Serial murder revisited: a psychological exploration of two South African cases

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Summary

The phenomenon of serial murder has fascinated people for many years. Despite this fascination, the body of scientific knowledge surrounding this topic seems quite limited. Research is often based on second- hand and anecdotal sources of information and not on direct contact with the individuals who commit these crimes. Based on this information, assumptions are made about these individual's mental state and personality. This research which was undertaken is unique in that it is an in- depth look at two individuals who committed serial murder. The research design, grounded in interactional theory, makes use of unstructured interviews, an interactional analysis, and psychological tests such as the South African Wechsler Adult Intelligence Scale, Thematic Apperception Test, Millon Clinical Multiaxial Inventory-IIIed, Minnesota Multiphasic Personality Inventory 2nd Edition, and 16 Personality Factor Questionnaire in an attempt to try and come to a psychological understanding and interactional description of these two individuals' beahviour. In doing so it revisits what has already been said about this phenomenon, makes comparisons, and provides a brief theoretical view of the phenomenon as part of man's social order.

Key terminology

Serial murder

Interactional analysis

Interpersonal considerations

Minnesota Multiphasic Personality Inventory 2nd Edition

Millon Clinical Multiaxial Inventory- 3rd Edition

Reciprocal causality

Dysfunctional systems

Communication theory

Antisocial personality disorder

In- depth interviews

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Opsomming

Vir baie jare is mense gefasineerd met die fenomeen van reeksmoorde. Ongeag hierdie fasinering blyk die versamelde wetenskaplike kennis oor hierdie onderwerp egter beperk te wees. Navorsing is meesal gebaseer op tweedehandse en anekdotiese bronne en nie op grond van navorsingsgegewens wat gebaseer is op grond van kontak met die individue wat hierdie misdaad gepleeg het nie. Op hierdie grondslag word aannames gemaak oor individue wat reeksmoorde gepleeg het se geestestoestand en persoonlikhede. Die navorsing wat onderneem is, was egter uniek in dié sin dat twee individue wat reeksmoorde gepleeg het, deelgeneem het aan die in-diepte ondersoek wat geloods is. Die navorsingsontwerp gegrond op interaksionele teorie, het ongestruktureerde onderhoude, interaksionele analises, en sielkundige toetse as navorsingsprosedures ingesluit. Die toetse wat gebruik is, was die Minnesota Multiphasic Personality Inventory 2de Uitgawe, Millon Clinical Multiaxial Inventory 3de Uitgawe, 16 Persoonlikheidsfaktor Vraelys, die Tematiese Appersepsie Toets en die Suid Afrikaanse Wechsler Intelligensie Skaal vir Volwassenes. Die doel van die ondersoek was om te poog om tot 'n sielkundige begrip en interaksionele beskrywing van hierdie twee individue se gedrag te kom. Op hierdie wyse het die navorsing die reeds bestaande kennis oor hierdie onderwerp nagegaan, vergelykings getref en kort teoretiese gedagtes gewissel oor hierdie fenomeen se betekenis as deel van 'n gemeenskap se sosiale orde.

Sleutelwoorde

Reeksmoorde

Interaksionele analise

Interpersoonlike oorwegings

Minnesota Multiphasic Personality Inventory 2de Uitgawe

Millon Clinical Multiaxial Inventory 3de Uitgawe

Wederkerige oorsaaklikheid

Disfunksionele sisteme

kommunikasie teorie

Antisosiale persoonlikheidsverstruring

In- diepte onderhoude

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About This Study

1.1 Introduction

The phenomenon of serial murder has been reported for more than a hundred years, yet it is only over the last few decades that a specific name was provided to label this phenomenon. But serial murder has always been a crime that has attracted much media attention, such as the case of Jack the Ripper who, even today, is the source of regular documentaries and popular television and film productions. This is perhaps indicative of human kind's morbid fascination with bizarre, extraordinary or so- called abnormal behaviours.

Serial murder has even become useful as a political tool (Jenkins, 1994). For example if one considers the circumstances where the victims often are from a minority group. Politically serial murder may then be used to highlight racial discrimination, such as police 'apathy' when investigating serial murder in a neighbourhood predominantly inhabited by a minority group.

1.2 Previous studies

Despite much popular interest there seems to be little research and no clear consensus on various aspects of serial murder. Furthermore, researchers seem to be unclear of the reasons for serial murder, the profile of the serial murderer, their personality and behaviours. Despite research, the results seem varied and vague in its conclusions. Another aspect which has been lacking is a clear exposition of the theory underlying a serious crime such as serial murder. If a theory is interpreted from the research which analysed the behaviours of the serial murderer, or those of crime in general, the underlying theoretical assumptions seem to be from bio- medical,

sociological, or psychiatric reasoning. In South Africa Pistorius (1996) has formulated hypotheses from a psychoanalytical approach in an attempt to provide a more thorough psychological explanation for this phenomenon.

Much of the research on this topic, as mentioned in coming chapters, has been severely limited by factors such as lack of access to the individuals who have committed such crimes. It is most often based on 'second- hand' reports. Also, the research seems to focus on a psychodynamic approach to this phenomenon. There seems to be a great need for more research involving the actual individuals who committed these crimes; the use of reliable psychometric tests; possible comparison studies of serial murder across cultures and a search for a thorough and substantial theory on behaviour such as serial murder.

1.3 Aims of this study

The study investigates the phenomenon of serial murder from a different angle. The research makes use of first- hand information obtained from actual individuals who committed serial murder and were convicted. Many assumptions have been made about serial murderers because of the lack of access to such individuals. The researcher attempts to look at some of these assumptions, by means of interviews and psychological tests, and try and create an interactional understanding regarding serial murder and the people who commit it. Furthermore it will make use of recognised psychometric tests to clarify assumptions on the behaviours and styles of behaviours of these persons. In future, if researchers are in the position to do the same which may assist in the building up of a database so as to see if there are any patterns in terms of personality, pathology, communication, and interaction. Lastly, new assumptions will be put forward in place of, or in addition to, those made by previous researchers.

The specific aims of the study are to provide an understanding of the interactional styles and communication behaviour of persons who have committed the crime of serial murder. Secondly, the study aims to determine the personalities, intelligence and traits of these persons as part of their patterns of communication. Thirdly, the study will attempt to integrate these findings and formulate a possible theoretical explanation of serial murder as part of man's social order (Haley, 1967).

1.4 The researcher and co- researchers

In this research, the researcher is a qualified clinical psychologist, licensed with the Professional Board for Psychology at the Health Professions Council of South Africa. He has four years experience in the psychiatric hospital environment, three of them as a consultant at a 900 bed in-patient state psychiatric facility, Weskoppies Hospital in South Africa. His job description involves forensic observations for individuals who have been instructed by the judicial system to undergo a 30- day observation while on trial for a crime. Furthermore the researcher acts as a consultant psychologist for a multi- professional team treated adult in- and out- patients at the same hospital. He is also a lecturer in the Department of Psychiatry at the University of Pretoria. His research for his masters degree was also on the topic of serial murder.

The co- researcher mentioned in Chapter 4 is also a qualified clinical psychologist and the promotor is a professor of psychology at the University of Pretoria.

1.5 Method

As mentioned, this research makes use of in- depth interviews, an interactional analysis, and psychometric tests to come to its conclusions. The results are integrated under the following

headings: profile considerations, interpersonal considerations and diagnostic considerations. The reason for these specific headings is firstly to examine the individual's approach to the testing which is used to draw many of the conclusions, hence the heading profile considerations. Secondly, since all behaviour is interpersonal communication, the heading *interpersonal considerations* was included, this looks at how these individuals relate to others and how do they behave. This is vital because hunting for diagnostic labels doesn't necessarily lead to a greater understanding, as most clinicians have experienced one depressed person as very different from another, and one person diagnosed with borderline personality disorder very different to another. The third heading investigates what, if any, diagnoses according to the DSM-IV might be relevant to the phenomenon of serial murder since much of the previous literature alludes to certain diagnostic categories. Yet, the information upon which such decisions are made are often second- hand reports, media, reports and court- transcripts.

1.6 Confidentiality and ethical considerations

One of the decisions which had to be taken into account by the researcher is a moral and ethical one. Often it is assumed that since a court case is open to the public, that confidentiality regarding the case and personal information is no longer required.

The researcher, in collaboration with the psychologist who assisted with the research, as well as the promoter, have decided that confidentiality and ethical considerations are still a high priority. This, however, brought a predicament on what information to include and/ or omit. Taking the main aim of the research undertaking into account, namely, the interactional behaviour of the two persons who committed serial murder, the focus was not aimed towards the types of murder or detail regarding the nature of possible sexual acts involved, or with whom, in these.

From another point of view it can be argued that these aspects are essential for any scientific endeavour regarding serial murder. Regardless this possible shortcoming and the fact that both persons committed serial murder, received large amounts of media attention, and were convicted, the researcher had a high regard for both persons and placed a high value on confidentiality.

1.7 Outlay of the thesis

This research begins with an introductory chapter giving a brief outline of what will be expressed throughout the process, then a literature review (chapter 2) to investigate what has already been said about the phenomenon of serial murder. Following these chapters, a look at the theory relevant to this study will be given (chapter 3) after which a chapter describing the method of research and the procedures used to arrive at the conclusions in this study (chapter 4). After this chapter 5 will provide the basic results from the investigation. Following this, a discussion of the results will be compiled, this chapter will also offer critique and highlight certain issues and suggestions for future researchers, and a conclusion.

Chapter Two

Serial Murder: A Literature Survey

2.1 Introduction

It seems that very little research has been done on the phenomenon of serial murder (De Hart & Mahoney, 1994; Keeney & Heide, 1995; Geberth & Turco, 1997; Grubin, 1994; Johnson & Becker, 1997; Piotrowski, 1997; Scott, 1996). Much of the research involves small clusters of descriptive cases, followed by larger, nonrandom descriptive studies of clinical and archival natures. These studies are usually followed by comparative nonrandom samples of sexual homicide cases focusing on intragroup and intergroup similarities and differences in relation to other paraphilias, Axis II phenomena, or homicides, aimed at the hopeful prediction of such occurrences (Meloy, 2000). Furthermore the majority of psychological research on individuals who committed serial murders is based on principles originating from the psychoanalytical paradigm (De Hart & Mahoney, 1994; Liebert, 1985; Liebman 1989; Pistorius, 1996; Pollock, 1995; Geberth & Turco, 1997), but viewing serial murder from a specific theoretical approach seems to be limitative. As Jenkins (1989) points out, this sort of crime can only be understood in the context of a broad sociological approach, especially since offenders achieve success by exploiting opportunities made available to them by changes in the broader culture (Jenkins, 1988). From further literature investigation it seems that no research has been done on serial murder from an interactional and/ or systemic standpoint. What also becomes pronounced during the literature survey is that little research has been done using actual serial murderers as respondents (Keeney & Heide, 1995), and most involve secondary sources such as reference books, biographies of offenders, police memoirs and accounts from forensic scientists (Jenkins, 1988, Meloy, 2000).

Lunde (1976) lists a number of factors that act as deterrents in psychological research on murderers: firstly, researchers rarely have access to a few, let alone large numbers of participants, therefore results are more difficult to generalise and repeat by other researchers. Secondly, access is another stumbling block: prior to conviction the individual is cautious about incriminating himself, and after conviction prisoners are inaccessible in maximum security prisons, or may have been executed. Finally Lunde states that interviewing murderers in the 'grim' atmosphere of a prison is an unpleasant undertaking. In summary it seems that Lunde believes that only a quantitative paradigm for research on serial murder is required and secondly, that pragmatic problems which confines research on murder, makes investigation of this phenomenon inaccessible. The research of this thesis aims to approach serial murder from a more descriptive approach and will investigate serial murder from a primary source of information, the individuals themselves and make use of psychological tests and interviews to draw conclusions.

Serial murders are fast becoming a common phenomenon and there has been a steady increase in awareness of these crimes over the past five years internationally and in South Africa (Pistorius, 1996). Jenkins (1989) says that multiple homicide captures large amount of public and media interest and feels that media coverage for such a crime committed in the early part of the century is similar to what might be found currently. Control is currently law enforcement's only viable strategy in response to the phenomenon of serial murder. Control means to identify, find, and apprehend (Egger, 1984). Researchers have noted that the understanding of the psychosocial context of serial murderers may aid in the identification, apprehension and prevention of these crimes (De Hart & Mahoney, 1994).

In the following section, the epidemiology, types of murder, definition of serial murder, the serial murderer and the victim, the modus operandi, crime scene and signature will be discussed. These points will be followed by a discussion of serial murder and gender, the effects of serial murder on the community, the role of technology in serial murder, the role of profiling, the role of different disciplines and finally serial murder in South Africa.

2.2 Epidemiology

The recent increase in awareness of serial murders over the past few years can give the false impression that the phenomenon is a contemporary one, but it has been reported for centuries. Cases have been documented as early as the 15th century when Gilles de Rais reportedly sodomised and killed over 140 young boys (Internet Crime Archives, 1996). German psychiatrist Richard von Krafft- Ebing published the first scientific study in 1886, commenting on, amongst others, the case of Vincenz Verzeni who murdered and disembowelled a young female. Verzeni reported to have enjoyed strangling women and experienced sexual pleasure during the murders (Meloy, 2000).

In the late 1980's the Federal Bureau of Investigation estimated that there were about 45 multiple murderers active in the United States of America at any one time (DeHart & Mahoney, 1994). Snyman (1992) states that in the United States (US), law enforcement officials claim that between 35 and 500 serial murderers are currently at large. Leyton (1986) stated that between 1970 and 1986 the incidence of serial murder in the US had increased approximately 400%. Meloy (2000) states that the number of murders which can be classified as sexual homicides represent less than 1% of homicides reported to law enforcement throughout the United States.

While recordings and research on this phenomenon are more extensive in the US, it gives the false impression that this country has an above average incidence rate of serial murder. Between 1960 and 1985, a total of 47 cases of serial murder were reported in countries like Hungary, Germany (Jenkins, 1989), England, France and countries in Southern and Southeast Asia (Snyman, 1992). Jenkins (1989) feels while often literature makes use of a historical perspective and mentions past cases in order to show that serial murder is not a new phenomenon, no one has attempted to analyse serial murder in any one historical period, either cataloguing or investigating social reactions. He feels it is this lack of a long- term historical view which has led to the misconception that there is a sudden increase of serial murders in America. For example, examining extreme cases of serial murder in which ten or more people were murdered there were approximately twenty- four known incidences between 1900 and 1940. If cases where the victim tally was five or more victims then the number would increase into the region of eight or more (Jenkins, 1989). In Germany between 1920 and 1940 there were a dozen cases in which a serial killer claimed over twenty victims (Jenkins, 1988).

Researchers differ in their explanation for the increase in incidence. Some say that serial murders have remained proportionately constant over the years, but identification, detection, and labelling has improved in recent years, while others claim there has been an increase. 'Linkage blindness' can also contribute to the 'dark' or hidden figures in that there is not a comprehensive system for linking data on crimes committed over long periods of time and in various geographical regions (Egger, 1984).

2.3 Types of murder

In the South African context, when charged, people are charged for murder, irrespective of the number of victims. How can one then distinguish academically between various types of murder and between murder and serial murder?

Douglas, Burgess, Burgess and Ressler (1992) distinguish between 32 different forms of homicide. The four broad categories that homicide has been divided up into are: criminal enterprise homicide, personal cause homicide, sexual homicide, and group cause homicide. Serial murder is a form of murder falling in the category of multicide (Hale, 1994). Multicide implies more than one homicide. The other two types are spree and mass murder. A person who commits mass murder, kills a number of people in a single episode (Egger, 1984), for example walking into a restaurant and shooting everyone inside. An example of spree murder would be a situation where a person travels across a country killing people at random.

2.4 Definition of serial murder

Creating a common definition for serial murder is a difficult task specifically if one aims to label the person as a serial murderer instead of trying to understand the person, his context and his circumstances. In dealing with a crime characterised by a lack of 'rational' motive, scholars have difficulty in deciding what is regarded as 'rational' (Jenkins, 1989). Furthermore, personality descriptions differ from region to region. American and European psychiatric classification systems differ and even within classification systems definitions change over time.

McKenzie (1995) feels that the issue has been complicated by authors using various terms interchangeably. These terms include: lust murder, serial murder, mass murder, sexual homicide,

multicide and multiple murder. She defines serial murder as "one- on- one murder, repetitive, involving a stranger, with a motive known only to the murderer" (McKenzie, 1995, p3). Meloy's (2000) definition includes that there must be sexual behaviour combined with murder to fulfill the criteria. Emphasising a sexual aspect to the criteria could lead to the exclusion of females from this category (Wilson & Hilton, 1998) because their murders, as with some males, do not necessarily have overtly sexual characteristics. Also, "sexual behaviour" can be a very ambiguous term, it can occur before, during and after the killing or throughout the murder. It can range from conscious fantasy, physiological arousal, masturbation, to penetration orally, anally or vaginally (Meloy, 2000). The 'sexualness' may be expressed symbolically through obvious means such as genital mutilation, or in a manner which is only known to the perpetrator, thus making it more difficult to determine the sexual nature of the crime.

Currently scholars have agreed that multiple murder be grouped into three categories:

1) mass
2) spree
3) serial murder

Mass murder would be killing three or more individuals at one time (Hickey, 1991; Keeney & Heide, 1995; Levin & Fox, 1985; Leyton, 1986; Norris, 1988). The killing of three or more individuals in different locations but within the context of a single event is called spree murder (Keeney & Heide, 1995). For serial murder it was the killing of multiple victims and the time factor that comes into play when creating many of the definitions for serial murder (Keeney & Heide, 1995). The time period can be days or up to years.

In trying to reach a conclusion in a definition of serial murder, two common assumptions are

arrived at in psychiatric literature:

i) The serial murderer is male, and

ii) this type of murder is a form of "lust murder" perpetrated by a "sexual sadist".

Keeney and Heide (1994, 1995) dispute the notion that serial murder is the domain of the male person. Other researchers assume that the phenomenon is so obvious that creating an operational definition is unnecessary (Keeney & Heide, 1995).

Holmes and DeBurger (1988) have divided the phenomenon of serial murder into four 'profiles'. The differences are based on behavioural background, victimology, modus operandi, and geographic mobility. *Visionary* serial murders occur because of a motivation of psychotic delusions or hallucinations. *Mission- orientated* serial murder occurs when an individual seeks to rid society of a certain 'undesirable' group of people. *Hedonistic* serial murder occurs for pleasure, thrills, or contentment. *Power/ control* serial murder occurs as a compensation for a lack of social or personal mastery by exerting control over victims (Holmes & DeBurger, 1988).Therefore definitions tend to be either too narrow or too broad or even too ignorant.

For communication and research purposes an operational definition was created for the purpose of this study. In this study the term serial murder will be used to describe a set of circumstances when the following occurs:

i) The person(s) is motivated to kill.

ii) The murder of three or more persons.

iii) The killings occur at different times.

iv) The killings appear unconnected.

v) The motive is not primarily for material gain.

vi) The motive is not primarily revenge. Revenge may play a role but it is not revenge against a single person or individual but rather against a category of individuals and the perpetrator selects his victims accordingly.

vii) The elimination of a witness is not the intention.

