It is more likely the case that psychosis acted as a facilitator of aggression in the sense that it reduced inhibition and perhaps twisted or contorted what deviant thoughts and fantasies were already present. It is arguable whether such individuals would have ended up committing homicide if they had not experienced a psychotic process at the time in question.

The crime scenes of those in the mental health sample were frequently more disorganised than those detained in prison. This is likely a reflection of their disorganised mental states at the time of the offence. Such a finding may be useful to law enforcement agencies who investigate such crimes, but more research is needed with greater sample sizes to establish this. Symptoms of mental ill health reflected in the crime scenes of participants was undoubtedly taken into account at their trial and carried forward in the court's decision to issue hospital orders. Some evidence of mental disorder was found in the prison-based sample, though not to the degree and not to the severity of which it was found in the hospital sample. Although the two samples differed markedly in this respect, it is interesting to note that the same motivational dynamics, at least in the form of an anger drive and a sadistic drive, were clearly noted in the sample.

6.5 Is the sexual homicide offender distinct from other sexual offenders?

It was highlighted in the review paper of this thesis that people who commit sexual homicide are not significantly different from sex offenders who do not end up killing their victim. This appears to be the case even in those who suffer from debilitating mental disorders at the time of their offence. The vast majority of participants in the mental health sample had committed other acts of non-sexual violence as well as acquisitive crimes and other offences before they had committed homicide. It is highly unlikely that all of their offending could be attributed to their disordered mental states. This thesis supports the view that sexual homicide cannot be understood in isolation from other forms of sexual violence and its perpetrators are best seen as generalists, rather than specialists when it comes to sexual violence. Only in cases where the killing itself provides a sexual return for the perpetrator (i.e. erotophonophilia) can one really say that sexual homicide is a distinct and unique form of offending, but one could say

this about any of the dangerous paraphilias (e.g. piquerism, hypoxyphilia, necrophilia etc…) that ultimately result in the individual offending.

6.6 Clinical applications of the research

It is hoped that this research has contributed to the scientific understanding of extreme acts of sexual violence, particularly those that end in homicide. The research has supported many findings from previous authors but also added to the existing knowledge base. It has investigated the defining features of sexual homicide and explored various motives for the offence in a review paper that was published. This has already attracted some attention from the academic community and has been presented at national conferences. On a more empirical level, it is has highlighted a number of themes that are likely to be motivational features of the offence, especially in those with diagnosed mental disorders. The research has suggested, for example, that elements reflective of abuse suffered at the hands of supposed care givers, are likely to be present within the crime sequence, particularly for offenders who are more sadistic in their approach.

This research has highlighted for practitioners that the offence of sexual homicide is indeed a very complex one and cannot be understood without consideration of both internal and external dynamics. Case studies have been used to illustrate the process and a review of evidenced-based treatments for each type of offender will inform clinicians about recovery pathways.

The research has also highlighted some of the differences between sexual homicide offenders given prison sentences and those given hospital orders. Previously, this had not been investigated, and given the assumption from the literature that offenders in each type of institution were very similar, science had little notion of what criminal courts were taking into account when deciding on culpability. Some interesting observations were noted; for

example, a higher than expected prevalence of psychotic disorders in the mental health sample and significantly more disorganised crime scenes were found. This research will be of use to those who treat sexual homicide offenders in hospital, and also to law enforcement officers faced with homicide crime scenes that are highly expressive and disorganised.

Finally, the research has heuristic property in the sense of highlighting several areas in need of more research attention. More will be said about potential areas of research in section 6.8 towards the end of the chapter.

6.7 Limitations of the research

Perhaps the most significant weakness of this thesis concerns the small sample sizes used, particularly with regards to data collected in the mental health setting. Initially, all three high secure hospitals in England were approached with a request to access patients who had committed a sexual homicide. In two hospitals, access was denied on the grounds that escorting staff could not be provided for a single researcher, and concern was raised about the impact of re-living potentially traumatic experiences in vulnerable individuals. In the one remaining hospital, the author held a post within the psychology department making access to secure parts of the institution easier. Use of small samples is a common problem in the area of sexual homicide research, which makes generalising from findings difficult. This is probably due to the rarity of the offence, but the high-profile status of some of its perpetrators, extreme nature of the crime, and poor defining criteria make accessing large samples difficult.