The researcher feels that the descriptive definition offered here, helps determine which persons could participate in the study, gives appropriate leeway yet has set parameters. It allows for pre-murder contact, such as the type of person who murders people staying at a boarding house, it allows for the presence or absence of sexual activity during the murder, it also allows for the aspect of revenge. As described above, it is revenge against a certain type or class of individual such as the homeless, or prostitutes, not revenge directed to specific victims for actions directly committed against the murderer prior to the murder.

This definition is also not gender biased and acknowledges that women are just as capable of committing serial murder as men are. What is noteworthy is that while most researchers acknowledge that there is a psychological motivation for the serial murder, the psychological aspect rarely features in any definitions of the term serial murder. Perhaps this reflects how little is actually known about the 'psyche' of the serial murder, and rather how much is known about hard evidence such as the crime scene, clues, geographical data, and chronology.

2.5 The serial murderer and the victim

The following questions can be posed: what picture does literature, separate from a clinical pathological point of view, offer on who the serial murderers are, and secondly, who are the

victims of serial murders?

2.5.1 Developmental themes in the serial murderer

Juvenile Sexual Homicide has also been recorded (Johnson & Becker, 1997; Myers, Burgess & Nelson, 1998; Myers & Blashfield, 1997) and can give insight into the development of individuals involved with such crimes. Meloy (2000) reports that adolescent sexual homicide occurs at approximately the same rate as adults. In a study on the childhood predictors of violent behaviour Friedman et al. (1999) indicated certain variables. Variables for both men and women were (a) having been rated by psychologists at age seven as displaying "deviant" or "stereotyped" behaviour in childhood, (b) having been rated at age four as being relatively less "normal" in behaviour. Therefore, abnormal behaviour in childhood could be considered to be the most reliable of childhood predictors of violent behaviour in adulthood. Lower intelligence was not a predictor of violence in women but was in men. Further findings for men indicated (a) lower intelligence and low scores on WRAT spelling and reading tests; (b) less cooperative, more resistant; (c) less friendly or responsive; and (d) having less attachment to mother at age seven. Three surprising indicators for men for the prediction of violent behaviour were (a) longer attention span at age four; (b) smaller number of persons cared for in the home, and (c) resuscitation at birth. The third indicator here could be due to the loss of oxygen at birth which could cause mild brain damage which could possibly impair control of aggressive impulses. Meloy (2000) states that adolescents would usually be diagnosed with conduct disorder according to the DSM-IV criteria and would be likely to have a history of psychotic symptoms, most commonly paranoia. With regards to Axis II phenomena, Cluster A traits (schizoid, paranoid, schizotypal) are more likely than Cluster B traits (borderline, antisocial, narcissistic, and histrionic), Meloy feels that this perhaps accounts for the psychotic symptoms and absence of a

psychotic diagnosis at the time of evaluation. They may also appear to be moderately psychopathic with most reporting sexually violent fantasies preceding the crime (Myers & Blashfield, 1997). Meloy further states that although many were reared in chaotic family environments and were physically abused, many do not have a history of sexual abuse.

In a study of 14 juveniles who had committed sexual homicide while under the age of 18 (Myers and Blashfield, 1997) 12 youths displayed one or more Axis I diagnosis at the time of the crimes, with conduct disorder being the most common (n= 12, 86%). Other Axis I diagnoses were substance abuse disorders (n= 6), ADHD (n= 3), anxiety disorders (n=3) and dysthymia (n= 2). This sample averaged 2.3 Axis I disorders per individual. None of the youths were found to have a current or past psychotic disorder by the Diagnostic Interview for Children and Adolescents (DICA-R) or clinical interview, however, a history of psychotic symptoms were found in 11 (85%) of the candidates. Although these were common they were not reported as being consistently experienced or leading to a major disturbance in psychosocial adaption to justify a psychotic disorder diagnosis.

Using the Schedule for Nonadaptive and Adaptive Personality (SNAP) eight of the candidates met the SNAP criteria for at least one personality disorder. Contrary to expectations antisocial personality disorder and borderline personality disorder diagnoses were not common. Candidates displayed more DSM-III-R cluster A symptomatology than cluster B. Five had high t- scores (>65) for schizoid, five had high t- scores for schizotypal. Four of the 13 had elevated t- scores for sadistic. Two of the candidates differed from the rest by having low psychopathy scores, no conduct disorder or personality disorder diagnosis on the SNAP. There were also the only two functioning reasonably well at school according to their grades, not having failed a grade, not

displaying any serious behaviour problems at school, and not in need of remedial classes.

Regarding family background, 13 (93%) members had chaotic family circumstances, this was defined as parental abandonment or neglect, child abuse, unstable living arrangements with frequent geographical moves, parental incarceration, parental substance abuse, and/ or serious parental arguing/ fighting. Almost all 14 had experienced significant academic problems.

Thirteen of the 14 were prepared to answer questions regarding sexual fantasies. Eight of the 12 youths questioned admitted to having violent sexual fantasies. Fantasy is commonly believed to be the root cause of almost all sex crimes and sex murders (Myers & Blashfield, 1997; Myers et al 1998; Warren, Hazelwood & Dietz, 1996). The phenomenon of catathymia is also believed to lead to sex murder. This occurs when the individual's psychological equilibrium is overwhelmed by powerful emotions, often stemming from conflicted relationships. Catastrophic, unprovoked violence results as the tension is released. The fantasy becomes a mental template which guides the individual in the commission of his crime. These fantasies often begin in early to middle teenage years and sometimes even in childhood.

Dietz (Johnson & Becker, 1997) believes that before a person becomes a serial murderer the crime has already been committed in fantasy in his own mind. When these individuals are young they express their aggression by torturing animals or being exceptionally cruel to their children, indicating that they are already thinking about committing adult- like violent acts. Johnson and Becker's study (1997) of 9 adolescents who expressed a desire to commit serial murder indicates that all nine expressed fantasies of a sexually sadistic nature, fantasies that were very similar to the types expressed by convicted adult and juvenile serial murderers (Myers & Blashfield, 1997;

Myers et al 1998) when they were adolescents. For example one of Johnson and Becker's case examples reported the following:

> S was a 16- year- old white male who was referred by a concerned social worker after he had admitted to multiple animal killings. He gained an interest in dissecting animals following a worm dissection exercise in his sixth grade science class. In the eighth grade, he stole a fetal pig from his biology class and dissected it on his own. He became curious about the textures of the animal tissues, tasted parts of it, and recalled becoming sexually excited by the dissection. S volunteered at an emergency room near his house where he eventually asked to witness a human autopsy, but this experience was denied him. He had a juvenile court history including shoplifting and runaway. S tested at an above- average IQ of 125, although he did relatively poor in school. He abused alcohol, sleeping pills, and marijuana when he became a teenager. At the age of 15, S began to kill animals. First, he killed a cat, and went on to kill rabbits, birds, dogs, ducks, and other cats. He usually killed via strangulation or stabbing. The animals skulls were prepared and proudly mounted as trophies in his bedroom. On one occasion, he became sexually excited while killing an animal and placed his erect penis inside the open wound of the animal and masturbated. S admitted to fantasies of killing humans including recurrent thoughts of rape ending in strangulation, necrophilia, and body mutilation. He fantasized about keeping the sexual organs and skulls as trophies. He also described other sexually sadistic fantasies that always ended in death. Additional paraphilic fantasies included voyeurism, exhibitionism, urophilia, fetishistic cross dressing, frotteurism, and bestiality. He had a long history of masturbation to pornographic materials.
>
> (Johnson & Becker, 1997 p. 337)

These fantasies expressed here by an individual expressing a desire to become a serial murderer are unnervingly similar to those expressed by other convicted serial murderers. It may therefore be pertinent for mental health workers to ask adolescents referred for violent crimes or sex offenses about the nature of their fantasies and take a thorough sexual history. Yet, many 'normal' individuals experience deviant fantasies, including sadistic content, but not all act out on them. Few take their fantasies to the point of murder and Holmes and Holmes (1994) do not believe that at present there exist a clear set of indicators that could help identify children who will ultimately kill. However, such fantasies may indicate a need for professional help no less. With regards to the victims, they typically appear to be female acquaintances of the same race who live near the perpetrator, they typically are 10 years older than the perpetrator. The victim is usually vaginally assaulted, stabbed and bludgeoned to death. The attack usually takes place in the victim's home (Meloy, 2000).

Ansevics and Doweiko (1991) examines various literature on 11 individuals who committed serial murder and came up with certain developmental themes that suggest common developmental characteristics for these people during childhood and adolescence:

Table 1: Percentages of Characteristics for Individuals who Committed Serial Murder

Age at Onset:	24.7 years
Education:	13.45 years
Religion:	64% Roman Catholic

	36% Born Again Christian
Marital Status:	73% Single
	(36% single and living with someone)
	27% Married
	(63% had live- in person)
Average IQ:	116,73
	(Bright normal- 84%)
	1 SD above average
Drug Abuse History:	82% no substance abuse history
	73% used drugs and/ or alcohol before commission of murder
Average Height:	71 inches
Police Affiliation or Paraphernalia:	91%
Family Violence History:	82%
Sexual Abuse History:	9%
Used Violent Pornography	73%
Adolescent Sexual Acting Out History Without Treatment:	91%
Sexual Fetish:	100%

(Ansevics & Doweiko, 1991, p118-119)

2.5.2 Diagnosis: mad or bad?

There is a strong tendency to try and label these individuals as having a psychiatric illness. This is also reflected in the terminology used in an attempt to classify such individuals. For some the question of early criminality plays a large role in an attempt to predict extreme violence later in life. The "MacDonald triad" was an attempt to predict such violence. The triad suggests the importance of a complex of symptoms in a child- bed-wetting, arson, and the torture of animals (Jenkins, 1988). Yet, like most theories there are cases that support and refute this hypothesis. There are instances of a group of individuals who have achieved respectability by their mid-thirties and by the time they committed their first murders over half were married, had stable family relationships, and been living in the same house for several years (Jenkins, 1988).

Much of the literature states or eludes in some manner that the serial killers are "psychopaths" while paying little or no attention to the clinical criteria necessary to make such a conclusion (Geberth & Turco, 1997). Research by Geberth and Turco (1997) attempts to examine the extent to which the criteria for antisocial personality disorder and sexual sadism are met by a sample of serial murderers whose cases were documented by media, academic literature and law enforcement literature. Crime scenes and case histories were employed to try and identify commonalities in the psychological composition and personal background of these offenders that are consistent with clinical criteria. Out of a total sample of 387 serial murderers they included 68 subjects who had sexually violated and murdered their victims. Of the 68 most were not grossly psychotic or insane in the legal sense because they were not judged unfit to stand trial at the time of the court proceedings. Psychological investigation has not led investigators to the conclusion that the majority of sexual murderers are psychologically ill, either in the medical or legal sense. Also, few have been driven by delusions or hallucinations. Of their 387 serial

murderers, only 68 met the DSM-IV criteria for antisocial personality disorder and sexual sadism (Geberth & Turco, 1997).

Geberth and Turco's explanation for this is as follows; the behaviours of the subjects indicated that psychopathic sexual sadists killed because they liked to kill. This means, they satisfied psychological desires through the murders. These desires were libidinal wishes that were not expressed in their daily lives and were a product of their developmental arrests and unresolved needs. Following a murder their behaviour returned to normal until the next outburst. The victim, a female, became the target on which the "badness" was displaced from the mother. The fusion of destructive impulses resulted from disorganised developmental experiences and faulty object relations along with the incapacity for empathic bonding characteristic of the antisocial personality disorder diagnosis (Geberth & Turco, 1997).

Research which may to some degree refute Geberth and Turco's work is that done by Holt, Meloy and Strack (1999) who took a non- random sample of 41 inmates from a maximum security prison who were classified as either psychopathic or non- psychopathic and violent or sexually violent. Their conclusions stated that there was a significant and positive relationship between sadism and psychopathy as measured by clinical interview, psychological testing, and behaviour history, thus replicating the work of Hart, Forth and Hare (1991). It fails, however, to demonstrate a relationship between sexual sadism and psychopathy. It also fails to show a difference on all measures of sadism when subjects were classified as violent or sexually violent.

Meloy (2000) later states the following:

> Virtually all sexual homicide perpetrators evidence narcissistic and psychopathic personality traits. The pathological narcissism, whether or not it meets the threshold for a DSM-IV diagnosis of narcissistic personality disorder, is usually seen in the perpetrator's sense of entitlement, grandiosity, and emotional detachment. The psychopathy, whether or not it meets the threshold for primary psychopathy (Hare, 1991), is usually manifested in the perpetrator's predation, cruelty towards others (at times diagnosed as sexual sadism), deceptiveness, and manipulation.
>
> (Meloy, 2000: 7)

This statement, however, neglects the pervasive nature necessary in the diagnoses of all personality disorders according to the DSM-IV, and focuses on behaviours currently being expressed by the individual.

A study done by Mullen, Pathé, Purcell and Stuart (1999) on stalkers concluded the following. They grouped stalkers into five subtypes; rejected, intimacy- seeking, incompetent, resentful, and predatory types. The predatory group is relatively small but are important to recognise given their potential for sexual violence. With sexual offenders elements of stalking are relatively common. Yet it appears that stalkers have a different collection of psychopathology as to those posed so far for serial murder. Stalkers may often fit into the spectrum of paranoid disorders. Intimacy-seeking stalkers include those who may have erotomanic delusions, both secondary to preexisting psychotic disorders such as schizophrenia and as part of a delusional disorder. Rejected stalkers

may display characteristics in which the clinging to a relationship in inadequate individuals merges into the assertive entitlement of the narcissistic and the persistent jealousy of the paranoid. Resentful stalkers present an almost pure culture of persecution, with paranoid personalities, delusional disorders of the paranoid type, and paranoid schizophrenia. Compared to public mental health patients, stalkers are more than twice as likely to have a previous conviction for violence, and also more likely to have comorbid substance abuse disorder (Mullen et al., 1999).

Certain researchers suggest serial murderers are not the product of a major mental illness but can be attributed to free will and conscious choice. Levin and Fox (1985) see psychopathology as being integral to the personality structure of the serial murderer. Yet psychopathology does not hold the key to explaining serial murder, not all people diagnosed with antisocial personality disorder will kill, and not all serial murderers are 'psychopaths'. Brown (1991) refers to several diagnostic categories when describing serial murder, they are; personality disorders (antisocial and sadistic personality disorder) or some form of sexual disorder, a small percentage can be diagnoses with a psychotic illness and some have been found to have an organic pathology. In another study by McElroy, Soutullo, Taylor, Nelson, Beckman, Brusman, Ombaba, Strakowski and Keck (1999), who examined the psychiatric features of 36 men convicted of sexual offenses, discovered that their participants displayed high rates of DSM-IV Axis I disorders. 83% had a substance use disorder, 58% a paraphilia, 61% a mood disorder (13 of the 22 with mood disorders had a bipolar disorder), 39% an impulse control disorder, 36% an anxiety disorder, and 17% an eating disorder. With Axis II disorders, 72% met DSM-IV criteria for antisocial personality disorder. Furthermore, respondents reported experiencing high rates of Axis I disorders, especially substance use and mood disorders, in first degree relatives.

Milton (1997) reports that Faulk proposed a typology for psychopathology and motive of sex offenders. He felt that offenders may fall into one or more of the following groups:

i) The 'normal' man in abnormal circumstances such as a person caught up in group excitement and commits group rape.

ii) Suppressed sexual desires, such as a man under stress who gives in to forbidden sexual desires.

iii) Sexual deviancy such as the paraphilias.

iv) Mentally ill subjects, in other words, sexual offending secondary to a mental illness including organic disorders.

v) Learning disabled individuals.

vi) Antisocial personality disordered individuals.

vii) Severely inhibited personality, such as resisted but overwhelming urges or drives leading to an offence towards adults or children.

Increasingly recognition is being given to dynamic variables. Four groups have been identified according to patterns of denial. Firstly, rationalizers who admit to offence but deny that they caused any harm. This group may include a large proportion of child molesters. Secondly, externalizers, who blame victims and spouses for their offences. This group may include people who offend against young females. Thirdly, internalizers, who admit both to offence and its harm, these people usually are heterosexual incest offenders. Fourthly, absolute deniers, who offend against adult females. Milton (1997) identifies offence specific characteristics in sexual offenders. In sexual homicide, which can arise out of any sexual offence, people who killed were characterised by lifelong isolation and lack of heterosexual relationships.

2.5.3 Victims

Often victims may share common characteristics such as prostitutes, females, or looks, but the events surrounding the murder may differ. The victim need not have taunted nor threatened the person in any way. Victims may share common features of being prestigeless, powerless, and from lower socioeconomic groups (vagrants, prostitutes, migrant workers, homosexuals, missing children and the elderly). Holmes and DeBurger (1988) list five primary elements of serial murder:

i) The murders are usually one- on- one events.

ii) The relationship between victim and assailant is usually that of a stranger.

iii) Due to the stranger perpetration, the motives are not clearly obvious.

iv) The individual is motivated to kill, yet often the murder comes at the end of a long period of brutality.

v) The central element is repetitive homicide (Holmes & DeBurger, 1988).

Meloy (2000) states that most victims of sexual homicide are female strangers or casual acquaintances, not consensual sexual intimates. Most often they are of the same race as the perpetrator. While the most common victims of violent crime are males, female victimization in sexually violent crimes is expected. From a *relational* point of view, what is different about sexual homicide is that it is similar to other paraphilias and dissimilar to other crimes of violence. While paraphilic individuals deliberately target strangers as victims, nonsexually violent individuals target victims who are well- known or intimately involved with them (Meloy, 2000). Sexual homicide perpetrators, even when intimately involved with a partner, will most likely go outside the relationship to select another object to sexually assault or kill. As a subgroup of sexual homicide perpetrators, sexual sadists may use consensual partners to assist them when

beginning to kill stranger female victims, they may even practice certain acts on their partners (Meloy, 2000).

Frequently the pattern of a person committing serial murder is revealed through his choice of victims. In many cases the victims are chosen solely on the basis that they crossed the path of the person. Victims are self- selecting only from their being at a place and point in time (Egger, 1984). These common features in serial murder victims contribute to the fear instilled in communities when such events occur.

2.6 Modus operandi, crime scene and signature

Sexual homicides are usually organised or disorganised in offence characteristics. This is a typology developed by the Behavioural Sciences Unit of the United States of America's Federal Bureau of Investigation (FBI). Since the creation of this typology research has suggested that (a) organised crime scenes are more likely to occur in serial sexual murders than single sexual murders and (b) organised crime scenes are highly suggestive of sexual sadism (Meloy, 2000; Warren, Hazelwood & Dietz, 1996). With this in mind, however, 'mixed' cases do occur. A disorganised crime scene may be indicative of a catathymic process, rather than a pre- planned crime.