Another concern relates to the incomplete data set of the prison-based sample. Much of the data, especially that relating to type of mental health diagnoses, was missing from the STEP data base. This was simply due to the fact that such information was not available from offender files at the time of the study, and participants were either unavailable or unwilling to

be interviewed. The prison-based data was also skewed in the sense of excluding all men with PCL-R scores of 25 or over. This undoubtedly precluded many of the more sadistic offenders from taking part in the study.

Because this thesis worked with such a small number of participants, two of its studies took a qualitative approach to analysis. Problems in generalising from findings have already been highlighted above, but with qualitative methodologies there is the added concern of potential bias from the researcher. This is a risk for any researcher, irrespective of level of experience. Adhering to guidelines, for example those suggested by Braun and Clarke (2006), and incorporating some level of interrater reliability, provided at least some attempt to think about the data objectively, but one can never separate the researcher's own pre-conceptions and knowledge of the subject area completely.

A final concern relates to the possibility that participants may have been less than honest when talking about their offences. Steps were taken to ensure honesty in the form of clinical file checks and the use of multiple sources of evidence (e.g. psycho-physical methods, crime-scene photographs, and depositions) but subjects such as fantasy, which are deeply personal and difficult to assess, may not have been captured fully in the study.

6.8 Future directions

Over the past ten years there have been many articles investigating sexual homicide from a number of disciplines (e.g. psychology, criminology, psychiatry). The literature is becoming more creative and beginning to find larger sample sizes. Since commencing this PhD, there have been two studies exploring sexual homicide in female perpetrators (Chan & Frei, 2013; Chan, Frei, & Myers, 2013). Like their male counterparts, Chan and colleagues found that female sexual homicide offenders are more likely to kill people known to them, though not intimate partners or family members, and unlike male offenders, they are more likely to opt

for fire arms as their weapon of choice. Although the definition of the offence used by Chan et al., was perhaps over-inclusive allowing such motives as jealousy to be included, women do commit acts of sexual homicide and these remain poorly understood. Further research is needed to explore this group of offenders.

Another interesting area of exploration is gang-related sexual homicides. Again, this remains very poorly understood from a psychological perspective, yet cases do occur world-wide. India, for example, has seen several very high profile cases of such crimes in recent years. On 31st May 2014 The Guardian reported a fifth arrest in the gang-related sexual homicide of two teenage girls who were raped, killed and then hanged from trees about a hundred miles from New Delhi. This follows another case of a young woman who was raped and brutally murdered by a gang of men in December 2012 on board a moving bus. Understandably, such crimes have "sparked national outrage" (The Guardian, 31st May, 2013).

There is also little empirical research exploring what factors might predict repetition of sexual homicide. Campos and Cusson (2007) have explored potential differences between serial and single sexual homicide offenders using data from the FBI (e.g., Ressler et al., 1988) and Schlesinger (2004) has written about "ominous warning signs", but there is little contemporary psychological knowledge to guide clinicians in their risk assessments of apprehended subjects. This is an important area in need of further attention.

Findings from the present research suggest that situational factors are crucial in understanding cases of sexual homicide. Given the significance of the immediate environment in these cases, it might be worth exploring the decision-making process of offenders using a method such as multiple-sequential functional analysis. This would allow the researcher to investigate, on a step-by-step basis, the function behind an individual's

actions throughout the pre-crime, crime, and post-crime phase of the offence, enabling a more complete understanding of why an offence has taken place.

Another finding from this research suggests that few sexual homicide offenders fit neatly into one of the offender categories identified in the literature (e.g. angry, sadistic, and sexual). Classification systems are useful in the sense that they can help reduce the amount of apparent chaos associated with these crimes and they also provide some guidance about treatment. When considering criminal behaviour as complex as sexual homicide, however, especially in those cases involving mental disorder, the current state of the literature supporting a three class system (i.e. sadistic, anger, and sexual) is very limited. Perhaps one way to address this would be to adopt an approach similar to that taken by Ward and Siegert in their pathways model of sexual offending. The pathways model was originally developed with child sex offenders in mind, but it has been applied successfully to non-homicidal rapists (Lockmuller, Beech & Fisher, 2008). Adopting a theory-knitting perspective, the model presents an amalgamation of the most salient features of previous theories into a new model (Ward, Polaschek & Beech, 2006). Each pathway has a primary dysfunctional mechanism, but interacts with the other mechanisms proposed to precipitate a sexual offence. Such an approach could be applied to those who kill within a sexual context.

6.9 Conclusion

At the start of this thesis a number of key aims were generated: 1) to explore how the offence of sexual homicide has been defined in the academic literature; 2) to investigate possible motivations for the offence; and 3) to consider the impact of mental disorder on offender motivation and how this might be reflected in the crimes of perpetrators. With regards to the first aim, there is little doubt that sexual homicide has proved an extremely difficult phenomenon to define. Although many attempts have been suggested, they have only served

to confuse the area further rather than provide any firm clarification. Definitions which attempt to clarify motive bring with them a great deal of bias which can be dangerous when the sexual element is more subtle or not easy to immediately discern. It is advised that definitions that are more general in nature are preferred, with motive only being established on the basis of sound assessment and detailed formulation.

With regards to the second aim, this thesis has found that establishing motive for the offence of sexual homicide can be extremely complex and often hampered by a number of constraints, such as offender honesty, lack of information and mental health issues. In most cases, the offence can only be understood as resulting from the combination of a number of internal (e.g. classically conditioned remnants of abuse) and external factors (e.g. the dynamic interaction between perpetrator and victim in the pre-crime phase of an offence).

Understanding the relationship between mental disorder and sexual homicide was the final aim of the thesis. A number of key motivational themes were identified from participants, which are likely to be significant in understanding the offence as it is committed by mentally disordered offenders. The precise relationship between mental ill-health and sexual violence is probably best understood at an individual level and on the basis of individual symptoms that are more likely to act upon what is already in the offender's mind (e.g. sexual deviancy, offence-related cognitions) rather than having any direct influence. In many ways, those with severe forms of mental disorder who commit crimes of sexual homicide are little different from those without such conditions. Their treatment needs are likely to be very similar, but adaptations to sex offender programmes are needed to address the relationship between disorder and function of the offence.

Knowing why an individual has killed a particular victim in a certain way is critical in the context of risk assessment and crucial if any therapeutic intervention is to be effective. Although hampered by the many difficulties in researching the field, it is hoped that this

thesis has highlighted many of the key issues pertinent to the field and also provided some clarity for this complex and disturbing crime.

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APPENDIX I

FUNCTIONAL ANALYSIS INTERVIEW

If the offender has been convicted of more than one sexual offence, please refer to the ***most serious offence*** throughout this questionnaire

DISTAL ANTECEDENTS What was happening in your life just before the offences started? 1a) Where were you living? (Specify) 1b) Employment (Specify) 1c) How did you spend your free time? (Specify)	 …… …… …… ……
MAJOR LIFE EVENTS 2a) Were there any major upsetting or unpleasant events in your life at that time? (please circle any that apply)	Bereavement 1) YES 0) NO Redundancy 1) YES 0) NO Relationship Break-up 1) YES 0) NO Marriage 1) YES 0) NO Birth of a Child 1) YES 0) NO Moving House 1) YES 0) NO Other 1) YES 0) NO

	If other please specify……..
RELATIONSHIPS: General 3a) Did you have a problem making close friends?	1) YES 0) NO
3b) Did you have a problem making superficial acquaintances?	1) YES 0) NO
3c) Did you have a problem keeping friends?	1) YES 0)NO
3d) How satisfied were you with your friendships general? (please circle the one that applies)	1) Didn't have any friends 2) Not Satisfied 3) Not Very Satisfied 4) Satisfied 5) Very Satisfied

SEXUAL PARTNERS	

4a) Were you involved in any sexual relationship at the time? If yes go to 4b if not go to 4i.	1)YES 0)NO		
4b) IF YES for how long had that relationship been ongoing?	Days..... Months…..... Years…….....		
4c) Can you describe your partner?	Age…… Gender: 1) M 2) F		
4d) How satisfied were you with the sexual part of the relationship?	Satisfied with Relationship Satisfied with Frequency Satisfied with Variety	1)YES 1)YES 1)YES	0) NO 0) NO 0) NO
4e) Did you or your partner ever have a sexual affair?	You For more Frequent Sex For more Varied Sex Partner For more Frequent Sex For more Varied Sex	1)YES 1)YES 1)YES 1)YES 1)YES 1)YES	0) NO 0) NO 0) NO 0) NO 0) NO 0) NO