Evaluation of the crime scene helps determine a modus operandi and if there is evidence of a signature (Douglas & Munn, 1990). The modus operandi is typically dynamic and serves the purpose of protecting the perpetrator's identity, ensuring success, and facilitating escape. The signature, however, is typically static and allows the investigator to infer the ritual or symbolic component of the sexual homicide that leads to the gratification of fantasies and remains sexually

arousing (Meloy, 2000). The signature is what often allows investigators to link several sexual homicides (Keppel, 1995).

2.7 Serial murder and gender

Statistics provided by the Bureau of Justice Statistics in the United States indicate that the overwhelming majority of murders are committed by males. In 1993, 9.4% of all murders were committed by women. This represents a slight decrease in the number of murders committed by women with the average being 10% to 13% of all murders being committed by women over the past 15 years in the United States. Explanations for female homicide fall generally into two perspectives, the Social- learning perspective and the Biological perspective. The Social- learning perspective places an accent on the differences caused primarily by the social roles assigned to males and females. Males are taught that aggression is more acceptable in males than in females. Popular media repeatedly show men in aggressive situations. Women also seem more aware of the consequences of aggressive behaviour for themselves and others.

Biological perspectives follow a variety of discourses. These include studies into the autonomic nervous system, neurophysical responses and genetic studies. Only few of these shed any light into the differences in aggression between men and women. Recent research into gender differences in the biology of aggression have focused on hormonal influences. The most important hormone to the study of aggression is testosterone. Testosterone stimulates the development of masculine characteristics when it begins to circulate at puberty. It is thought to influence behaviour in two ways: firstly, by organising the development of the brain in such a way that particular responses become more likely and, secondly, by activating the physiological mechanisms that help govern certain behaviours. A relatively high concentration of testosterone

can push the central nervous system in a masculine direction, and the individual develops more masculine physical characteristics and tends to act in a more "male" manner at certain times. Research has indicated that young girls who have been exposed to elevated levels of male hormones before birth as a result of a malfunctioning adrenal gland tend to engage in more masculine behaviours and tended to initiate more fighting than their sisters. Similar results were found among children who were exposed to the hormone progestin, which can also have a masculising effect on developing fetuses. Although there seems to be evidence that sex hormones have a brain organising influence, there is less consensus about whether hormones can activate aggression (Hale & Bolin in Holmes & Holmes, 1998).

Although serial murder has been committed by females, the perception is that the crime of serial murder is a male dominated area. There are several reasons for this perception, firstly, the typical violent offender is male, secondly, only since the 1970s as a result of an expanding women's movement, have women become the focus of research in the area of violent behaviour. A third reason may be that a crime such as serial murder is associated extreme violence. The perception is that it is men, not women, that have the physical strength to commit such acts repetitively. Finally, the media has sensationalised the acts of males who commit serial murder. There are a significant number of women throughout history who have committed this crime. Elizabeth Bathory, the "Countess Dracula" from Hungary, tortured more than 80 female victims before bathing in their blood. Her career lasted from 1580 and continued until 1610. It is estimated that 183 other women have committed multicide (Hale & Bolin in Holmes & Holmes, 1998).

Women who commit multicide tend to share a number of common characteristics. The average age at the time of the first murder tends to be just over 31. Seven percent are less than 20 years

of age. On average they tend to kill for five years until apprehended by police. The average number of victims tend to be 17 and most of the murders take place inside the perpetrators home. Often the murderer and the victim share a residence. The most common method of murder is arsenic. The majority of victims tend to be family members, either immediate or extended. Other victims have close ties to the perpetrator. The more defenceless the victim, the more direct and aggressive the perpetrator tends to act. Amongst the 184 perpetrators included in the study by Hale and Bolin (in Holmes & Holmes, 1998) a variety of weapons were used to commit murder. 59 women preferred poison, 24 firearms, 11 knives, 10 strangulation, 9 suffocation, 8 drug overdose, 7 asphyxiation by gas, 3 bludgeoning, 3 starvation, 3 arson, 2 drowning, 1 torture, 1 hatchet, 1 automobile, 1 throwing from a tall building, 1 pushing from a bridge, 1 hanging, 39 by various forms (2 or more of the previously mentioned).

Arsenic was the most commonly used poison, and to contextualise these methods it is necessary to understand the history of female serial murder. Many females who committed serial murder did so before the 1900s when arsenic was available as an over- the- counter product. Since it was barely detectable when mixed with hot food or drinks it was easy to get the victim to ingest it without him or her being aware. Depending on the dose death could come in a few short hours or months. In modern society drugs such as potassium chloride and succinylcholine are often used by people in the medical field.

While still fulfilling the criteria for serial murder, there may be subtle differences in the modus operandi of females who have committed serial murder. They tend to be 'place specific', operating at home or in health care environments (Wilson & Hilton, 1998). In a study involving cases from America, Australia, Austria, Belgium, Canada, England, France, Germany, Greece,

Hungary, Italy, Mexico, New Zealand, Romania, Russia, South Africa, Spain, and Switzerland where female serial murderers were the perpetrators Wilson and Hilton (1998) investigated the modus operandi of the perpetrators involved. Toxic methods of murder included arsenic, strychnine, morphine, and other poisons and overdoses. Insults to the body included; strangulation, beating, burning, stabbing, starvation and the use of various firearms by perpetrators.

Trends have been also changing regarding the victims, since 1976, 68% of victims were strangers to the female perpetrator. When American female serial murderesses were compared to those from other countries there were some significant differences. Victims per case were significantly higher (average 26,5) in the other countries compared to the American sample (average number of victims 6,86). Female murderesses seemed similar when comparing the duration of time as murderers but differed in modus operandi. Low profile modus operandi, poisons and drug overdoses, in the American sample was associated with longer duration of activity. In the sample from other countries however, there was no such association despite a preference for using poisons. Therefore, the sample from other countries had a higher victim tally, but females in the American sample had a longer killing career when using low profile modus operandi (Wilson & Hilton, 1998).

2.8 Serial murder and its effects on the communities

The presumed presence of one killer can have a large impact on the greater community. While still small in numbers in comparison to other crimes, indirect effects of serial murder on communities are far reaching. Incidences of various anxiety- based disorders dramatically increase in a community terrorised by serial murder (Biernat & Herkov, 1994). In the United

States of America after the slaying of five college students at Gainesville, Florida, nearly 700 students dropped out of the University. Handgun, mace and security system sales increased dramatically and sleeping habits changed. Counselling centres claimed to be overwhelmed by client demand (Biernat & Herkov, 1994). Green (1991) found that large- scale disasters produce symptoms such as phobias, anxiety, fear, depression, interpersonal problems, physical symptoms, post- traumatic stress and grief reactions It seems as if communities exposed to serial murder share many of these features.

Because of the effects on a community one can say that a serial murder does not only have the murdered person as a victim, the whole community seems to be victimized through the terror. The following factors according to Young (in Biernat & Herkov, 1994) are likely to increase the sense of victimization:

1) Violence represents a realistic threat of death to all members of the community.
2) Violence exposes the community to extraordinary carnage or misery.
3) Community members are strongly affiliated to each other.
4) The event is witnessed by community members.
5) Victims are individuals who have special symbolic significance to the community.
6) Events call for many rescue workers or helpers.
7) Event attracts a great deal of media attention.

(Biernat & Herkov, 1994)

Serial murders display many of these points especially the threat to the community, the symbolic significance of the victims and the effects in the community by exposing it to extraordinary

carnage or misery when such crimes occur. Further, serial murder usually attracts much media attention.

Research done by Herkov and Biernat (1997a) indicate that in a community exposed to serial murder there was a widespread endorsement of PTSD symptoms following the murders. These appeared to decrease over time with few subjects still reporting symptoms at 18 months. The highest endorsement of symptoms was found among residents demographically similar to the victims. The media in part are responsible for this 'vicarious victimisation' in that during the times of serial murder news sources such as television, radio and newspaper are widely used as information sources by the population, with police press conferences being regarded as the most accurate and trustworthy. While residents regarded media reports on means of reducing personal risk as beneficial and contributing to a sense of safety, details of mutilations and sensational reporting were judged to increase fears (Biernat and Herkov, 1997b). A study by Herkov, Myers and Burket (1994) into children's reactions to serial murder indicates that children experienced a number of psychological changes following the murders, even though in this instance none of the victims were children. The most frequently experienced symptoms were anxiety based such as a fear of being alone, difficulty falling asleep, and wanting to sleep with parents. Most of these showed a decrease across time with significant interventions being discussing issues of risk minimization, talking about the murders, and parents spending more time with their children (Herkov et al., 1994). This can perhaps be seen as one of the systemic effects of serial murder.

2.9 Serial murder and technology

While technology can certainly help in the investigation of certain murders, it may also facilitate serial murder, such as in the case of the Internet. *Online serial murderers* are now becoming a

concern. It has been cited that they commonly use similar techniques in luring victims. They gain their victim's confidence, and then arrange for the meeting. All seem to seek out emotionally vulnerable victims and play on their victim's insecurities. They make use of 'chat- rooms' to avoid discovery by others (Serial Killer Report, 1996). *Cyberstalkers* (Deirmenjian, 1999) harass people on the Internet and is regarded as no less a crime as other computer crimes like hacking, child pornography, and hate crimes spread on the Internet. The harassment takes place via E-mail, chat rooms, newsgroups, mail exploders, and the World Wide Web. Personal information can be obtained and used for more direct harassment or even contact. Four basic motivations for cyberstalking are: sexual harassment, love obsession, hate/ revenge vendettas, and power/ ego trips (Deirmenjian, 1999).

Furthermore, the 'face' of serial murder may change due to technology According to Jenkins (1989) the axe was a common household item in the early twentieth century but not in modern households, hence the decrease in murders perpetrated with this type of implement. Axe murders were common up until the mid- 1940s. In the early twentieth century poison was also readily available and autopsies were infrequent therefore perpetration of such a crime would possibly go unnoticed. Yet technology may also be the downfall of the serial murderer. It was life-insurance companies in the early part of the twentieth century that slowly began to employ their own investigators to examine deaths, it was also insurance companies that compiled and publicised reliable homicide statistics long before the creation of Uniform Crime Reports (Jenkins, 1989).

2.10 The role of profiling in serial murder

In instances where the motive for a murder is not clear a psychological profile can be of great use to investigators. A psychological profile aims at providing investigators with information as to the type of individual who committed the crime. While not suited to all instances, profiles tend to be most useful in cases where an unknown perpetrator has displayed signs of psychopathology (Holmes & Holmes, 1996). Profiling seems to be useful in the following crimes: sadistic torture in sexual assaults, evisceration, postmortem slashing and cutting, motiveless fire setting, lust and mutilation murder, rape, satanic and ritualistic crime, and paedophilia (Holmes & Holmes, 1996). It is the crime scene itself that reflects the pathology.

The three broad goals intended with profiling are to provide the criminal justice system with the following: social and psychological assessment of offenders, psychological evaluations of belongings found in the possession of suspected offenders, suggestions and strategies for interviewing suspected offenders when apprehended.

Ultimately these goals help investigators narrow their investigation thus reducing the number of days spent on the case. The profile may help predict future possible murders and probable sites of the murders. Regarding the second goal, the profile might suggest certain items a suspect may have in his possession, such as souvenirs, photos, or pornography. Once apprehended these may help investigators tie a suspect to a crime. Regarding the third goal, interviewing suggestions and strategies, these are of use when the suspect has been apprehended. These will aid in eliciting information from that particular individual (Holmes & Holmes, 1996).

Certain individuals do not agree that profiling is of much benefit to investigators. Many view it

as an art and not a science. Campbell, a psychologist, maintains that;

> (a) the profiles submitted to police departments as gospel concerning the types of offenders who commit violent acts are probably little better than the information one could obtain from the neighbourhood bartender, (b) profiles are either too vague and ambiguous or no more than simple common sense, and (c) as long as police officers are impressed with the credentials, status, and education of academicians, many academicians will continue to play their educational guessing games (in Holmes & Holmes, 1996:7).

Even the FBI shows doubt regarding the efficacy of profiling. In a study of 192 cases where profiling was performed, 88 cases were solved. Of the 88 solved cases, only in 17% did a profile help in the identification of a suspect. Despite these claims by the FBI, there is not total agreement amongst investigators that profiles constitute a key element in the investigations into these crimes (Holmes & Holmes, 1996).

An early use of profiling, could be seen when, in 1943, the Office of Strategic Services (OSS) commissioned Dr Walter Langer, a psychiatrist, to 'profile' Adolf Hitler. Langer hired three research assistants familiar with the psychodynamic model. They sourced the New York City Library and their own reading lists, solicited personal interviews with people who had intimate knowledge of Hitler. The profile was intended to offer insights into the personality of Hitler so that if captured an interrogation strategy would be in place to help authorities to elicit information from him (Holmes & Holmes, 1996). Hitler's suicide towards the end of the second world war prevented their research from ever being put to the test, but it marked the first incidence of what was to become later known as profiling.

More recently, the 'Bobby Joe' Long case in Hillsborough, Florida, USA, which commenced in 1984, made use of an FBI profile after finding similarities in several murders in the area. A profile was returned indicating strong similarities between cases. The FBI Criminal Personality Profile appeared as follows:

Table 2: FBI criminal personality profile

Race	Caucasian
Age	Mid 20's
Personality	"Macho" Image Assaultive
Employment	Difficulty in Holding Job
Marriage	Probably Divorced
Vehicle	"Flashy Car"
Weapons	Likely to Carry Weapons
Personality	Inclined to Mentally and Physically Taunt and Torture
Victims	Randomly Selected Susceptible to Approach
Geographics	Confine Activity to Given Geographic Region

(from Terry & Malone, 1989:16)

In a further attempt to consolidate information to assist in creating links between crimes, the National Center for the Analysis of Violent Crime (NCAVC) became operational in 1984 with the purpose of acting as a 'clearing house' of information regarding violent crimes. It is a law-enforcement- orientated behavioural science and computerised resource centre which consolidates research, training and operational support functions. The NCAVC consists of four

programs: Research and Development, Training, Profiling and Consultation, and the Violent Criminal Apprehension Program (VICAP). Their Profiling and Consultation Program conducts analyses of violent crimes on a case- by- case basis in order to construct profiles of unknown offenders so the focus of the investigation can be narrowed to concentrate more readily on the most likely suspects. Consultation also includes planning case strategies, furnishing information for search warrant preparation, personality assessments, interview techniques and coaching prosecutors of violent criminals (Brooks, Devine, Green, Hart and Moore; 1987).

2.11 The role of different disciplines

In the early twentieth century the study of crime was being revolutionised. In America the *Journal of Criminal Law and Criminology* was begun and the series *Modern Criminal Science* began to make known the works of Ferri, Lombroso and Gross (Curran & Renzetti). This new input helped create a new vocabulary and framework for understanding these murders. Criminal anthropology, psychiatry and psychology tried to come up with scientific explanations for crime. Even in the early part of the twentieth century the need for sharing of information was seen as necessary in the solving of crimes, yet problems such as small police forces, linkage blindness and even racism hampered effectiveness amongst investigators (Jenkins, 1989)

Examples such as the "Bobby Joe" Long case in the Tampa Bay area, Florida, in the United States of America, involved personnel from six different organisations in an eight month long investigation. Traditionally murders are solved because the victim and suspect have some or other link. Investigators would, for example, focus on individuals who may have had a motive for the murder. The problem with serial murder is that there is no apparent link between victim and suspect. It is under these circumstances that the necessity for cooperation between different

agencies becomes highlighted. A current tool used in helping apprehend mobile serial murderers is the Violent Criminal Apprehension Program (VICAP). This was founded by the FBI in 1985 and attempts to track this type of crime nationally by matching cases that could be linked to the same individual (Green & Whitmore, 1993).

2.11.1 Perspectives on crime and violence

For centruries humankind has attempted to understand and find meaning for criminal behaviour and violence. For the past few hundred years there have been more 'scientific' attempts to understand these events. Pioneers such as Beccaria and Bentham (Curran & Renzetti, 1994) moved towards a more humane approach to criminals and how to deal with them. Later, as other fields began to develop, sociological, biological and psychological explanations for crime began to appear. At times the individual has been reduced to a chromosome, and at others the individual was seem as being involved in complex social relations. At times certain trends come and go thus indicating that we are far from finding an established, final 'truth' as to why such phenomena occur. This chapter intends to provide an outline of more modern perpectives on crime, to provide a context in which the current research can be placed.

2.11.1.1 The Classical School

Pre- twentieth century criminological thought was dominated by individuals such as Cesare Beccaria and Jeremy Bentham; they largely make up what is known as the Classical School of Criminology (Conklin, 2000; Curran & Renzetti, 1994). They represented the pioneers in attempting to provide a thought structure to explaining crime in society. They felt that hedonism, rationality, and free will were the underlying bases of human behaviour. Beccaria, an Italian criminologist, published one of the most influential papers of the eighteenth century which led

to reforms in the criminal justice system. Like many reformers his ideas were not necessarily readily accepted and his famous essay "Dei delitti e delle pene" or "On Crimes and Punishments" was initially published anonymously, because its "contents were designed to undermine many if not all of the cherished beliefs of those in position to determine the fate of those accused and convicted of crime" (Monachesi, 1973, p38). Criminal law at the time of the eighteenth century in Europe was largely barbaric and repressive. Abuse was rampant amongst those in the criminal justice system as prosecutors and judges were allowed tremendous latitude in their decision making. Judges were given unlimited discretion in the punishment of criminals. Beccaria felt that every punishment that was not absolutely necessary was tyrannical (Martin, Mutchnick & Austin, 1990). Beccaria felt that it was not within the judges authority to make laws and set penalties, instead it is the judge's duty to determine the guilt or innocence of the accused on the basis of fact. Furthermore this was to be done impartially without regard for individual circumstances or social status. If found guilty the judge was to impose the penalty prescribed by the law. Punishment was to be regarded as a deterrent, not for revenge or retribution. However, if it is to be a deterrent it must be swift, certain, proportionate and appropriate to the seriousness of the crime. He felt that the certainty, not the intensity, of the punishment is the deterrent and thus opposed capital punishment (Curran & Renzetti, 1994)..

Jeremy Bentham was a British contemporary of Beccaria. Like Beccaria he too accepted the concept of a social contract, and that human beings behaviour stemmed from one motivation: the pursuit of pleasure and the avoidance of pain. Laws were therefore intended to align the person's pursuit of pleasure with the collective interests of the whole society.

Neither Bentham nor Beccaria explored the reason *why* individuals committed crime, their

primary concern was social control, they felt that criminal motivation was a given.

2.11.1.2 The Positivist School

The Positivist school was dominated by individuals such as David Emile Durkhein and Casare Lombroso (Curran & Renzetti, 1994; Siegel, 2000). Advances in the physical and natural sciences played a large role in the development of this school of thought. Human beings were beginning to be regarded merely as one type of creature with no links to divinity. The influence of biological and cultural factors were being seen as central to determining behaviour and the view that humans were self- determining beings, free to do what they wanted was becoming less central. The shift was that the positivist school focused on criminals, not crimes as the classical school did. Their goal was to discover the underlying causes of criminal behaviour. These causes could be biological, psychological, social or a combination of all these. By rejecting the premise of free will, they adopted the position that human behaviour was a product of factors within the individual or his or her external environment. This is referred to as *determinism*.

The assumption that behaviour is both determined and measurable had important implications. If crime is not the result of a rational decision freely made by the individual, but rather the product of forces that, to some extent, are beyond the individual's control, then punishment is ineffective. The positivists maintain that offenders should rather undergo treatment with the goal of rehabilitation, and since behaviour can be measured, progress can be monitored in the rehabilitation process. They opposed the classical view that punishments must be standardised and fixed and favoured a more flexible strategy whereby an offender is institutionalised for the period of time necessary for rehabilitation, which, in turn, will be influenced by personality, condition at the time of admission and other individual factors.

The classical and positivist schools do, however, agree in one area. They both posit that laws are the embodiment of a set of values and norms shared or agreed upon by a majority of the members of society; the law is the codification of societal consensus (Curran & Renzetti, 1994; Martin et al, 1990).

2.11.1.3 The Marxist View

The Marxist view is difficult to demarcate since Karl Marx never made law nor crime, primary topics in his writings. Marx begins with the premise that the most basic human activity is labouring to meet one's survival needs (Conklin, 2000). To do this man must enter into a relationship with nature with the aims of transforming nature to meet his needs for food and shelter. The ways in which this transformation is done depends upon such factors as the resources available in the environment, the tools and technology available, and current knowledge and skills. But since meeting one's survival needs is not done in isolation but rather in association with other people, it is also a social process. These associations of production are fundamentally social class relations. A social class is a group of people who hold the same position in the production process. Marx felt that any society organised into social classes is inherently unequal since different people have different access to societal resources and rewards. Members of a particular class will act in accordance with the interests of that class. The class at the top of the hierarchy will act so as to maintain their position by the exploitation of those at the bottom (Curran & Renzetti, 1994).

The Marxist paradigm focused on the law, although Marx never explicitly defined law, he and Frederick Engels were concerned with how law is created and how it operates. They feel that given the class characteristic of the capitalist mode of production, the law and legal system will

preserve the inequality created by having different social classes, thus maintaining the capitalist system as a whole.

The Marxist paradigm has three basis views on crime. Firstly, what they called the *lumpenproletariat* which is a class consisting of thieves, extortionists, beggars, prostitutes and others who survive by criminal means, and is a 'criminal class'. They viewed this class as untrustworthy and the enemy of the workers. Secondly, the *primitive rebellion thesis* which states that some crime is a form of revolt against the ruling class and capitalist system. Thirdly, crime is the result of the *demoralisation* produced by living as one of the 'have- nots' in the capitalist system. Thus Marx and Engels placed the blame for some crime as being a rational response to dehumanising conditions, and the only effective means of eliminating crime was by changing the social system (Curran & Renzetti, 1994).

2.11.1.4 Biological and physiological theories of crime

It is common for us as individuals to make inferences about another's character based on appearance. The concept of physiognomy dates back centuries to Greek and Roman times. By the middle of the eighteen century physiognomy had fallen into disrepute. This led to a group of theories called 'Physical Type Theories'.

Phrenology was a term coined by Forster in the nineteenth century proposing that the shape of one's brain affects personality and social behaviour. Franz Joseph Gall is considered the founder of phrenology. He identified twenty- six faculties or organs which were housed in three major regions of the brain. There were the intellectual faculties, moral faculties, and the lower, base or animal faculties. The lower faculties were believed to include such traits as destructiveness and

secretiveness, and were believed to be overdeveloped in criminals. Phrenology lost its popularity in the mid 1800's (Conklin, 2000; Curran & Renzetti, 1994).

Lombroso, who was mentioned under the positivist school, was an Italian physician. His central thesis was that the criminal was a biological degenerate, a 'throwback' to an earlier evolutionary state. He termed this atavism. He felt that atavism manifested itself in certain characteristics or stigmata, and these stigmata could be used to identify atavists or 'born criminals'. After examining 383 Italian criminals he reported that 21 percent had one atavistic trait, but 43 percent had five or more. He concluded that five or more stigmata indicated atavism. Lombroso was widely criticised for ignoring social and economic causes for crime, and later works explored these also. He ultimately expanded his typology to include criminals who committed crime because of insanity and epilepsy, crimes of passion, and occasional criminals who could be divided into three subtypes: *pseudocriminals*- who committed crimes involuntarily such as in self- defence; *criminaloids*- whose predisposition to crime was activated by environmental circumstances op opportunities; and *habitual criminals*- people who became criminal because of poor education or weak parental training. Ultimately he revised his initial position that approximately 70 percent of the criminal population was atavists to about 33 percent (Curran & Renzetti, 1994).

Along similar lines, the notion that criminals could be identified as having a certain physique was proposed by German psychiatrist Ernest Kretschmer (in Martin et al, 1990; Curran & Renzetti, 1994). American theorist, William Sheldon, also made similar claims. His theory was known as somatotyping. He proposed that the human body is composed of three components: *endomorphy*-soft roundness; *mesomorphy*- square masculinity and skeletal massiveness; and

ectomorphy- linearity and frailty. Each of these components can be found, to lesser and greater degrees, in all individuals. He claimed that an endomorph is viscerotonic- relaxed and sociable, love physical comfort, food, affection, approval, and others company; mesomorphs are somatic- active, assertive, aggressive, noisy, lust for power and enjoy dominating others; ectomorphs are cerebrotonic- being private, restrained, inhibited and hyperattentive.

A second approach amongst the biological and physiological views of crime was that there is a relationship between crime and heredity. Genetics has become a popular way of explaining certain behaviours, from crime to schizophrenia (Kaplan, Sadock & Grebb, 1994) and other medical conditions. The genetic approach is obtaining ever increasing stature. Early genetic approaches to crime saw it as a direct result of genetics but more contemporary theories take into account genetic and environmental factors. Family studies is a popular method of researching genetic links.

The difficulty of these types of studies is that while sharing genetic material, family members usually share a common environment making it difficult to single out either as a cause for criminal behaviour. Twin studies are another method of helping determine genetic links. Certain studies have indicated that the concordance rate for crime in both members of a twin pair is higher amongst monozygotic as opposed to dizygotic twin pairs. Yet such studies are often fraught with methodological difficulties, definitions are problematic and sampling dubious. Again the problem of the environment comes into play. Monozygotic twins are more likely to be treated similarly than dizygotic twins, and may spend more time together. Adoption studies were another attempt to prove the genetic link in criminality. Here behaviours of twins separated at an early age were compared. Research, such as that done by Mednick and his colleagues, only

indicates that sons with a convicted biological parent have an elevated chance of being convicted of a crime. Similar studies in the United States had similar results (Curran & Renzetti, 1994). Yet, once again, methodological problems plague these studies.

Faulty chromosomes have also been targeted in explaining crime. Normally people are born with forty- six chromosomes arranged in twenty- three pairs. One of each pair is contributed to by the mother and one by the father. One pair is composed of the sex chromosomes. The sex chromosomes of a genetically normal male consist of one X and one Y chromosome, a genetically normal female consists of two X chromosomes. Since the mother's contribution is always constant, an X chromosome, it is the father's contribution that determines the sex of the infant (Kaplan, Sadock & Grebb, 1994). Sometimes anomalies occur, one type of anomaly is called nondisjunction. This refers to the failure of the sex chromosomes to divide properly. This can result in an offspring having XO, XXX, or XYY chromosomes. The XO condition is referred to as Turner's syndrome and the XXY syndrome is known as Klinefelter's syndrome (Kaplan et al, 1994; Curran & Renzetti, 1994). The syndrome which seems most relevant to criminology is the XYY syndrome. These individuals tend not to have major physical problems but tend to have a high incidence of internal and external genital abnormalities, tend to be above average in height and below average in intellectual ability. The incidence is estimated at one per 1000- 2000 males. It appears that due to the low presence of XYY males in the general population, XYY males appear over represented in the institutionalised population. However, even if there is a relation between XYY syndrome and crime, these individuals make up for only a very small percentage of crimes committed (Curran & Renzetti, 1994).

Amongst other biological contributions to the etiology of crime are disorders of the central

nervous system, autonomic nervous system, hormonal imbalances, body chemistry, neurotransmitters, and diet. Yet all of these are far from being comprehensive explanations for the etiology of crime and still require further research and none seems to explain crime in isolation. Biological research often ignores psychosocial influences as moderators of biology-violence relationships. In a study on prefrontal glucose deficits in murderers lacking psychosocial deprivation, Raine, Stoddard, Bihrle and Buchsbaum (1998) concluded that only murderers without clear psychosocial deprivation such as physical abuse, sexual abuse, neglect, extreme poverty, foster home placement, criminal parent, severe family conflict or broken home, could be characterised by lower prefrontal glucose metabolism compared with control groups by means of Positron Emission Tomography (PET). Murderers without deprivation showed a 4.7% reduction in lateral and medial glucose metabolism compared to the deprived murderers. One hypothesis for this anomaly is that violent offenders from deprived social backgrounds may commit violence for more psychosocial reasons than as a result of a biological brain abnormality. It is possible that prefrontal dysfunction in murderers lacking psychosocial deprivation is genetically mediated, but further studies would be required to test this hypothesis. The orbitofrontal cortex represents a brain region of particular interest when it comes to violence because dysfunction in this area results in personality and emotional deficits that parallel criminal psychopathic behaviour. Murderers without psychosocial deprivation had poorer orbitofrontal functioning specifically in the right hemisphere. Compared to controls they had a 7.4% reduction in left orbitofrontal functioning, and 14.2% reduction in glucose metabolism in the right orbitofrontal cortex compared to controls.

One hypothesis is that this laterality effect is associated with reduced responsitivity to aversive, emotional activity and possibly an emotionally blunted personality lacking in conscience

development. Activation of the right, but not left, orbitofrontal cortex has been positively associated to aversive classical conditioning as indicated by PET and recollection of emotionally aversive events as indicated by regional cerebral blood flow. Previous research has indicated that antisocial individuals who had no socioeconomic deprivation show deficits in aversive classical conditioning , a trait hypothesized to lead to impaired conscience development and low emotional reactivity to socialising punishments. Consequently, reductions in right orbitofrontal functioning may be particularly important in predisposing individuals to violence. It must however be noted that although prefrontal dysfunction characterises murderers lacking psychosocial deprivation, not all prefrontal- impaired individuals end up committing murder (Raine et al., 1998).

2.11.1.5 Psychiatric and psychological explanations of crime

Psychiatry and Psychology have also attempted to provide explanations as to the etiology of crime. There have been great debates surrounding the notion whether or not serial murderers can be diagnosed with Antisocial Personality Disorder, some form of psychosis, or another Axis I diagnosis (Geberth & Turco, 1997; Hemprel et al., 1999; Holt et al., 1999; Kaplan et al., 1994). Early in the twentieth century Charles Goring first proposed that criminals displayed abnormally low intelligence and argued that this led to lowered levels of morality. While Alfred Binet came up with the concept of Mental Age (MA) (Kaplan et al., 1994) and is largely credited as being the first individual to develop an intelligence test, it was German psychologist, W Stern who devised the concept of an intelligence quotient, or IQ (Curran & Renzetti, 1994). A major proponent of the IQ and criminality theory was Henry Goddard. Using intelligence tests he determined that "morons" or the "feebleminded" or "high- grade defectives" posed a great concern since, although they could be trained to function in society, their lowered intelligence

would very likely cause them to get into trouble. Goddard proceeded to prove his point by testing inmate populations, whereupon he 'discovered' that seventy percent of criminals were "feebleminded". By examining family histories he went on to 'prove' that feeblemindedness was hereditary. This led to the segregation of the feebleminded in institutions and sterilisations as means of dealing with the problem. Goddard then became concerned with the large amounts of immigrants entering the United States, many of which, as testing indicated, were feebleminded. Routine IQ testing was conducted on immigrants. Critics of these policies were largely ignored until the US army agreed to allow the testing of its draftees during World War I. The army testing revealed an unusually high number of feebleminded draftees. In fact, extrapolating from the results led to the conclusion that at that time about half the USA population was made up of morons. This led to researchers questioning the reliability and validity of these tests, and the relationship between 'feeblemindedness' and crime was refuted (Curran & Renzetti, 1994).

The second avenue of exploration in the fields of Psychology and Psychiatry relating to crime is that of the criminal personality. Most widely known of this approach was Austrian neurologist Sigmund Freud, who is attributed with being the creator of the psychoanalytic model. While Freud did not specifically write about criminality, many researchers have used his theories to postulate assumptions about crime and criminality. Freud viewed crime as the result of a malfunctioning ego or superego. Underdeveloped superegos lead to the lack of experiencing guilt or remorse, an overdeveloped superego may lead an individual to subconsciously desire to be punished thereby committing crimes in the hope of being caught. An underdeveloped ego cannot resolve conflict and may cause an individual to act out in a criminal way. The ego may make use of defence mechanisms which could lead to criminal behaviour (Curran & Renzetti, 1994).

South African counselling psychologist, Pistorius has used Freud's concepts to try and explain serial murder in her doctoral work entitled A Psychoanalytical Approach to Serial Killers (1996). In her conclusion she determines the following:

> The explanation of Freud and Klein's theories in the case studies have answered the question as to "what is the origin of serial homicide?" Psychoanalysis succeeded in explaning the psychosexual development and fixations of the two selected case studies of serial killers. The thesis illustrates that each case has its own developmental path and fixations and although there were similarities and differences between them, the author is of the opinion that the psychoanalytical theory succeeds in explaining the origin of serial homicide.
>
> (Pistorius, 1996 p.253)

Even though Pistorius' research was based on two case studies she feels confident that "...the psychoanalytical theory and her supported statements therefore be generalised to all serial killers." (Pistorius, 1996 p.253).

Other approaches exploring crime and personality focus on specific personality traits. This is often done by making use of psychometry such as personality inventories. One of the most popular personality tests is the Minnesota Multiphasic Personality Inventory (MMPI) while more recent tests such as the Millon Clinical Multiaxial Inventory (MCMI) and more traditional projective tests such as the Rorschach Inkblot Method and the Thematic Apperception Test (TAT) are also commonly used. Ganellen (1996) is of the opinion that the Rorschach and MMPI are the most widely used tests when it comes to clinical personality assessment. Early research

using the MMPI indicated differences on personality scales of offenders and non- offenders when tested using the MMPI. A combination of both projective and objective methods could yield much need information on these individuals (Piotrowski, 1997).

A third avenue in the fields of Psychology and Psychiatry in terms of criminality is that of metal illness and crime. The US Supreme Court (Kaplan et al., 1994) states that the prohibition against trying someone who is mentally incompetent is fundamental to the US system of justice. The McGarry instrument was created to help determine an individual's competence to stand trial. It focuses on 13 areas of functioning: ability to appraise the legal defences available, level of unmanageable behaviour, quality of relating to the attorney, ability to plan legal strategy, ability to appraise the roles of various participants in the courtroom proceedings, understanding of court procedure, appreciation of the charges, appreciation of the range and the nature of the possible penalties, ability to appraise the likely outcome, capacity to disclose to the attorney available pertinent facts surrounding the offense, capacity to challenge prosecution witnesses realistically, capacity to testify relevantly, manifestation of self- serving versus self- defeating motivation (Kaplan et al., 1994). Furthermore, the M'Naghten rule was established in 1843 and states that an individual is not guilty by reason of insanity if they laboured under a mental disease such that they were unaware of the nature, quality and consequences of their acts or if they were incapable of realizing that their acts were wrong (Kaplan et al., 1994).

One diagnosis which is commonly associated with crime is that of the Antisocial Personality Disorder, in which an individual's lack of remorse and inability to learn from previous behaviours may lead to the transgression of laws. A diagnosis of a psychosis may also lead to an individual committing a crime, as a result of auditory hallucinations commanding the individual

to do so, or out of fear from a hallucination. Kleptomania, by the nature of the diagnosis, may lead to the individual committing a crime (APA, 1995). Meloy (1998) profiles the majority of stalkers as males who are likely to have Axis I mental disorders, such as a drug or alcohol history, mood disorders, or schizophrenia. In another study my Meloy and Gothard (1995) they found that 85% of their sample qualified for a personality disorder diagnosis such as antisocial, schizoid, borderline, avoidant, paranoid and personality disorder not otherwise specified. Binder (1999) who heads research groups on the correlation between mental illness and violence, has the following conclusions:

(a) Short- term predictions of violence risk are fairly accurate.

(b) Clinicians are better at predicting violence in certain patients than in others, for example violence in women is under predicted.

(c) Certain clusters of symptoms are more predictive of violence than overall diagnosis.

(d) The stereotype of psychotic patients wandering neighbourhood randomly attacking strangers was disproved.

Mullvey (1994) examined relevant research and concluded that there was an association between mental illness and the likelihood of being involved in violent incidences, even when demographic characteristics are taken into account. Link and Streuve (1995) also reviewed relevant research and concluded that in Western cultures since 1965 the rates of violence tend to be higher for people with serious mental illness than for the general population and in reality, the minority of psychotic people who do become violent are more likely to attack family members acting as caregivers.

In a study of mental disorders and homicidal behaviour in Finland it was found that individuals with antisocial personality disorder and severe alcohol dependency increased their risk for homicidal behaviour (Eronen, Hakola & Tiihonen, 1996). Also that individuals diagnosed with schizophrenia had an increased risk of being involved in violence, especially when it is of a paranoid type and/or when substance abuse is present.

In a study by Wallace, Mullen, Burgess, Palmer, Ruschena and Browne (1998) on serious criminal offending and mental disorder they found that a relationship does exist between mental disorder and criminal offenses but the nature and extent of the association remains in doubt. Their study involved linking two databases, one of the higher court records of convictions and the other a state- wide psychiatric case register in the state of Victoria, Australia. The age of the sample was 18 and above and included 4156 individuals (3838 men and 315 women) convicted in the higher courts between 1993 and 1995. Of these 1044 (25.1%) were recorded on the psychiatric case register.

When it came to crimes against the person, 2153 individuals were convicted for crimes involving interpersonal violence, of these 643 (29.9%) were also recorded on the Victoria psychiatric case register (VPCR). There were significant associations for schizophrenia, personality disorders, substance abuse and the wider grouping of affective disorders and for affective psychosis in men. Of the people recorded on the VPCR with a diagnosis of schizophrenia, 0.5% of men and 0.05% of women had a conviction for interpersonal violence. For personality disorders it was 2.5% in men and 0.4% in women that had a conviction and for men and women with a primary diagnosis of substance misuse it was 1.1% and 0.4% respectively.