4f) Did you or your partner ever use prostitutes?	You	1)YES	0) NO
	For more Frequent Sex	1)YES	0) NO
	For more Varied Sex	1)YES	0) NO
	Partner	1)YES	0) NO
	For more Frequent Sex	1)YES	0) NO
	For more Varied Sex	1)YES	0) NO
4g) Did you or your partner have any sexual problems?		1)YES	0) NO
4h) If yes please circle	Low Libido	1)YES	0) NO
	Problems Getting an Erection	1)YES	0) NO
	Problems Maintaining an	1)YES	0) NO
	Erection	1)YES	0) NO
	Premature Ejaculation	1)YES	0) NO
	Doubts about Penis Size	1)YES	0) NO
	Other	1)YES	0) NO
4L) How did you feel about the relationship?	If other please specify.....		
	.....		
	.....		
	.....		

PRIOR TO THE OFFENCE 6a) Did you feel in control of your life at that time?	1)YES 0) NO
6b) If not, why not? (list factors)	....
6c) How would you describe the way you felt at the time just before the offence. (Please circle any that apply)	Happy 1)YES 0) NO Upset 1)YES 0) NO Anxious 1)YES 0) NO Detached 1)YES 0) NO Humiliated 1)YES 0) NO Confused 1)YES 0) NO Afraid 1)YES 0) NO Angry 1)YES 0) NO Depressed 1)YES 0) NO Other 1)YES 0) NO If other, please specify.....
6d) Did you feel under any pressure for any reason before the offence?	1)YES 0) NO

6e) If yes please circle what was making you feel under pressure.	Relationships	1)YES	0) NO
	Family	1)YES	0) NO
	Work	1)YES	0) NO
	Financial	1)YES	0) NO
	Other Offending	1)YES	0) NO
	Major Life Events	1)YES	0) NO
	Other	1)YES	0) NO
	If other please specify…….....		
ALCOHOL 7a) How much alcohol did you consume on average (UNITS/WEEK)? (1 unit = ½ pint of beer/ 1 glass of wine)	....		
7b) Did you consider it a problem?	1)YES	0) NO	
7c) Did your alcohol use cause you any problems in the following areas? (Please circle)	Family Relationships	1)YES	0) NO
	Friendships	1)YES	0) NO
	Money	1)YES	0) NO
	Offending-Sexual	1)YES	0) NO
	Offending-non sexual	1)YES	0) NO
	Employment	1)YES	0) NO

	Health	1)YES 0) NO
	Mood	1)YES 0) NO
DRUGS		
8a) Were you using drugs at the time?	1) YES 0) NO	
8b) If yes, which drugs and what was your usage?		
CANNABIS	0) No 1) Occasional 2) Regular 3) Heavy	
AMPHETAMINES (e.g. Speed)	0) No 1) Occasional 2) Regular 3) Heavy	
BARBITURATES (e.g. Sleeping tablets)	0) No 1) Occasional 2) Regular 3) Heavy	
TRANQUILIZERS	0) No 1) Occasional 2) Regular 3) Heavy	
HALLUCINOGENS (e.g. LSD)	0) No 1) Occasional 2) Regular 3) Heavy	
COCAINE	0) No 1) Occasional 2) Regular 3) Heavy	
OPIATES (e.g. Heroine)	0) No 1) Occasional 2) Regular 3) Heavy	
ECSTACY	0) No 1) Occasional 2) Regular 3) Heavy	
STIMULANTS (e.g. Glue)	0) No 1) Occasional 2) Regular 3) Heavy	
8c) Did you consider it a problem?	1) YES 0) NO	
8d) Did your drug use cause you any problems in the following areas?	Family Relationships	1)YES 0) NO
	Friendships	1)YES 0) NO
	Money	1)YES 0) NO

	Offending – Sexual	1)YES	0) NO
	Offending – Non Sexual	1)YES	0) NO
	Employment	1)YES	0) NO
	Health	1)YES	0) NO
	Mood	1)YES	0) NO
FANTASY 9a) Prior to committing this offence had you thought or fantasised about this sort of thing?	1) YES 0) NO		
9b) If yes, how long prior to committing the offence?	Minutes…….. Hours…..…….... Days…….. Months…..…… Years…..……		
9c) How often did you have these types of fantasies?	No. of times per week……		
9d) Expand on why	…… …… …… …… ……		

	…… …… …… …… ……
TRIGGER 10a) How long before the homicide did you first have the thought of committing this offence/acting out of the fantasy? 10b) Was the trigger a particular incident or a build-up of things?	Minutes……..... Hours…..…….... Days……..... Months…..…..... Years…..……..... Particular Incident Build-up of things Specify trigger:…….... ……. …….……
PLANNING 11a) How long before the offence did you start planning it?	Minutes…….... Hours…..…….. Days……..... Months…..…….....