In the 168 convictions for homicide 62 individuals (55 men, 7 women) were recorded on the VPCR. For men recorded on the VPCR who had been convicted, 0.09% had a diagnosis of schizophrenia and 0.01% of women. For property offenses 1253 individuals had been convicted in the time frame of which 305 (24.3%, 273 men and 32 women) were recorded with the VPCR. Those diagnosed with schizophrenia, personality disorders and substance misuse showed significant association with convictions, a relationship between affective disorders and conviction was only found in men. In the category of sexual offending 890 individuals (876 men, 14 women) were convicted with 252 (28.8%) of the men having been recorded on the VPCR, whereas none of the women convicted were found on the VPCR. Of the 115 arson convictions (106 men, 9 women) 48 were on the VPCR. In men only personality disorder and substance related disorders were significantly associated. In women 7 had had contact with mental health services but due to the small numbers no meaningful conclusions could be made. Of the 504 individuals convicted of drug- related offenses (455 men and 49 women), 100 (19.8%) were recorded with the VPCR (93 men and 7 women). In men only the diagnosis of personality disorder and substance abuse showed significant association. The numbers for women were again too low to make conclusions. Regarding traffic offences, 122 individuals (116 men and 6 women) of whom 28 (23.0%) were recorded on the VPCR, there was only a significant relation between substance related disorder in men.

Their study concluded that men with schizophrenia were more likely to have been convicted if they also had a diagnosis of substance abuse. In the three- year study 0.28% of those with schizophrenia with no recorded comorbid substance misuse were convicted with violent offenses compared to 2.2% of those with substance misuse. a significant association with schizophrenia was found only in those with a history of substance misuse in arson and drug- related offences.

Therefore in the present study of Wallace et al. (1998) 7.2% of men convicted of homicide had been treated for schizophrenia. How these figures are expressed can radically alter one's perception of violence amongst individuals with a psychiatric history. The data indicates that men with schizophrenia have a risk 5- 18 times higher than that of the general population of committing a homicide and 3-5 times the risk of conviction for serious violence. Conversely they indicate that 99.97% of those with schizophrenia, irrespective of a comorbid substance misuse, will *not* commit a homicide in any given year and 99.8% will *not* be convicted of a serious offence. In summary, they state that the notion that increased levels of serious violent behaviour in those with schizophrenia are of a type and degree that places the process of community care in question, thus indicating a need for a return to a more custodial approach, is nonsense. And in reality mental illnesses make up for a very small percentage of crimes committed, the overwhelming majority being committed by 'normal' individuals.

Amongst spousal murderers there was a high incidence of personality disorders. It was found that as the severity of non- lethal physical abuse increased, so did the likelihood of a personality disorder. Surprising was the number of "over controlled" personality disorders such as passive-aggressive and dependant personality disorder, with antisocial personality disorder being less frequent. Over controlled men are more likely to commit abandonment murders, attempt suicide afterwards, and kill "reactively". Murders may occur during failed reconciliation, or when the spouse first announces a desire to leave. Most of these spousal murderers lacked recorded histories of assaultive or other socially disturbing behaviour. Antisocial men killed for more instrumental reasons such as to collect insurance policies and their killings were planned in a "cold- blooded" way (Dutton & Kerry, 1999).

Certain diagnoses have been associated aggressive behaviours. Aggressive behaviour in children with Attention Deficit/ Hyperactivity Disorder (ADHD) is associated with greater psychological disturbance, antisocial familial factors and development of antisocial personality disorder and substance abuse. Conduct disorder has characteristic behaviours which fall into four main groups; aggression towards people or animals, destruction of property, deceitfulness or theft, and serious violation of rules. Since only three of the four patterns of behaviour are necessary for diagnosis, aggression is not compulsory for a diagnosis of conduct disorder. Pervasive developmental disorders can also feature aggressive behaviour that may be directed toward other people or may be self- directed (Weller, Rowan, Elia & Weller, 1999). Intermittent Explosive Disorder is another diagnosis where aggression is a central characteristic. The criteria include discrete episodes of failure to resist aggressive impulses that result in serious assaultive acts or destruction of property an the degree of aggressiveness expressed is grossly out of proportion to any provocation or precipitation psychosocial stressor (APA, 1994). At present intermittent explosive disorder is more common in men, although when premenstrual women may be more inclined to intermittent explosive symptoms. The association of explosive episodes with mood and energy changes similar to manic and hypomanic symptoms, the high rate of comorbid bipolar disorder, and the favourable response of impulsive, aggressive symptoms to treatment with mood stabilizers suggest the possibility that intermittent explosive disorder may be linked to bipolar disorder (McElroy, 1999).

2.11.1.6 Sociological theories of crime

Sociological theories include the thinking of the Chicago School, the Anomie Theory, the Differential Association Theory, the Control Theory, the Labelling Perspective, and the Subcultural Theories (Conklin, 2000; Siegel, 2000). Although each of these theories are distinct,

they share at least one proposition in common: they seek the causes of crime in factors outside of the individual, that is, they believe that the environment influences otherwise 'normal' people to commit crime.

The University of Chicago was home to the first academic department of Sociology in the United States, being established in 1892 (Bulmer, 1984; Siegel, 2000). Until the 1940's sociologists looked to Chicago as the centre of sociological research. Robert Park applied plant and animal ecology to the problem of social deviance, therefore the Chicago School is also known as the Ecological School or School of Human Ecology. Park and his colleagues identified several distinct zones that expanded out in a pattern of concentric circles from the centre of the city. The outer zones, 4 & 5, were populated by predominantly white, middle and upper class homeowners who had lived in those communities for many years and were well integrated into the dominant culture of the United States. Zone 3 was characterised by working- class neighbourhoods where second and third generation immigrant families lived. The heart of the city, zone 1 & 2, had high concentrations of transients and hoboes, black immigrants and newly migrated immigrants, who occupied street corners and dilapidated housing.

These theorists believed that not all zones had similar concentrations of problems. They theorised that the further one moved away from the city centre the lower the incidence of social problems. The stated that this was the result of social disorganisation, which in turn is caused by rapid social change that disrupts the normally smooth operation of a social system.

Two explanations of crime use the title "anomie theory", one was developed by Emile Durkheim (British Centre for Durkheimian Studies, 1994) and the other by Robert Merton (Sykes, 1992).

Durkheim believed humans have innate needs and desires which must be satisfied if they are to be content. However, humans needs are social, not physical, and the more one has, the more one wants. Consequently human "nature" must be regulated by the "collective order"- society. Durkheim distinguished between two types of societies: those characterised by mechanical solidarity and those characterised by organic solidarity. In a society of mechanical solidarity members are very similar and there are few differences amongst them. The members do the same type of work, fulfill similar social roles, have the same world view and understanding of right and wrong. This 'totality of social likeness' is termed the collective conscience by Durkheim. It binds people together and promotes conformity. These are not crime- free societies, and social deviance is met with strong social reaction, law tends to be repressive. Mechanical societies tend to be small and relatively underdeveloped technologically. With population growth and technological advancement, social diversity increases and the collective conscience is weakened. Still, social order is preserved because the proliferation of diverse jobs, roles and ideas actually creates an interdependence among the society's members. Thus the division of labour largely replaces the collective conscience as the binding force in society. The parameters of acceptable behaviour become broader and punishment less harsh. Law takes on a more administrative role whose primary goal is to preserve contracts amongst society's members, this type of society is characterised by organic solidarity. Durkheim was concerned that this type of society as being susceptible more to crime and other social problems. When such societies change rapidly they might not be able to adequately develop appropriate regulations to govern social interaction, this condition was called anomie (British Centre for Durkheimian Studies, 1994; Curran & Renzetti, 1994; Siegel, 2000).

Subcultural theories focus on the proposition that each social class develops it own value system unique to it, reflecting its place in the status hierarchy. These theories appear impressive and are often supported because they provide an explanation for statistics why delinquency and other crimes are committed by members of the lower class. However, empirical research has challenged many of these assumptions. These theories thus seem to be a reflection of middle-class stereotypes about the poor, rather than an empirically proven description of the 'lower-class' (Curran & Renzetti, 1994).

Certain theories emphasise that the role of socialisation in criminal behaviour, it is therefore the socialisation process, not physiognomy, genetics, race, sex or social class that affects one chances of becoming a criminal. Sutherland's Differential Association Theory (Curran & Renzetti, 1994) proposed the following nine points. Firstly, criminal behaviour is learned. Secondly, it is learned through interaction with others in a process of communication. Thirdly, the principle part of learning occurs within intimate personal groups. Fourth, when this behaviour is learned it includes (a) techniques of committing the crime, (b) the specific direction of motives, drives, rationalizations and attitudes. Fifth, the direction of motives and drives is learned from definitions of legal codes as favourable and unfavourable. Sixth, a person becomes delinquent because of an excess of definitions favourable to violation of law over definitions unfavourable to violation of law. Seven, differential association may vary in frequency, duration, priority, and intensity. Eighth, the process of learning criminal behaviour by association with criminal and anti- criminal patterns incorporates all the mechanisms that are involved in any other learning. Ninth, although criminal behaviour is an expression of general needs and values, it is not *explained* by those general needs and values since non- criminal behaviour is an expression of the same needs and values. Thus criminality is a learned behaviour, via communication in social

interaction with primary groups. Individuals learn attitudes and motivations as well as techniques for committing crime. However, being exposed to attitudes, motivations and techniques does not imply one will automatically engage in crime. One must also learn specific situational meanings or definitions, a person becomes delinquent because of an excess of definitions favourable to violation of law over definitions unfavourable to violation of. The process of social interaction whereby such definitions are acquired is termed differential association by Sutherland (Curran & Renzetti, 1994).

Control theories have one basic similar tenet, they adopt a position that all people are basically criminal at heart. People are equally motivated towards crime because fulfilling one's desires usually can be done most effectively by violating the law. The question then posed to control theorists is why do people obey the rules of society? In answer, they believe that it is a person's ties to conventional social institutions such as family and school, that inhibit the person from acting on criminal motivations. Neutralisation theory, such as that of Sykes and Matza (Sykes, 1992), disagreed with positivist schools since even active delinquents spend more time engaged in non- criminal activities than in criminal ones. Instead of seeing delinquency as a rejection of societal norms they see it as an end product of a process they call neutralisation. According to them behaviour runs along a continuum, with total freedom at one end and total constraint on the other. Adolescents fluctuate between these two extremes. The drift into delinquency is facilitated by learning justifications or rationalisations that neutralise the constraint of society's norms of behaviour and thus legitimise deviation. These justifications are called techniques of neutralisation, of which there are five basic types: denial of responsibility, denial of injury, denial of victim (victims deserve what happens to them), condemnation of condemners (authority is corrupt therefore also guilty), and appeal to higher loyalties (offender committed crime not for

self but for others). These techniques are put into action before the commission of the crime and help to loosen the moral constraints, acting as mitigating circumstances in the persons logical reasoning. Once societal norms are neutralised the person is free to drift into delinquency. Once the bind of the law has been neutralised it becomes easier to drift again (Curran & Renzetti, 1994).

The final movement to be discussed is the Labelling perspective which became popular in the 1960s and 1970s. Also known as social reaction theory it was developed in reaction to the dominance of the positivist paradigm in criminology. They focused on how certain behaviours became defined as criminal and the consequences of these definitions for individuals engaging in these activities. Labelling theorists see crime from a relativist point of view. An act becomes deviant only when defined as such by a group of observers. Certain points thus become relevant from this point of view. What is defined as criminal depends on a number of factors including situational and historical contexts in which the behaviour occurs, the characteristics of the person engaged in the behaviour, and the characteristics of the definers. Another major point is that crime is the product of social interaction. What is important is not that a person breaks a law but rather others reaction to it, labelling him as criminal or deviant. When a label is attached through either informal or formal means, such as the criminal justice system, the individual undergoes fundamental identity changes. Being labelled as a criminal becomes a master status, superseding any other description of the person. Others interact with this person on the basis of stereotypes. What often occurs is a self- fulfilling prophecy, with the person acting out his label (Curran & Renzetti, 1994, Seigel, 2000).

Jenkins (1994) discusses the social construction of serial murder. He raises the question, as in

the serial murder case of Jeffrey Dahmer, of how much aberrant behaviour is to be understood and contextualised. Few would disagree that Dahmer's behaviours were terrible, but it is difficult to reach consensus on whether or not his behaviour would be best understood as a symptom of individual pathology or linked to broader social issues. Financially, serial murder has become an important phenomenon. From 1991 to 1993 more was published on serial murder in fiction and true crime than the whole of the 1960s and 1970s combined. This high level of appearance in the media leads to law enforcement agencies investing far more resources into the investigation of such crimes. When compared to the number of 'normal' murders perpetrated, it is vastly out of proportion, in terms of perpetrators and victims. Perhaps the serial murderer is the ultimate product of a capitalist society, how can one individual generate so much interest and money? Why is it that some multiple- murder cases are more well known than others? Not because they are more dangerous than others but rather because they are more 'useful', serial murder seems to be exploited by radical feminists, advocates for black rights, defenders or critics of homosexual rights, traditionalists and even anti- modern reactionaries. Constructionist research focuses on three main concerns: firstly, the interests particular groups have in promoting a problem; second, the resources available to them; finally, the ownership they eventually secure over the issue, or degree to which their analysis is accepted as authoritative.

There exist certain thresholds which mark out the limits of social tolerance, at the one end of the spectrum are the more 'permissive' and at the other, the higher thresholds of legality and ultimately of violence. The higher an event can be placed on the hierarchy of thresholds, the greater a threat it is to social order and the tougher and more automatic is the coercive response. An event can be escalated by linking it to other apparently similar phenomenon, especially if by connecting it to a relatively harmless activity. This signification spiral makes the danger appear

more wide- spread and diffuse, for example, 'homosexual serial killer' or 'racist serial killer'. As this spiral continues it becomes easier to mount 'legitimate' campaigns of control. Serial murder exists on the highest of these thresholds, and associating any phenomenon with it offers rich rewards in terms of claims- making (Jenkins, 1994).

2.12 Serial murder in South Africa

In South Africa a lack of detail hampers the identification of people who have committed serial murder. Official crime statistics only report the murder weapon and the race of the offender and victim (Snyman, 1992). Also, people are not convicted of serial murder, the charge remains as murder, irrespective of the number of victims. Thus statistics are not available as to the exact incidence of serial murder in South Africa (Pistorius, 1996).

In South Africa in 1996 alone the following people labelled as 'serial killers' were recorded in local newspapers: Samuel Jacques Coetzee (5 victims), Christopher Zikode (18 victims) (Die Burger, 1996), unknown NASREC killer (12 victims) (City Press, 1996), unknown Brakenfell Killer (19 victims) (Pretoria News, 1996), unknown Tzaneen Killer (3 victims) (Citizen, 1996), unknown River Strangler (5 victims) (Saturday Star, 1996). In 1995 Moses Sithole was apprehended for 38 murders, 40 rapes, and 6 robberies (Saturday Star, 1996). In 1994 David Selepe was apprehended for the murder of 11 people (Saturday Star, 1996).These number indicate that it is not such a rare phenomenon. Keeney and Heide (1995) state that over the past 20 years serial murder has received and increase in attention from law enforcement and the media, this can also attribute to the 'increase' in the phenomenon.

2.13 Conclusion

The history and developments regarding serial murder have been a long process in the making. The modernisation of society has brought with it changes that have altered the face of serial murder with regards to the commission of the crimes and apprehension of such individuals. Various theories regarding serial murder were mentioned in this chapter, their positive and negative aspects highlighted. It is as if a 'dance' has developed between the murderer and the agents of the criminal justice system. Yet what is often ignored is the place serial murder has created for itself in our society and the importance society attaches to this phenomenon emotionally, politically and financially.

Various theories of crime were proposed, each one reflecting the dominant discourse at the time its conceptualisation. This process is natural as society tries to define itself and at the same time thereby re- create itself. The end result being that scientists are far- off from being able to understand and explain this phenomenon and perhaps part of the problem is the way in which scientists have been trying to approach serial murder. The next few chapters hopes to reveal another way in which this phenomenon can be observed.

Chapter 3

Interactional Theory

3.1 Introduction

In 1989 Claiborn and Lichtenberg provided a coherent framework for the understanding of interactional thought, though they declined the claim that their intention was to provide a theoretical view of interactional counselling. Nevertheless, they did contribute to an understanding of interactional concepts. These include the definitions of interaction, personality, communication, systems and disordered behaviour.

3.2 Definition of interaction

Claiborn and Lichtenberg (1989) say that the concept of interaction has two meanings. The first is the idea that man's behaviour is "... jointly influenced by person (or trait) and situation (or environment) variables. The second meaning refers to "... the behaviour with one another, as in interpersonal interaction" (p. 356). They conclude, taking both these views into account, by saying that "... in an interactional view... behaviour is considered to be simultaneously influenced by the person's view of the world- interpretations, expectations, and choices- and by the world the person is viewing, particularly the behaviour of others with regard to the person" (p. 356).

From their theoretical conceptual framework, they have explained the concept of personality and defined the concept according to Endler and Magnusson's characterisation of an interactional view of personality in 1976. These are:

a) Behaviour is determined by a continuous process of interaction between the individual and the situation he [or she] encounters (feedback).

a) The individual is an interactional, active agent in this interaction process.

b) Cognitive factors are important in this interaction.

c) The psychological meaning of the situation to the individual is an essential determinant of behaviour.

(Endler & Magnusson, 1976, p. 12, in Claiborn & Lichtenberg, 1989, p. 356)

This means that the concept of personality, often viewed as the social aspect of a person, or his general behavioural characteristics or 'basic' nature are more than these popular views. Meyer, Moore and Viljoen (1997) define personality as "... die gedurig veranderende, maar tog stabiele, organisasie van alle ligaamlike, psigiese en geestelike eienskappe van die individu wat sy of haar gedrag bepaal, in interaksie met die konteks waarbinne die persoon hom of haar bevind" (1997, p. 12).

The emphasis here is slightly different from the Endler and Magnusson view. They lean towards the "stable organisation" of personality, while Claiborn and Lichtenberg's idea is a personality of "continuous interactional process" with the exception that behaviour is determined by the psychological meaning of a situation by an individual.

In a similar way, Jackson (1977, p.2) refers to Shibutani (1961) who says:

> ...many of things men do take a certain form not so much from instincts as from necessity of adjusting to their fellows... What characterises the interactional approach is the contention that human nature and the social order are products of communication... The direction taken by a person's conduct is seen as something that is constructed in the reciprocal give- and- take of interdependent men who are adjusting to one another. Further, a man's personality- those distinctive behavioural patterns that

characterise a given individual- is regarded as developing and being reaffirmed from day- to- day in his interaction with his associates.

(In Watzlawick & Weakland, 1977)

From the above, the assumptions of the interactional theory are seen as:

(a) Individual personality, character and deviance are shaped by an individual's relationships with others;

(b) a person's distinctive patterns of behaviour which characterises a specific person are those developed and reaffirmed continuously during his life by others, and

(c) human nature and the social order are products of communication.

The DSM-IV (APA, 1994) describes a personality disorder as an "enduring *pattern* of inner experience and *behavior* that *deviates* markedly from the *expectations* of the individual's *culture*..." (p. 629, italics added). It further states "[p]ersonality traits are enduring patterns of perceiving, relating to, and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts" (p. 630).

The interactional approach views personality traits as components of relationships, these affect how the person experiences others and also how he or she allows others to experiencing them. Personality traits therefore become relationship traits. This shifts the focus from 'why' a behaviour occurs to, 'how' or 'for what purpose' does a behaviour occur (Claiborn & Lichtenberg, 1989; Swart & Wiehahn, 1979).

From these assumptions, the theory of interactional thinking states that a person can not other than be continuously and interactionally entangled with others. This interactional process confirms and reaffirms who he or she is, and will determine the person's distinctive behaviours. Lastly, which seems to be very pertinent, these interactions of people and their communications shape human nature and the social order.

Some personality theories focus on the early development of the individual, such as Freudian and Neo- Freudian theories, others emphasize learning processes as is the case with behaviourists, and phenomenologists describe behaviour as the answer which the individual ascribes to his or her world. However different these approaches may seem, they share a common element, all these theories include an element of interaction (Swart & Wiehahn, 1979). Even Millon's (Millon, 1996; Millon & Davis, 1996) theory of personality and classification, focuses on the interpersonal behaviour of the various personality disorders.

From this point of view then, the psychologist needs to come to an understanding of the client's interactions with his world. He or she needs to gather certain information that hopefully answers questions from the psychologist's theoretical framework. While traditional psychologist's would try to diagnose the person, the interactional, psychologist tried to gain an understanding of what maintains the problem and the person's interactional role in the system. He or she then aims to analyse the interactions of the client(s). One can almost call this a method of 'diagnosing' the system instead of the person.

Although this is today not an entirely 'new' manner of conceptualisation, as Watzlawick and Weakland described it in 1977, the way forward in this thesis is to apply these concepts within

a broader framework of extreme behavioural patterns such as serial murder. This means that human beings nature and the 'social order' is also shaped by pathological patterns of behaviour, in the sense that all behaviour is defined within a social network which we inhabit (Haley, 1967).

Although no super- theory in clinical behaviour will be arrived at, one may arrive at a point which may serve as a guide towards the understanding of this complex phenomenon: clinical interactional behaviour with the specific emphasis on serial murder.

3.3 Theoretical view

Claiborn and Lichtenberg (1989) disclose five major areas of interactional thought. Namely, reciprocal causality, the communicational view of behaviour, the organisation of interactions into sequences that have characteristic patterns and accompanying interpersonal perceptions, how relationships are formed and maintained through interpersonal interaction and the concept of relationship as related to cybernetic principles.

In this exposition of interactional theory these five areas will be briefly explained, in addition to these attention will be given to disordered behaviour and dysfunctional systems.

3.3.1 Reciprocal causality

In contrast to a linear causality, reciprocal causality means that the person(s) and situation(s) variables affect each other in an ongoing, circular (or multidirectional) way and that each variable in the process functions as both cause and effect (Claiborn & Lichtenberg, 1989). From this point of view it is difficult to take a linear stance, which may be arbitrary (Carson, 1969) and is basically the idea of how participants perceive their interactions. These, at best, can be defined

as punctuations of behaviour at a certain point in time.

3.3.2 Communicational concepts

The interactional approach can be seen as developing from communication theory and systems thinking. The communications approach to psychotherapy emerged from two interrelated research projects. The first was from the Double Bind Communications Project begun in 1952 involving Bateson, Haley, Weakland and Jackson as a consultant. The second was from research done by the Mental Research Institute (MRI) founded by Jackson in 1958 with Satir and Watzlawick as important members involved. Both these closely related projects shared the common assumption that communication is the key to the understanding of human behaviour (Prochaska & Norcross, 1994).

While the focus of this early research was on families, this did not make the findings irrelevant to individual psychology. Jackson (1965) of MRI states that even if the object of study is the family unit, any examination of the characteristics of the various individual family members remains in the realm of individual theory. It is the shift to interactions that allows one to therefore apply this approach to smaller units such as a dyad of therapist and client. By punctuating a sequence of events one can isolate interaction and determine interventions that will lead to a different effect on the interaction. Changes in one part of a system can lead to change in another part (Gurman & Kniskern, 1991). The implication is that one need not work with all the members, such as a family, to bring about change in the whole system.

Thus the interactional view leans heavily on communication theory. One of the most important concepts of communication theory is that all forms of behaviour can be seen as having message

value. This means that messages, as ways of communication, are continuous: one cannot escape from communicating, everything one does is a form of communication. Sometimes one's silence says more than volumes of literature. Depending on the people involved, the same look can take on different meanings. A look between two lovers means something completely different than a look between two arch- enemies. What makes the difference is the type of relationship 'between', the two people involved create the context and meaning of the look. Investigation into these communication patterns that exist will allow the researcher to hopefully identify those patterns that may lead to pathogenic forms of interaction (Nardone & Watzlawick, 1993). This also means that one cannot escape influencing others or being influenced (Claiborn & Lichtenberg, 1989).

Watzlawick, Beavin and Jackson (1967) came to the following five conclusions about human communication:

i) It is impossible not to communicate.

ii) Every communication has both a content and a relational aspect.

iii) The nature of the relationship depends on how the participants punctuate the sequence of their behaviour.

iv) Communication can be both digital and analogic.

v) Communication is either symmetrical or complementary.

These relationships are expressed through communication, the messages we send to one another. These messages shape the nature and future of the relationships we have with others and can occur verbally and non- verbally. The acceptance or rejection of messages therefore helps to define what is appropriate behaviour in that specific relationship, in other words, what roles each

participant will play in the relationship (Haley, 1990). The acceptance of the message can occur in two forms, firstly, total acquiescence of the definition or, secondly, the person qualifies his acceptance with the message that although he has allowed the other person to define the relationship, he is letting the other person do so (Swart & Wiehahn, 1979).

Rejection of the message is the other option available, this occurs when a person rejects the 'proposed' definition. The person who defines the relationship is said to be in control of the relationship, this control can change hands since relationships are dynamic in nature (Haley, 1990). One can view the psychiatrist- patient relationship as an example. A psychiatrist imposes a diagnostic label on a patient, if a patient rejects this then often the diagnosis is seen as being confirmed, or a new diagnosis is imposed by the psychiatrist. On the other hand, many patients allow the psychiatrist to imposed such labels upon them. In either case the psychiatrist is seen as being in the 'control' position.

Relationships can be seen as being either symmetrical or complimentary. A symmetrical relationship exists when the two parties give similar messages to each other, effectively exchanging the same behaviour. Here there is competition for control since neither accepts the definition of the other. A complementary relationship exists when the definition is accepted by both parties and the ensuing messages continue to reaffirm the definition (Hanson, 1995, Watzlawick, Beavin & Jackson, 1967).

3.3.3 Patterns of interaction

Claiborn and Lichtenberg (1989, p. 363) state that "Interactions are not random, they are highly organised exchanges", which also includes the interactants' cognitive construction of the

interaction. According to these authors the primary function of interaction is the continuous confirmation of self, which means that all interaction "emanates from and returns to the self" (p. 363).

But as messages of interaction are exchanged, these form sequences, which Watzlawick et al. (1967) describe as stochastic processes- nonrandom chains of events, in which some affect the probabilities of other events (Claiborn & Lichtenberg, 1989). Claiborn and Lichtenberg then state that because of the nonrandomness, the sequence exhibits regularities or redundancy. They explain as follows:

> Redundancy in the exchange of messages make for patterns of interaction, which are... essential for... any kind of meaningful exchange and... for forming a relationship. Patterns provide stability in interaction... is often taken to represent the "rules' of a relationship or system (p. 363)

The process of contrasting interactional sequences is called punctuation which is in essence the way interactants perceptually organise events in their unique sequence (Watzlawick et al., 1967; Claiborn & Lichtenberg, 1989).The roles which people usually ascribe to themselves rest on the way in which they punctuate interactional sequences which then become a description of the nature of the relationship.

3.3.4 Relationship functioning

A relationship definition determines what takes place in a relationship and what does not. It regulates the process of interaction as well as the outcomes of the interaction. Carson (1969) refers to the relationship definition as a kind of implicit interpersonal contract. Carson (1969) also

says, referring to long- term relationships such as marriage, that there is some stability in the basic position that each partner occupies vis- a- vis the other, even though there may be occasional adjustments in various specific joint activities.

3.3.5 System functioning

General Systems theory was first conceptualised by von Bertalanffy in 1937 but it was only towards the end of the Second World War that a major epistemological shift took place in Psychology. At the time people began to realise that many biological and non- biological phenomena shared the attributes of a system. This so- called 'new' epistemology was based on the concept of information and involves an understanding of the pattern, order and negentrophy the individual system in its broadest sense. These new epistemological principles are circular in nature and therefore feedback plays an important role. It was realised that communication and self- regulation through communication are essential for the functioning of a system. Information concerning the results of the system's past performance are reinserted into the system, altering its future functioning. This process is called self- corrective feedback (Gurman & Kniskern, 1991)

Individuals such as Gregory Bateson were instrumental in the formulation of this approach. He observed the relevance of this way of thinking to the description of human interaction. He was especially aware of the fundamental assumptions underlying general systems theory as explained by Buckly (1968) and Bertalanffy (1968). These assumptions stated that by observing systems it was possible to formulate rules that could explain the functioning of the interrelated parts. This was a move away from focusing on content, material substance, distribution of physical energy, to considering process, pattern, and communication as being the essential elements in description and explanation (Gurman & Kniskern, 1991). Ironically Bateson had no interest in family therapy

per se. His ultimate goal was to develop a unitary view of nature. Families and their communication patterns was just a short pause for him. He then moved on to study porpoises and their methods of communicating amongst themselves and their trainers (Gurman & Kniskern, 1991).

Coetzee (1996) lists the following 6 assumptions with regards to systems:

i) They are made up of subsystems and are in turn part of a larger suprasystem.

ii) Each of the subsystems have a purpose related to the survival of the whole.

iii) A system operates according to certain general rules.

iv) Systems have properties more than the sum of its individual parts.

v) Communication and feedback mechanisms between the different parts are essential for the functioning of the system.

vi) Growth and evolution are possible.

Von Bertalanffy (1950) further distinguishes between a closed system in which there is no interaction with surrounding environs and an open system which maintains itself through a constant exchange of materials with its environment and continuous building up and breaking down of the materials' components. Human interaction systems are regarded as open systems with the following characteristics:

i) Homeostasis: this refers to the permissibility of variation among the subsystems of a system, thus allowing the system maintain its identity

(Watzlawick, Weakland & Fisch, 1974)

ii) Wholeness: a change in one part will cause a change in the whole system (Barker, 1986)

iii) Feedback characteristics: which can be positive or negative. Positive feedback causes

disruption and therefore change. Negative feedback keeps the system in a state of equilibrium (Watzlawick et al., 1974; Prochaska & Norcross, 1994). Servomechanisms: are automatic devices which correct the performance of a mechanism by means of error- sensing feedback (Prochaska & Norcross, 1994)

iv) Equifinality: the same end result may be achieved through changes in different parts (von Bertalanffy, 1950).

Systems therapies/ approaches maintain that the individual can only be understood in the social context in which they exist and to understand the functioning of whole organisms, one must study not only the separate parts of the organism but the *relationships between* those very parts (Prochaska & Norcross, 1994).

3.3.6 Disordered behaviour

The interactional approach is concerned with how individuals cope with the problems they experience in everyday -life, the interactions between individuals, and the perceptions and relations individuals experience within themselves, with others and the world. It is concerned with people 'in relation to' since one cannot be removed from a context (Haley, 1990; Nardone & Watzlawick, 1993). Since every person is involved in one or more context simultaneously more than one reality exists. Therefore every interpretative model that claims to hold an all encompassing, single truth as to the explanation of human behaviour will inevitably refute itself due to self- reference. If a theory finds confirmation within itself or through its own instruments it falls into the trap of becoming non- falsifiable. An example would be:

> The dogmatic assumption that the discovery of the real causes of the present problem constitute a *conditio sine qua non* (essential condition) for change creates what the philosopher Karl Popper has called a self- sealing proposition; that is, a hypothesis that is validated both by its success and its failure and thus becomes unfalsifiable.
>
> (Nardone & Watzlawick, 1993 p.2)

In essence the search for the cause of a problem becomes a never ending cycle only put to an end by a theory creating its own definition of what the answer should be.

The interactional view focuses on the interaction between individuals, themselves, and their world. These are organised into interactional patterns which may maintain a problem. Here lies the reason for the emphasis on process rather than content. The interactional view holds the assumption that an individual's rigid perceptive- reactive system leads to the individual applying one or more 'good solution' indiscriminately to a variety of problems (Nardone & Watzlawick; 1993, Watzlawick, 1997).

From the communication point of view, there are two types of phenomena which must be present for a psychiatric symptom to be a proper symptom: the patient's behaviour must be extreme in its influence on someone else and he must indicate in some way that he cannot help behaving as he does. The extreme behaviour does not have to be a particular type as long as it is extreme and therefore out of the ordinary. Usually symptoms fall into classes of opposites; for every symptom at one extreme there is a comparable one at another. Those people who cannot touch a doorknob and are called phobic are comparable to those people who must touch a doorknob six times before

turning it and are classed as compulsive (Haley, 1990).

From an interactional point of view one does not talk in terms of classification of mental illness, but rather in terms of the quality of the communication between people. Communication is optimal if both parties are open to the messages exchanged between them, and if both parties can express themselves freely and directly (Swart & Wiehahn, 1979). By implication then, a psychological problem exists when there is

(a) a rigidity of roles,

(b) a lack of openness, or

(c) an inability to express freely and directly. (Swart & Wiehahn, 1979, p. 19)

Rigidity refers to an individuals inability to alter his or her interpersonal strategies to unique situations, while ignoring feedback from the context. This can be referred to as a 'closed system' since it doesn't allow new information in to allow for self- corrective behaviour (Hanson, 1995). Also, the individual's own behaviour helps shape the interpersonal situation, thus eliciting certain responses from the context, often in a complementary fashion, thus contributing to the creation of a self- fulfilling prophecy. This then 'justifies' the individual's behaviour. This helps develop faulty cognitive construction of the environment or context (Claiborn & Lichtenberg, 1989). It is for these reasons that an interactional analysis can help determine what the elements of the unique problematic situation are.

Psychological problems are almost exclusively seen as behaviours which are observable in interpersonal contexts (Haley, 1959). Problems from an individual perspective are inadequate or inappropriate interpersonal manoeuvres. Problems from a systems view, the focus is on the

function of the problem behaviour within the person's system. Claiborn and Lichtenberg (1989) give four characteristics to maladaptive individual behaviour. These are: rigidity of behaviour (i.e. due to insensitivity to feedback); when a person's own behaviour to some extent shapes the interpersonal situation (prompting others to respond with complementary behaviours and the maladaptive behaviour becomes self- fulfilling); faulty cognitive construction of the environment and lacks reciprocity and tends to become exploitive (Claiborn & Lichtenberg, 1989).

The symptoms which are exhibited are like all behaviours, messages with content and relationship values. These symptoms can be a self- disqualification of meta- communications; transactional disqualification, which means an "incongruity in the response of one speaker in relation to the thesis (content) of the previous message of another" (Sluzki et al., 1967, p. 496, in Claiborn & Lichtenberg, 1989, p. 379); and by relationship control by means of the symptom, and by denying the control (Haley, 1963; Claiborn & Lichtenberg, 1989).

A specific systemic view of disordered behaviour was first formulated when clinical studies of schizophrenics' and their families were conducted. This view was to become known as the double- bind theory of schizophrenia.The double- bind research (Bateson, Jackson, Haley & Weakland, 1956) involved Bateson and his colleagues investigating families in which one of the members were expressing schizoprhenic behaviour. They based their research on a part of communications theory termed the Theory of Logical Types by Russel (Whitehead & Russel, 1910). This theory's basic assumption is that there is discontinuity between a class and its members.

Related to interpersonal behaviour this means that there is a discrepancy between the communication and the meta- communication in human interaction. In Watzlawick et al.'s (1974) terms, this means a shift from one level to a higher one "...a shift, a discontinuity or transformation- in a word, a change-..." (p. 9). When studying communication certain pathogenic forms of interaction can be identified, for example, messages which contain two contradictory- mutually exclusive- orders, and which results in disturbed behaviour of the person in that interactional context, cannot leave (Nardone & Watzlawick, 1993). When double messages are given, the receiver has difficulty discerning between the two. The basic ingredients for such a situation are:

(a) Two or more persons

(b) Repeated experience.

(c) A primary negative injunction.

(d) A secondary injunction conflicting with the first at a more abstract level.

(e) A tertiary injunction preventing the individual from escaping the field.

(f) The individual is involved in an intense relationship that he or she feels they must accurately discriminate between messages.

(g) The individual, or another member of the system, is unable to comment on the discrepancy (Bateson et al., 1956).

When these events occur then problematic behaviour will start to manifest itself. The relevance of this research at the time it was published is that it illustrated a shift from the intrapsychic focus to looking at relationships between people and the role that communication plays in the development of 'psychological' problems.

3.3.7 Dysfunctional systems

The dysfunctional systems' perspective emphasizes the controlling and disqualifying nature of symptoms with the primary focus on the systems', rather than the symptom's, dysfunctional character (Claiborn & Lichtenberg, 1989). Dysfunctional relationships within a system are usually characterized by inflexible and rigid complementary relationships, for example double- bind situations; the members of such dysfunctional relationships have incongruent expectations; are exploitive, for example deceptive or paradoxical; these relationships involve sabotage and lastly, involve mutual disconfirmation (Claiborn & Lichtenberg, 1989). All of these characteristics apply to relationships and systems, such as families, which consist of many members.

This approach believes that the key to any psychological disorder lies in dysfunctional communications between the individual and those surrounding him or her. This led to a shift away from the individual as a self- contained unit to the individual as a system that interacts with other systems in a complex, structured network of relationships. This approach therefore says that "so- called psychopathological behaviour is not a problem of the individual, but a manifestation of pathological interaction between individuals" (Nardone & Watzlawick, 1993 p.38). Haley (1990) states that the ills of the individual are not separable from the ills of the social context created and inhabited by the individual. He further states that it would be incorrect to take the individual out of his cultural milieu and label him as sick or healthy. Therefore since one is in constant communication and interaction with one's environment and symptoms are a form of communication then society must take some of the responsibility for that very symptom. A symptom becomes a way of dealing with another person (Haley, 1990) and can allow a person to gain control over someone else.

3.4 Conclusion

All these theoretical and methodological contributions to the interactional view aim at trying to understand the individual in a context. The individual is not the focus but rather a part of a continually moving and changing organism. When some form of problem occurs these approaches look broader than the individual and therefore have a larger focus. Instead of looking at the person intra- psychically they look at how he is relating to his environment and what are the effects of his behaviour on those around him and vice versa.

Chapter 4

Methodology

4.1 Introduction

As seen in the chapter on theory, the emphasis for the research is from an interactional point of view. To attain research from this viewpoint, Haley (1967) comments that one needs to have:

(a) a collection of facts- observable events which either occur or do not occur,

(b) to formulate these facts into patterned regularities, and

(c) to devise theories to account for these regularities and be willing to discard past ideas if these handicap us in our effects.

With the difficult and controversial issue of determining which are facts, and that 'facts' are determined by the ways in which we collect them, the researcher's way forward is to obtain information from as many varied viewpoints as possible, though also limited due to certain contextual aspects, regardless of the controversy.

4.2 Aims of the research

The aims of this research, already set out in chapter one, are:

(a) to provide a psychological understanding of the interactional styles and communication behaviour of persons who have committed the crime of serial murder.