	Years…..…….....
11b) Did you fantasise/masturbate about offending?	1) YES 0) NO
11c) Did you plan who the offence would be against?	1) YES 0) NO If yes, please specify……
11d) Did you plan where it would happen?	1) YES 0) NO If yes, please specify……
11e) Did you plan when it would happen?	1) YES 0) NO If yes, please specify…… .....
PRACTICAL PREPERATIONS 12a) What preparations did you make for this offence?	Weapon 1)YES 0) NO Disguise 1)YES 0) NO Gloves 1)YES 0) NO Condom 1)YES 0) NO Isolating victim 1)YES 0) NO

	Intoxicating victim 1)YES 0) NO Restraining equipment 1)YES 0) NO
VICTIM 13a) Who was the victim of homicide?	Stranger Casual Pick Up Prostitute Slight Acquaintance Acquaintance Family Member Business Associate Other If other, please specify…… ……
13b) Why did you choose that victim? (Was there anything about that victim that made you choose him or her?)	Picked at Random Felt attracted to him/her Represented a group Chosen to get at somebody else Other If other, please specify…… ……

13c) How old was the victim?	Age in years……
13d) How old did you think they were?	Perceived Age……
13e) Did you find the victim attractive?	1) YES 0) NO
13f) Before you began the assault, what were your thoughts about the victim?	Specify…… ……. ……. ……. ……. ……. …….
PERSONAL PREPARATION 14a) Were you feeling sexually aroused when you met the victim?	1) YES 0) NO
14b) Had you taken any alcohol or drugs just before offending?	1) YES 0) NO
14c) If yes, which?	Please circle 1) Drugs 2) Alcohol 3) Both

	Specify what……. .....
GROOMING VICTIM INTO SITUATION 15a) Where did you meet the victim?	Victim's Home Own Home Joint Home Out of Doors Neutral Building Public Transport Car
15b) What do you think the victim was expecting to happen?	Specify……. ……. ……. ……. ……. ……. …….
15c) What were you expecting to happen?	Specify……. ……. …….

	…… …… …… ……
15d) Where did the actual homicide occur?	Victim's Home Own Home Joint Home Out of Doors Neutral Building Public Transport Car
15e) How did you get the victim to the location of the homicide?	Victim Lured Victim Forced Already at Location
15f) Why did you choose that place/time?	Specify Time…….. Specify Place……..
15g) How long were you with the victim before the assault took place?	Minutes……... Hours…..……. Days…… Months…..……..

	Years……..		
OFFENCE 16a) Did you commit the offence alone?	1) YES 0) NO		
16b) How did you overcome the victim's resistance?	Payment	1)YES	0) NO
	Deception	1)YES	0) NO
	Verbal Threats	1)YES	0) NO
	Threat of weapon	1)YES	0) NO
	Force, no serious injury	1)YES	0) NO
	Force with serious injury	1)YES	0) NO
	Victim consented	1)YES	0) NO
	Victim seduced perpetrator	1)YES	0) NO
16c) Did you have a weapon with you?	1)YES 0) NO		
16d) If yes, please circle usage	Present but not used	1)YES	0) NO
	Mentioned but not used	1)YES	0) NO
	Used	1)YES	0) NO
16e) What type of weapon was used?	Knife	1)YES	0) NO
	Gun	1)YES	0) NO
	Weapon came to hand	1)YES	0) NO