(b) To explore the expression of their personalities and intelligence, as part of their patterns of interaction, and

(c) to investigate the findings and formulate ideas on possible theoretical

explanations of serial murder as part of man's "social order" (Haley, 1967).

The reader is reminded that 'understanding' is defined from an interactional approach, namely as "...a person's personality traits... The interactional model views these traits as components of relationships... (and) asks how one person experiences another, and furthermore, how he allows others to respond to him" (Swart & Wiehahn, 1979, p. 14). The concept of personality is seen as relational. It means that the personality can be defined in terms of relational qualities or attributes (Beyers, clinical psychology lectures, 1996)

The following is an exposition of the methodology.

4.3 Qualitative research

The human sciences, when seen from a positivist point of view, have in many instances taken their lead from physics and chemistry. This has lead to a dominance of beliefs such as objective observation, quantifiable data and verifiable 'truths'. This dominant discourse has lead to a patriarchical view in which viewpoints differing from that discourse were marginalised. Feminist theories and post- modernism have slowly begun challenging that view, making qualitative research an acceptable way of doing science.

Historically qualitative research can be seen as marginalised in both its participants and methodology (Maykut & Morehouse, 1994). Freud studied neurotic women and children, both groups which were on the margins of the male patriarchal scientific culture. Anthropologists studied 'primitive' tribes, and criminologists studies gangs and institutionalised people, again all these groups are considered to be 'marginalised' by society. Furthermore, qualitative researchers

present their findings in a language that does not directly challenge traditional ways of doing science. Often methods of research conducted are not even included in the findings or reports. This creates the idea that there are no rigorous ways of collecting and analysing qualitative data (Maykut & Morehouse, 1994). The following table briefly lays out the differences between the quantitative (positivist) approach versus a qualitative approach, such as one from a phenomenological point of view.

Table 3: Postulates of the research paradigms

Questions	Postulates of the Positivist Approach	Postulates of the Phenomenological Approach
1. How does the world work?	Reality is one. By carefully dividing and studying its parts, the whole world can be understood.	There are multiple realities. These realities are socio-psychological constructions forming an interconnected whole. These realities can only be understood as such.
2. What is the relationship between the knower and the known?	The knower can stand outside of what is to be known. True objectivity is possible.	The knower and the known are interdependent.
3. What role do values play in understanding the world?	Values can be suspended in order to understand.	Values mediate and shape what is understood.
4. Are causal linkages possible?	One event comes before another event and can be said to cause that event.	Events shape each other. Multidirectional relationships can be discovered.
5. What is the possibility of generalisation?	Explanations from one time and place can be generalised to other times and places.	Only tentative explanations for one time and place are possible.

Questions	Postulates of the Positivist Approach	Postulates of the Phenomenological Approach
6. What does research contribute to knowledge?	Generally, the positivist seeks verification or proof of propositions.	Generally, the phenomenologist seeks to discover or uncover propositions.
	These postulates undergrid different approaches to inquiry.	These postulates undergrid different approaches to inquiry.
	Quantitative research approach	Qualitative research approach

In qualitative research three issues are relevant. The first is the relationship between words and numbers in the two different approaches to research; secondly, the perspectival observer versus the objective observer; and thirdly, discovery versus proof.

Relationship between words and numbers: Qualitative research emphasises understanding through examining people's words, actions and records. The traditional or quantitative approach looks past the words, actions and records, to see only their mathematical significance. The traditional approach quantifies these results. Statistics plays a large role in shaping this view of science. The major differences lie not in the presence or absence of 'counting' of a particular word or behaviour, but rather in the meaning given to the words, behaviours or information as interpreted through qualitative analysis or statistical analysis as opposed to patterns of meaning emerging from the data (Holloway, 1997; Maykut & Morehouse, 1994). To understand the world under investigation, people's words and actions are used by qualitative researchers. Qualitative research seeks to understand a situation as it is constructed by the participants. The task of the qualitative researcher is to capture the process of interpretation conducted by the person. Words are the way that most people come to understand their situations. Then the researcher must find

patterns within those words and actions, and present those patterns for others to inspect while at the same time staying as close to the construction of the world as the participants originally experienced it. However, to present the results of the research to the participants in a manner which they can understand is to include the participants in the discovery (Keeney & Ross, 1992). If the knower and the known are interdependent then there must be integrity between how the researcher experiences the participants in the study, how the participants experience the situation and their participation in it, and how those results are presented (Maykut & Morehouse, 1994).

Perspectival versus objective views: The traditional position has had the advantage of being defined objective and subjective in relation to research. The term objective has become synonymous with truth, facts and reality. The term subjective has become synonymous with partially- true, tentative and less- than- real. Another way of looking at these terms is to say that 'objective' is to describe something or someone as an object, an object is *other,* therefore to be objective is to make something into 'other'. Objectivity is to be cold and distant. Subjectivity is to be aware of the 'action'. Phenomenologically it is to be aware of the actor's perspective, the purpose of the qualitative researcher is to become aware of the world of the agent or subject (Denzin & Lincoln, 2000; Maykut & Morehouse, 1994). Qualitative researchers also realise that they are not outside of the process as impartial observers, but are also subjects or actors. They are exposed to the same constraints in understanding the world as are the persons they are investigating. The term perspectival is perhaps a more apt description since it has the advantage of being inclusive of differing perspectives, not only the one of the researcher.

Discovery versus proof: The goal of qualitative research is to discover patterns which emerge after close observation, documentation, and analysis of the research topic. The results are not

generalisable but rather are contextual findings. Searching for a pattern to help understand a person, situation or phenomena is an activity for qualitative research and is based on postulates I which states that reality is multiple and constructed; IV which states that events are simultaneously and mutually shaped; and VI which states that the goal of this approach is discovery (Maykut & Morehouse, 1994).

The present study, as supported by the above arguments, is qualitative in nature.

4.4 Designing the qualitative research

The questions one asks determines the answers one finds. A qualitative study has a focus but it is initially broad, allowing for important meanings to be discovered. The foci for the design are on the following aspects:

An exploratory and descriptive focus: qualitative research studies are designed to discover what can be learned about some phenomenon, in this instance serial murder. The research subjects, as they are traditionally known, are called participants, in this case individuals who have committed serial murder. The outcome of this study is not the generalisation of results, but a deeper understanding of the individuals who commit such crimes (Denzin & Lincoln, 2000; Marshall & Rossman, 1999).

Emergent design: for many the idea of a design developing over time is ludicrous. Yet many researchers have experienced the scenario where, during their research, they discover a feature for which their research design did not allow consideration. The very notion of pursuing such discoveries is what underlies qualitative approaches to investigation. This broadening or

narrowing of the focus of inquiry, and consequent sampling of new candidates is anticipated and planned for, as best as one can, in qualitative research designs. Non- emergent research designs can be employed where the focus of inquiry is pursued using qualitative methods of data collection and data analysis, but the data is collected then analysed. This study can be said to have elements of both since the initial phase which involved clinical interviews, which generated clinical impressions and an interactional analysis, led to the selection of certain psychometric tests selected to focus on certain areas that the researcher 'discovered' during that initial phase (Holloway, 1997, Marshall & Rossman, 1999; Maykut & Morehouse, 1994).

Purposive Sample: In qualitative research the participants are carefully selected for inclusion, based on the possibility that each one will expand the variability of the sample. This type of sampling increases the likelihood that variability common in any social phenomenon will be represented in the data. Here the participants were selected on the basis that:

(a) They had to fulfill the criteria for serial murder [see chapter 2]:

* They were motivated to kill.
* They murdered three or more persons.
* The murders occurred at different times.
* The murders appear unconnected.
* The motive is not primarily for material gain.
* The motive is not primarily revenge.
* Elimination of a witness is not the intention.

(b) The chosen participants had to have been convicted of their crimes.

(c) Participants had to be from the same culture.

Data collection in the natural setting: Qualitative researchers are interested in understanding participant's experience in context. The natural setting is where the researcher is most likely to discover what is to be known about the phenomenon of interest. Obviously, with a topic such as serial murder one cannot enter into the environment in which the murders take place, but in attempting to understand the individual who commits such crimes one can go to the 'natural' environment of the person's current situation, which is the correctional facility context. All interviews and testing were conducted in correctional facilities. If one also follows the dictum that the interview situation is a microcosm of the person's outer world, then the interview can be seen as a source of information as to how the person would relate to others in the macrocosm (Denzin & Lincoln, 2000).

Emphasis on 'human- as- instrument': This stresses the role of the researcher in the qualitative research process. The qualitative researcher has the added responsibility of being both the collector of data and the culler of meaning from that data, usually in the form of words and actions. It is possible to include other formal instruments such as tests or questionnaires in a qualitative study (Keeney & Ross, 1992; Maykut & Morehouse, 1994).

In this research the researcher conducts unstructured interviews and conducts an interactional analysis, thereby collecting and culling the data. Furthermore the researcher uses psychometric tests such as the MMPI-2, MCMI-III, TAT, and 16PF, to add to the 'culled' data with the intention of contributing to the description of the individual. Even within the tests however, information is 'culled' in the sense that it is weighed up against information gathered from the interview.

Qualitative Methods of Data Collection: The data of qualitative inquiry is most often the words and actions people use, and this requires methods allowing the researcher to capture and make use of that data. The most useful ways are through participant observation, in- depth interviews, group interviews, and collection of relevant documents (Denzin & Lincoln, 2000; Holloway, 1997; Marshall & Rossman, 1999).

This data is collected by the researcher in the form of field notes, audio and video- taped interviews. This research made use of the following per individual:

(a) forty hours of in- depth interviews, which were unstructured in nature,

(b) participant observation, both which were video- recorded,

(c) psychometric tests, as described later, which were used descriptively contributing to different 'angles' in the description of the person, and

(d) medical and background history as recorded in the individual's competency to stand trial forensic observation records.

Maykut and Morehouse (1994) state that a combination of various data collection methods increases the likelihood that the phenomenon under study is being understood from various points of view and ways of knowing. Furthermore, that a convergence of a major theme or pattern in the data lends strong credibility to the findings. The interactional analysis was the result of 3 researchers opinions with only the common themes highlighted by all three researchers being included. In addition, certain tests were scored or interpreted by independent sources, often 'blind' to the nature, purpose and sample of the study to prevent certain biases influencing the test results.

Early and ongoing inductive data analysis: The points mentioned above lead to two important characteristics of qualitative data analysis. Firstly, it is an ongoing research activity, in contrast to an end stage as in quantitative research. Secondly, is it primarily inductive, as opposed to deductive in quantitative research (Holloway, 1997). Data analysis begins when the researcher has accumulated a subset of the data, providing an opportunity for the salient aspects of the phenomenon to emerge. These initial leads are followed up by pursuing the relevant, persons, settings or documents that will help shed light on the phenomenon of interest. This can lead to either a narrowing or broadening of the research focus as the data suggests. In other words, what is important is not predetermined by the researcher, but rather the data (Marshall & Rossman, 1999).

In this study unstructured interviews were initially held after which an interactional analysis was done on the video- recorded interviews. A psychometric test was also used to see if the themes elicited matched the overall interactional analysis from the interviews. Later a battery of selected psychometric tests were selected to follow- up certain aspects the researcher felt were indicated from the previous data. Finally the information was compared to see which aspects were constant themes that could help in the description of the individual.

A case study approach to reporting research outcomes: The results of a qualitative research study are most effectively presented within a narrative, also referred to as a case study. The number of cased studies and their length can vary. Long case studies allow reader sufficient information for understanding research outcomes. A qualitative research report characterised by rich description should provide the reader with enough information to determine whether the findings of the study possibly apply to other settings (Holloway, 1997; Denzin & Lincoln, 2000, Maykut &

Morehouse, 1994).

This report shall include in- depth unstructured interviews, psychometric testing and information from the initial forensic observations conducted during the initial court proceedings. This information therefore covers a period of between 5 and 7 years in these individual's lives. As Bromley (1986) states, the aim of a case- study, as with any scientific investigation, is not to find the 'correct' or 'true' interpretation, but rather to eliminate erroneous conclusions so that the researcher is left with the best possible interpretation.

4.5 Procedures and methods

The aim of the study is to obtain an understanding of the interactions of persons who have committed serial murder. With the concept "understanding" is meant an analysis of their interactional behaviour with their world, including themselves and others and secondly "understanding" their interactions through the use of psychometric tests. The focus of the study is not murder per se, in the process the murders may become irrelevant, though the analyses may shed light on the phenomenon of serial murder. The research procedure was conducted as follows:

1) A literature study was conducted to gain an understanding of the field of serial murder and to review what research has already been conducted.

2) A research proposal was drafted and presented before the research committee of the Department of Psychology of the University of Pretoria.

3) Once approval was granted the proposal was submitted to the Department of Correctional Service's Psychology Section for approval.

4) Once approval was obtained by the Department of Correctional Services, possible candidates were sought by consultation with members of the South African Police Services, members of the Department of Correctional Services, and the Print Media.

5) Discussions with the relevant correctional facilities for confirmation of the identified individuals whereabouts.

6) Two candidates were selected as potential participants due to the fact that they fulfilled the previously mentioned criteria of the operationalised definition of a serial murderer. Their background details are mentioned in chapter 5 as part of the results.

7) These candidates were approached and explained the purpose and nature of the research and were given the opportunity to express their views and pose any questions, after agreeing to participate they all signed research agreements. These agreements also guaranteed confidentiality of their identity (see appendix 1)

8) The researchers and process of research

a) The next phase involved the researcher and a colleague, also a clinical psychologist, together interviewing each individual in the correctional facility according to the interview method described below. These interviews were video- recorded with the permission of the candidates and the Department of Correctional Services

b) Clinical impressions were recorded immediately after the first interview. Discussions between the researcher and his colleague helped to determine common major observations and impressions between the researchers.

c) Review of the forensic file of the competency to stand trial evaluation.

d) Application of the following tests over numerous sessions by the author: Thematic Apperception Test, Minnesota Multiphasic Personality Inventory 2nd Edition, Millon Clinical Multiaxial Inventory IIIed, 16 Personality Factor Questionnaire, South African

Wechsler Adult Intelligence Scale.

e) Interpretation of the above- mentioned tests. The TAT was interpreted blindly by a licensed clinical psychologist, the MMPI-2 and MCMI-III were scored and interpreted by means of a computer generated report, the 16PF was interpreted by the author as was the SAWAIS. The interactional analysis was done by the author, his colleague, the above mentioned clinical psychologist from point (a), and the research supervisor, a professor of psychology. Only the common elements from all three were included in the noted interactional analysis.

f) Integration of all relevant material by the author by means of grouping common themes in the feedback from the tests conducted and interactional analysis. Where appropriate these were grouped under the headings: profile validity (see chapter 5), diagnostic considerations, and interpersonal considerations (see chapter 6).

g) Reporting on the individual and integrated findings.

4.6 Tools used in the research process

4.6.1 Scrutiny of the competency to stand trial forensic evaluation file

The author had access to information from the individual's forensic evaluation for competency to stand trial. The files provided information regarding their personal history such as their family background, socio- economic condition, and also provided information regarding the crimes for which they were accused. This information is discussed under the heading 'Brief history' in chapter 5. The file also included the results of medical tests that were conducted at the time of the evaluation. These results are mentioned under the heading 'Medical investigations previously conducted' in chapter 5. While the file also included psychometric test information, only the intelligence level, as determined by the South African Wechsler Adult Intelligence Scale

(SAWAIS), was included. This was in addition to the researcher's own administration of the SAWAIS and clinical impression of the individual's intelligence level during the research. These results are discussed under the heading 'Intelligence level' in chapter 5.

4.6.2 Clinical impressions

The impressions were written down independently by the researcher and his colleague after the first interview. Discussions led to consensus on the clinical impressions and only those common to both researchers were made use of.

4.6.3 The interview

According to Taylor and Bogdan (1984, p.77) "By in- depth qualitative interviewing we mean repeated face- to- face encounters between the researcher and the informants directed towards understanding informants' perspectives on their lives, experiences, or situations as expressed in their own words."

The research for this dissertation followed in- depth qualitative interviews. In contrast to Douglas' challenging interview, the 'soft' interview method was followed, which means in- depth interviewing, basically unstructured in nature (Olivier, Haasbroek, Beyers, DeJongh van Arkel, Marchetti, Roos, Schurink, Schurink & Visser, 1991). With this method freedom of exploration is largely left to the offender. The interviews were intended to be unstructured so as to limit contamination by preconceived concepts or ideas on behalf of the researchers. Approximately 40 hours per individual were used in the research. On the basis of the unstructured interviews, the interactions were analysed.

4.6.4 Interactional analysis

The interactional analysis was used to help in determining the individuals interactional styles. It was based on the first 3 interviews, each interview was one hour long. This was also used in relation to the above mentioned methods to determine certain common themes and interactional styles. Nardone and Watzlawick (1993) feel that the following questions need be answered to arrive at an interactional conclusion:

i) What are the client's observable behaviours and usual behaviour patterns?

ii) How does the client define the problem?

iii) How does the problem manifest itself?

iv) In whose company does the problem appear, worsen, disguise itself, or disappear?

v) Where does it usually appear?

vi) How often does it appear and how serious is it?

vii) What has been done so far to solve the problem?

viii) Who would be most affected by the disappearance of the problem?

Swart and Wiehahn (1979) have a similar approach but term it a descriptive interactional analysis. They posit the following five steps will lead the clinician to arrive at fairly complete understanding of the client's situation:

i) *How does the client talk to the therapist?*

Is his speech logical, coherent, or are there any thought disorders? Is there aggressive speech, ambivalence, anxiety, sympathy. It is also necessary to take note of any non- verbal actions which may validate or contradict the verbal communication.

ii) *How does the individual talk about the problem?*

Is there blaming, insight, denial, intellectualisation, vagueness on behalf of the person?

iii) *What is the nature of the patient's relationships with other people?*

How does the person talk about these relationships, and how are these relationships helping maintain the symptom in the here- and- now? By examining the client- therapist relationship and the client's previous relationships in his past, an understanding of how the person relates to others and his environment can be reached. The relationship is regarded as a microcosm of the client's world (Yalom, 1995 & personal communication, June 1997) and serves as a basis for 'analysing' the client's interactional style. For the author this serves as the most important aspect of the interactional analysis in that the interaction in front of one in a therapeutic situation is the only reality the therapist has.

iv) *What does the individual achieve by his actions?*

Here secondary gain plays a large role. On a more meta- level, what is the symptom's function? Here the effect on others is vitally important. If the 'others' behave in a consistent way that benefits the individual then the behaviour will most likely continue. If the 'others' start to behave differently then the same 'benefits' might not be there for the individual and the action therefore loses its meaning and becomes purposeless. The individual must then find other means to achieve the same goal. In layman's term, the individual can only behave in a certain way if the 'others' allow him to. Hence the systemic viewpoint of altering the feedback and the ability to 'cure' 'sick' individuals without having ever seen them in therapy. The therapist may use his own feelings and reactions in therapy as a 'springboard' for the therapeutic interventions he embarks on, (traditional therapies such as psychoanalysis may term these feelings and reactions as 'counter- transference').

v) *In what context is the interview taking place?*

The context can have an influence on the type of interaction taking place. An individual who has been ordered by a court to enter therapy, or because of a spouse who has insisted on the therapy, is going to bring to the therapy situation a different style of communicating than someone who has entered therapy voluntarily. Taking the context into account allows the therapy to be adapted to the individual, thereby being respectful of the client's situation instead of drawing certain conclusions about the client's resistance' or 'denial' and forming a therapeutic base on hypotheses attached to these 'defence' mechanisms as is the case with more traditional approaches.

vi) Beyers (personal communication, 1995) believes another question needs be asked to complete the analysis: what are the client's strengths? By determining these as far as possible the therapist aims at finding out which interactional factors, which may even include the above, could contribute to a positive prognosis in therapy. It is necessary to exploit these strengths to help affect change in even a small area of the individual's interactional style. In this was the interactional analysis is seen as a rigid way of behaving and the attempt is to become more flexible in one's interactions with the world.