	If other, please specify..... .....
16f) Did you or the victim remove any clothing?	1)YES 0) NO
16g) If yes, please specify any that apply	Perpetrator undressed self 1)YES 0) NO Perpetrator undressed victim 1)YES 0) NO Victim undressed self 1)YES 0) NO Victim undressed perpetrator 1)YES 0) NO If other, please specify……. …….
16h) Was the victim incapacitated/restrained in any way?	1) YES 0) NO
16i) If yes, with what? (Please circle)	Tied up 1)YES 0) NO Gagged 1)YES 0) NO Blindfolded 1)YES 0) NO Drugged 1)YES 0) NO Unconscious 1)YES 0) NO
16j) What was the significance of this?	Practical 1)YES 0) NO

	Sadistic 1)YES 0) NO Power 1)YES 0) NO Other 1)YES 0) NO
	If other, please specify……. ……. ……. ……. ……. ……. …….
16k) Did you do anything or get the victim to do anything to get you sexually aroused?	1) YES 0) NO Specify……. ……. ……. ……. ……. ……. …….
16l) Did you have an erection before the assault began?	1) YES 0) NO

16m) If no, did you do anything to get an erection? (Please circle any that apply)	1)YES 0) NO		
	Masturbated self	1)YES	0) NO
	Victim masturbated perpetrator	1)YES	0) NO
	Fetish Act	1)YES	0) NO
	Could not get an erection	1)YES	0) NO
16n) Did you want to sexually arouse your victim?	1)YES 0) NO		
16o) If yes, what did you do when attempting to get the victim aroused?	Nothing	1)YES	0) NO
	Already aroused	1)YES	0) NO
	Fondling body	1)YES	0) NO
	Fondling genitals	1)YES	0) NO
	Masturbating	1)YES	0) NO
	Victim got aroused	1)YES	0) NO
	During assault	1)YES	0) NO
	Other	1)YES	0) NO
	If other, please specify……. …….		
16p) During the actual offence, what did you do to the victim or make the	Touching body	1)YES	0) NO
	Perpetrator masturbates victim	1)YES	0) NO

victim do?	Victim masturbated perpetrator	1)YES	0) NO
	Penetrate/touch vagina with		
	● Penis	1)YES	0) NO
	● Fingers	1)YES	0) NO
	● Object	1)YES	0) NO
	Penetrate/touch anus with		
	● Penis	1)YES	0) NO
	● Fingers	1)YES	0) NO
	● Object	1)YES	0) NO
	Perform oral sex		
	● Perpetrator on victim	1)YES	0) NO
	● Victim on perpetrator	1)YES	0) NO
	Urinate/Defecate	1)YES	0) NO
	Inflict Pain	1)YES	0) NO
	Tied Up	1)YES	0) NO
	Other	1)YES	0) NO
	If other acts were done, please specify……		
	…….		
	…….		

	…… …… …… …… …… ……
16q) Recap on what the patient has just said "During the assault, this is what you did…….. Would you normally do these things to a consenting partner?" 16r) Explore and specify any significant differences	1)YES 0) NO Specify…… …… …… …… …… …… …… …… …… …… …… …… …… …… ……

	…… ……
16s) Did you say anything to the victim during the assault? If yes, please circle what was said.	1)YES 0) NO Questions 1)YES 0) NO Instructions 1)YES 0) NO Insults 1)YES 0) NO Threats 1)YES 0) NO Compliments 1)YES 0) NO Apologies 1)YES 0) NO Other 1)YES 0) NO If other things were said, please specify…….. …… …… …… ……
16t) In what tone of voice were the things said?	Threatening 1)YES 0) NO Angry 1)YES 0) NO Controlled 1)YES 0) NO Reassuring 1)YES 0) NO Other 1)YES 0) NO

	If other, please specify…… …… …… …… ……		
16u) What were you thinking about during the assault? (Please circle any that apply)	Yourself	1)YES	0) NO
	The victim	1)YES	0) NO
	Others	1)YES	0) NO
	Unrelated issues	1)YES	0) NO
	Other	1)YES	0) NO
	If other, please specify…… …… …… …… ……		
16v) What was the victim doing during the assault? (Please circle)	Crying/Pleading	1)YES	0) NO
	Compliant/going along with it	1)YES	0) NO
	Humouring	1)YES	0) NO
	Resisting/Complaining	1)YES	0) NO
	Trying to talk to you out of it	1)YES	0) NO

	Verbally hostile	1)YES	0) NO
	Physically hostile	1)YES	0) NO
	Other	1)YES	0) NO
	If other, please specify…….		
	…….		
	…….		
	…….		
	…….		
16w) How do you think the victim felt during the assault?	Elated	1)YES	0) NO
	Aroused	1)YES	0) NO
	Confused	1)YES	0) NO
	Detached	1)YES	0) NO
	Excited	1)YES	0) NO
	Angry	1)YES	0) NO
	Anxious	1)YES	0) NO
	Frightened	1)YES	0) NO
	Other	1)YES	0) NO
	If other, please specify…….		
	…….		
	…….		
	…….		
	…….		

16x) What were you feeling during the assault? (Please circle)	Elated	1)YES	0) NO
	Aroused	1)YES	0) NO
	Confused	1)YES	0) NO
	Detached	1)YES	0) NO
	Excited	1)YES	0) NO
	Angry	1)YES	0) NO
	Anxious	1)YES	0) NO
	Frightened	1)YES	0) NO
	In control	1)YES	0) NO
	Other	1)YES	0) NO
	If other, please specify……. ……. ……. ……. …….		
16y) Did your mood change at all during the course of the assault?	1)YES 0) NO		
16z) Did you ejaculate at any time?	1)YES 0) NO		
If yes, please circle when	During the assault	1)YES	0) NO
	Masturbated self after assault	1)YES	0) NO

	Victim masturbated you 1)YES 0) NO At any other time 1)YES 0) NO
16zz) If not, please specify why not	If at another time, please specify when……... ……. Specify……. ……. ……. ……. ……. …….
16zzz) How long did the assault take from start to finish?	Minutes…….. Hours…..……. Days……
IMMEDIATE POST OFFENCE REACTION 17a) Immediately after the offence, how did you feel <u>physically</u>? (Please circle)	Tired Sick If other, please specify…….

17b) How did you feel emotionally?	Frustrated	1)YES	0) NO
	Anxious/Afraid	1)YES	0) NO
	Guilty/Remorseful	1)YES	0) NO
	Excited	1)YES	0) NO
	Detached	1)YES	0) NO
	Humiliated	1)YES	0) NO
	Relieved	1)YES	0) NO
	Elated	1)YES	0) NO
	Other	1)YES	0) NO
	If other, please specify…….		
	…….		
17c) How did you behave towards the victim after the assault?	Wish to prolong	1)YES	0) NO
	Attempt to cover up tracks	1)YES	0) NO
	Other	1)YES	0) NO
	If other, please specify…….		
	…….		
17d) Did you try and reduce the risk of getting caught?	1)YES 0) NO		
17e) If yes, how did you do this?	Removed fingerprints	1)YES	0) NO

	By - Wiping 1)YES 0) NO Washing 1)YES 0) NO Condom 1)YES 0) NO Tied victim up 1)YES 0) NO Dismembered body 1)YES 0) NO Disposed of body elsewhere 1)YES 0) NO Other ways 1)YES 0) NO
	If other, please specify……. ……. ……. ……. …….
17f) Did you steal anything from the victim? 17g) If yes, please indicate when you stole 17h) What did you steal? 17i) How long did you spend with the	1)YES 0) NO Victim told, theft intended After thought Before thought Specify…… Minutes…….....

victim after the homicide?	Hours…..……... Days…….…..		
17j) What was going through your head immediately after the homicide? (Please circle)	Yourself	1)YES	0) NO
	The Victim	1)YES	0) NO
	Others	1)YES	0) NO
	Unrelated Issues	1)YES	0) NO
	Other things	1)YES	0) NO
	If other, please specify……. ……. ……. ……. …….		
17k) What did you do after the homicide?	Run away	1)YES	0) NO
	Panic	1)YES	0) NO
	Attempt to cover up tracks	1)YES	0) NO
	Carry on assaulting body	1)YES	0) NO
	Go to the police	1)YES	0) NO
	Other	1)YES	0) NO
	If other, please specify……. …….		

	…… …… ……
GENERAL POST OFFENCE REACTION 18a) Did you find the offence enjoyable? 18b) Why was this?	1)YES 0) NO Expand…… …… …… …… …… …… …… …… ……
18c) How did you feel?	Frustrated 1)YES 0) NO Anxious/Afraid 1)YES 0) NO Guilty/Remorseful 1)YES 0) NO Excited 1)YES 0) NO Detached 1)YES 0) NO Humiliated 1)YES 0) NO

	Relieved 1)YES 0) NO Elated 1)YES 0) NO Other 1)YES 0) NO
	If other, please specify……. …….
18d) After the homicide, have you ever fantasised about the offence? 18e) If yes, how often do you masturbate to these fantasies? (No of times per week) 18f) Has the offence affected any of your relationships? 18g) If yes, please specify with whom and how 18h) Have you ever discussed the	1)YES 0) NO Specify……. Specify……. 1)YES 0) NO Who……. How……. ……. ……. ……. 1) YES 0) NO

offence with anybody else?	Specify…….. ……..
18i) If yes, with whom?	Specify…….
18j) Did you consider the victim to be any of the following? (Please circle)	Promiscuous Seductive Hostile/vindictive

APPENDIX II

Dear Participant,

This project aims to explore homicide that has occurred within a sexual context and hopefully identify the clinical psychological needs of the individuals who have committed such crimes. The project is in collaboration with the University of Birmingham and 

 It requires you to talk in some detail about your index offence, particularly the immediate short-term events that led up to the homicide, details of the offence itself, as well as your experiences shortly after. Interviews will also be tape recorded. This is only to make sure that all details are recorded correctly. Information will be transcribed from the tapes (i.e. written down) and then the information will be cleared from the tape. There are also some psychometric tests for you to complete as part of the project. There is no time limit to complete the assessment, but it may take several hours. Upon taking part, some information, such as early historical life events, will be taken from your file so this will save time for you on the assessment. Let me assure you that you will not be pressured into answering anything that you don't want to, and any information you provide will be given an ID code to maintain your anonymity. You may also withdraw from the project at any time.

I have read the above and wish to take part in the project.

Signed:..... Date:.....

APPENDIX III

[redacted]

[redacted]

Date: 10/06/2010

UNIVERSITY OF BIRMINGHAM

[redacted]

Participant Information Sheet

Study title

Psychological characteristics of mentally disordered offenders who commit sexual homicide

What is the purpose of the study?

The purpose of this study is to investigate the link between mental disorder and the offence of sexual homicide in men.

Why have I been chosen?

Because you have committed a certain type of offence and your experiences would be beneficial to inform treatment, not only of yourself, but of others too.

Do I have to take part?

No. It is up to you to decide whether or not to take part.

What will happen to me if I take part?

You will be asked to participate in a one to one interview and, with your permission, this will be tape recorded for transcript. You will also be asked for permission to allow access to your

case notes. We will not use any identifiable information so nobody will be able to know that you took part in the study. As soon as the interview has been transcribed the material on the tape will be erased.

What will happen to me if I choose to no longer do the research?

If you withdraw from the study, we will destroy all information and results that we have collected. This will in no way affect your treatment at [redacted] or your care path way.

What are the possible disadvantages and risks of taking part?

You may be asked questions in relation to your offending or diagnosis that you would not like to answer. However, you are not obliged to give any answers if you don't want to.

What are the possible benefits of taking part?

We cannot promise that the study will have definite benefits until completed. However, the information you provide will be very useful and may have a direct impact on the delivery of treatment services to individuals who have committed similar offences to yourself.

What happens when the research study stops?

If requested we will provide you with some feedback. All information will be secured safely and is the responsibility of the chief investigator.

The study will be written up and will also contribute to an educational degree.

However **ALL** identifiable information will be removed to ensure you remain anonymous and any comments or answers you make will be confidential.

Will my taking part in the study be kept confidential?

Yes. All the information about your participation in this study will be kept confidential. The procedures for handling, processing, storage and destruction of data are compliant with the Data Protection Act 1998. The only time when your participation may not be kept confidential is if during the study you discuss any matters that would indicate a risk of concern for you or others or if you disclose any other serious offences that your clinical team is not aware of. If this were to happen such disclosures would need to be followed up with your clinical team.

What if a problem arises?

If you have a concern about any aspect of this study, you should ask to speak with the researchers who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure. Details can be obtained from the hospital nursing staff.

Contact Details:

If you wish to contact us regarding the research please ask a member of nursing staff to contact Kevin Kerr (Forensic Psychologist in Training) in Psychological Services on 4478.

If you withdraw from the study, we will destroy all information and results that we have collected. This will in no way affect your treatment at [redacted] or your care plans.

Thank you for your time