The following method, as revised from the above by the author, was ultimately used:

i) How does he speak?

ii) How does he speak about the problem?

In the case of serial murder, the concept of 'problem' is defined as the participant's behaviour of serial murder.

iii) In what context does the problem appear?

The context is twofold: (i) the then- and- there context of the murders, and (ii) the here- and- now context of the Department of Correctional Services' facility.

iv) What has been done to solve the problem?

v) Nature of the individual's relationships with people?

vi) Context of interview?

vii) Strong points of individual?

viii) Negative points?

ix) Effect of individual on researcher?

The researcher felt that these questions were more relevant to the research goals, whereas some of the questions, as posed by Nardone and Watzlawick (1993) seem too pathology- orientated.

4.6.5 The South African Wechsler Adult Intelligence Scale (SAWAIS)

The SAWAIS, although largely criticised by many as being inaccurate and possessing deep-rooted problems with the tests' construction (Nell, 1994), was nevertheless used by the author to obtain a 'rough' IQ figure. This figure was then compared with the results of the SAWAIS conducted during the individual's competency to stand trial evaluation and the author's clinical impression of the individual's IQ, to see how the three results compared. No neuropsychological conclusions were made from this test and sub-scales were not compared to each other, primarily because of the inaccuracies inherent in the test. For full SAWAIS results see appendix 2.

4.6.6 Thematic Apperception Test (TAT)

The TAT was used as a further means of determining how the individual interacts with his environment and sees interpersonal relations. The TAT protocols were interpreted by a qualified clinical psychologist from the University of Pretoria who was not given any information as to the individuals identities or the nature research project. This was done to prevent the interpreter

from reading certain themes into the protocols and biasing his comments. The TATs were then used to see if any themes that were noted in the interviews, clinical impressions and interactional analyses were repeated or refuted. The cards that were used were the following: 1, 2, 3BM, 4, 6BM, 7BM, 8BM, 10, 12M, 13MF. The full TAT protocols are included as appendix 3.

4.6.7 Millon Clinical Multiaxial Inventory IIIrd Edition (MCMI-III)

The MCMI-III was incorporated into the research because of its focus on pathology. The test covers certain Axis I pathologies, and all the Axis II pathologies including two that Millon felt needed to be included even though they were not included in the DSM-IV. Besides the diagnostic emphasis it allows for a description of the individual's personality, even though more based in the language of pathology. It also has certain validity scales which help control for the exaggeration or under reporting of symptomology. This under- or -over reporting will also give the researcher an indication of the individual's possible overall attitude to the assessment process. The scales which are included are, on Axis II; Schizoid, Avoidant, Depressive, Dependant, Histrionic, Narcissistic, Antisocial, Aggressive (Sadistic), Compulsive, Passive- Aggressive, Self- Defeating, Schizotypal, Borderline and Paranoid. On Axis I; Anxiety Disorder, Somatoform Disorder, Bipolar: Manic Disorder, Dysthymic Disorder, Alcohol Dependance, Drug Dependance, Post- Traumatic Stress, Thought Disorder, Major Depression and Delusional Disorder.

4.6.8 Minnesota Multiphasic Personality Inventory 2nd Edition (MMPI-2)

The MMPI-2 was used because it is a broad- band test designed to assess a number of major patterns of personality and emotional disorders. A standard six level reading ability is required making it accessible to a large audience. It also provides internal checks to assess the level of

cooperation on behalf of the individual being tested, a distinct issue when testing in the forensic setting. It consists of the following clinical scales; Hypochondriasis, Depression, Conversion Hysteria, Psychopathic Deviate, Masculinity- Femininity, Paranoia, Psychasthenia (similar to obsessive- compulsive disorder), Schizophrenia, Hypomania, Social Introversion. Besides these clinical scales there are a number of supplementary scales offered to assist in interpreting the basic scales and augment the coverage of clinical problems and disorders. These supplementary scales are; Anxiety, Repression, Ego Strength, MacAndrew Alcoholism Scale Revised, Over controlled Hostility, Dominance, Social Responsibility, College Maladjustment, Gender- Role Scales, Post Traumatic Stress Disorder Scales, Marital Distress Scale, Addiction Potential Scale, and Addiction Admission Scale. Furthermore Content Scales have also been developed and are useful in describing and predicting personality variables. These scales include; Anxiety, Fears, Obsessiveness, Depression, Health Concerns, Bizarre Mentation, Anger, Cynicism, Antisocial Practices, Type A, Low Self- Esteem, Social Discomfort, Family Problems, Work Interference, and Negative Treatment Indicators.

Critical Items were developed in an attempt to assess an incipient disorder or prodromal syndrome. The Koss- Butcher Critical Items Sets and Lachar- Wrobel Critical Item Sets are the most widely used (Butcher et al., 1989). The Harris- Lingoes Subscales were developed for scales 2, 3, 4, 6, 8, and 9. The following were developed; D1: Subjective Depression, D2: Psychomotor Retardation, D3: Physical Malfunctioning, D4: Mental Dullness, D5: Brooding, Hy1: Denial of Social Anxiety, Hy2: Need for Affection, Hy3: Lassitude- Malaise, Hy4: Somatic Complaints, Hy5: Inhibition of Aggression, Pd1: Familial Discord, Pd2: Authority Problems, Pd3: Social Imperturbability, Pd4: Social Alienation, Pd5: Self- Alienation, Pa1: Persecutory Ideas, Pa2: Poignancy, Pa3: Naivete, Sc1: Social Alienation, Sc2: Emotional Alienation, Sc3: Lack of Ego

Mastery (Cognitive), Sc4: Lack of Ego Mastery (Conative), Sc5: Lack of Ego Mastery (Defective Inhibition), Sc6: Bizarre Sensory Experiences, Ma1: Amorality, Ma2: Psychomotor Acceleration, Ma3: Imperturbability, Ma4: Ego Inflation (Butcher et al, 1989). Thus the MMPI-2 allows for the examination of a lagre variety of aspects of personality function.

4.6.9 The 16 Personality Factor Questionnaire (16 PF)

Since one's personality plays a role in behaviour in almost all areas of life and the 16PF covers the most important dimensions of personality, it is an obvious choice when wanting to assess an individual's personality, as defined in 4.2. The advantage of this test as opposed to others such as the MMPI-2 or MCMI-III is that it is not pathology based, in other words it does not attempt to correlate an individual to a diagnostic category. Instead this test is descriptive in nature, it is for these reasons that the test has gained wide usage in various research fields. This test is incorporated to add a 'healthy' balance to the method of investigation so that the research does not slip into the pitfall of trying to just force the individuals into one or another existing diagnostic category.

4.6.10 Integration

All material gathered by means of the above procedures were integrated by finding the corresponding main or primary themes and using them for the basis of any hypotheses made. Words are the way that most people come to understand their context. Research must find patterns within those words and actions and present those patterns. By identifying common words and patterns in the test and interview data, these can be presented under common headings or categories, these are: profile considerations (in the case of tests), diagnostic considerations, and interpersonal considerations.

In the following section the rational of the tests are put forward and discussed.

4.7 The South African Wechsler Adult Intelligence Scale

As the name implies, the SAWAIS was adapted from the 1939 Wechsler- Bellevue Adult Intelligence Scale. The purpose of this test is to measure a number of aspects of intelligence that could be clinically useful and also to provide separate measures for Verbal IQ, Practical IQ and Total IQ for English and Afrikaans speaking South Africans. There are five verbal and five practical subtests in the scale as well as a vocabulary subtest which is administered separately. The vocabulary subtest however, is not commonly used. The test was published by the National Institute of Personnel Research in 1969 under the name South African Wechsler Adult Intelligence Scale, this has led most psychologists to believe that the South African version is a local version of the 1955 WAIS which in itself was a fundamentally revised and re- normed Wechsler- Bellevue (Nell, 1994).

The norms are age related and make provision for the natural effects of ageing. The subtests are thought to measure different aspects of intelligence at different ages. The norm sample was drawn from English and Afrikaans- speaking white South Africans between the ages 18 and 59. Information regarding the reliability of the subtests and composite scales and regarding the equivalence of the English and Afrikaans forms for the norm group is not available. There is also uncertainty surrounding the representativeness of the norm sample (Owen & Taljaard, 1989). Coetzee and Madge (1981) developed norms for the full- scale as well as short- forms for a white South African psychiatric population.

A large amount of literature is available about the use of the Wechsler Adult Intelligence Scale, however, due to a lack of empirical evidence, one should be cautious about assuming that this literature is also applicable to the SAWAIS (Owen & Taljaard, 1989). This test is at present under revision at the Human Sciences Research Coucil.

4.8 Projective techniques

Projective Techniques fall into the realm of personality assessment. These may include tests such as the House- Tree- Person Drawing Test, Kinetic- Family- Drawing Test (KFD), the Rorschach Inkblot Method (Rorschach) , and the Thematic Apperception Test (TAT). The term projective test originates from Freud's development of the concept of projection. This is defined as a psychological mechanism by which the individual "projects" inner feelings onto the external world and then imagines that these feelings are being expressed by the outside world towards himself (Bellak & Abrams, 1996; Brill, 1938). Projective Tests have no correct answers and are considered to be less structured, more open ended, more creative with the individual freer to express inner feelings and reveal basic personality orientation. Projective Tests are also used in personality assessment.

4.8.1 Concepts involved in projective testing

The meaning of projection: According to Kline (2000) a simple definition of a projective test is that of a stimulus to which subjects have to respond, designed so that it encourages subjects to project into their responses their own feelings, desires and emotions. Eysenk (1959) raised the objection that projective testing lacks a coherent theory in the sense that there is no theoretical account as to why or how or in which conditions as individual would project anything about him- or herself onto a projective test stimulus. It must be also said that the defence mechanism of

projection is not necessarily involved in projective testing.

The Projective Stimulus: The most widely used examples of projective techniques, the Rorschach Inkblot Method and the Thematic Apperception Test, use ambiguous visual stimuli which subjects have to describe. The essence therefore is ambiguity since it is the ambiguous nature that forces the individual to project, thus reflecting something about themselves. In other words, responses not stimulus bound must have arisen from something within the subject (Kline, 2000).

Identification: Many of these tests assume that individuals will identify with the individual portrayed in the picture. Murray (1938) assumed that, and for those reasons there are often different cards for males and females.

Projective Test Stimuli (non- visual): While the most well known projective tests are visual in nature, the Rorschach and TAT, there are projective tests that are not 'visual' in the same sense. Sentence completion tests, free drawing such as the House Tree Person Test (Buck, 1970), Solid Objects, Auditory Projective Tests such as the Sound Apperception Test (Bean, 1965).

Reasons for continued use of projective tests: Despite certain criticisms projective techniques continue to be used. Various reasons exist for this situation: they are unique sources of data, some results from projective techniques suggest that they are powerful techniques, the richness of projective test data, the success of some objective scoring methods (Kline, 2000).

4.8.2 Thematic Apperception Test (TAT)

When Murray developed the TAT he was a professor of Psychology at Harvard University. It was

during this time that Freud's works were being translated into English and brought to America by students of Freud, such as Murray's graduate student Leopold Bellak. It was felt that since the TAT story is a personal narrative similar to a dream that might be reported to psychotherapist, the TAT would lend itself well to similar methods of analysis as in Freud's *Interpretation of Dreams* (Brill, 1938). At the Harvard Psychological Clinic, Murray experimented with a number of different methods of studying human imagination and personality organisation. One day one of Murray's students reported to Murray that her son had created stories to different pictures in a magazine. One of Murray's assistants set out to collect a number of different pictures of paintings, advertisements, pictures for movies and other sources. These were redrawn so that the pictures would have a consistent style of presentation. Card 1 for example was a picture of child prodigy violin virtuoso, Yehudi Menuhin. Because Murray felt Freud's view of man to be too one- sided he emphasized that his need- press approach provides a way of scoring the TAT so that a psychologist can use the variables without subscribing to any particular theory of drives (Bellak & Abrams, 1996). In 1948, upon a suggestion by Ernst Kris, Bellak and his wife, Sonya Sorel, set out to create a series of different pictures of animals in different situations in an attempt to see if the pictures would be of more clinical use with children, this became known as the Children's Apperception Test (CAT). In 1973 Bellak and his wife went about in a similar manner to create a series of pictures appropriate for use with the elderly population, this was to become known as the Senior Apperception Test (SAT) (Bellak & Abrams, 1996).

The TAT of Henry Murray consists of 31 pictures of people in different situations. Cards are given in specific sequences depending on age and gender. Some cards are used for all ages and genders. Murray developed a method of scoring the TAT but, despite a copy being sold with every set of plates, his method never became popular because his need- press method took almost

four hours to complete. With Murray's support Bellak developed a method of scoring the TAT in 1941 which was much shorter (Bellak & Abrams, 1996).

In the field of psychology today there is an increasing interest in the narrative mode of thought and explanation. This mode of thought is more concerned with experience as it unfolds over time; the intentions, desires, and wishes of characters; their understanding of human motivation; and with the goals for which they strive. Human lives, like stories, are narratives, and there is a structure to these experiences which gives them meaning (Cramer, 1999). This meaning is neither true nor false, the same story can be subject to many interpretations, or meanings. The TAT is also a narrative; it also expresses the narrative of the storyteller, representing a construction of reality, not a reconstruction. The storyteller creates meaning through the construction of story lines, the listener through interpretation. All these constructions are influenced by context, and reflect the intentions of both creator and interpreter (Cramer, 1999).

4.8.2.1 Using the TAT to assess level of object relations

Westen (1991, 1995) used the TAT to assess the developmental level of object relations, also the distortion of object relations, as this occurs in the Borderline Personality Disorders (BPS). Westen regards the TAT as a good source of data for assessing object relations because subjects are asked to draw on their internal object representations to construct characters and interaction in response to an ambiguous interpersonal situation as depicted on the TAT cards. He developed what is known as the Social Cognition and Object Relations Scale (SCORS) in which there are four areas of psychological functioning; (a) knowing about a person's internal, psychic representations of significant others; (b) knowing about the quality of affect in relationships with others; (c) knowing about the capacity for emotional investment in relationships, moral

standards and values; (d) knowing about the capacity of the individual for understanding interpersonal motivation. Each of these areas can be characterised by five developmental levels, ranging from primitive to mature (Cramer, 1999). The use of a coding system like SCORS is that it provides the clinician with a way of systematically determining the developmental level, or relative pathology, of different respondents, based on the assessment of object relations.

4.8.2.2 Using the TAT to assess defence mechanisms

Another more recent approach for using the TAT is the Defence Mechanisms Manual developed by Cramer (1991). This method is used to assess the presence of three defence mechanisms, each chose to represent varying degrees of maturity. *Denial* is the most primitive mechanism of the three; *projection* being somewhat more complex, and more mature defence that denial; and finally *identification* which is a considerably more complex and more mature defence. All three defences are coded according to a series of set criteria. Each story is rated for each defence by more than one rater. Various studies have demonstrated adequate inter- rater reliability (Cramer, 1991; Cramer, Blatt & Ford, 1988).

4.8.2.3 Reliability and validity of the TAT

Measures of reliability based on internal consistency are not appropriate for the TAT. The cards are not the same as a series of items on a personality scale, all which are supposed to measure the same personality trait. The cards were designed to represent different areas of psychological functioning and tap different kinds of psychological conflict (Cramer, 1999). Looking for close consistency across different TAT cards is therefore pointless, coefficient alpha being an inappropriate measure of reliability for the TAT. Furthermore, there are difficulties with test-retest reliability. Initial exposure to the cards could alter subsequent responses on a second testing

(Bellack & Abrams, 1997). Also, test- retest reliability is based on the assumption that the characteristic being measured does not change over time. In the case of certain personality aspects, such as defence mechanisms, this is not always the case.

Cramer (1999) feels that the only appropriate method of determining TAT reliability is an approach used in all observational methods, the TAT being one such method, not a psychometric test. Reliability in observational studies is based on the agreement between two or more independent observers, therefore an inter- rater reliability is perhaps a more appropriate method of determining reliability with the TAT. Cramer (1999) feels validity should also be sought in the confirmation of theoretical predictions.

4.9 The Millon Clinical Multiaxial Inventory III (MCMI-III)

For the past four decades Theodore Millon has been developing a theory of personality in scientific literature (Millon, 1996). In an attempt to develop an integrated, unified science of personology and psychopathology he has advocated that, rather than developing independently and in a disconnected manner, an approach should embody four explicit elements. These are *theories*, or heuristic conceptual schemes. Secondly, these theories enable the development of a formal *nosology*, such as the DSM-IV. Thirdly, this nosology allows for the development of coordinated *instruments*, such as psychometric tools, empirically grounded enough to enable the hypotheses of the theory to be scientifically investigated. Fourthly, from these instruments, areas can be targeted for *interventions* (Davis, 1999).

Millon's original Biosocial Model was developed in the late 1960s. In the early 1990s he re-conceptualised his model of personality into an evolutionary model. The Biosocial model focused

on two main points, firstly, biophysical constitution and past experiences. The personality style with which a person relates to his world is based in basic constitutional factors. A child's energy, tempo, intelligence, physical strength, and sensory activity, all comprise a given set of capabilities that colour how events are perceived and influences his or her responses to the events. If pressures and demands upon the child are too severe, they may force the child to devise alternative strategies that are potentially problematic or contrary to his or her natural inclination (Choca, 1999; Davis, 1999; Millon, 1996).

The model that was reconceptualised in the 1990s indicated a reevaluation of the deeper or latent features that may underlie human functioning. For this Millon turned outside of the field of psychology. He felt that the deeper laws of human functioning may best be explained by looking at universal principles found in non- psychological manifestations of nature such as physics, chemistry and biology. What he deduced from these was that the principles and process of evolution are essentially universal, yet are expressed differently, as seen in the diverse fields of physics, chemistry, biology, and psychology. Millon observed a parallel between the phylogenic (history of evolution of animal or plant type) evolution of the genetic composition of a species and the ontogenic (the origin and development of an individual) development of the adaptive strategies of an individual organism, in other words its personality style. At any point in time a species will possess a limited set of genes that serve as trait potentials. Over succeeding generations the frequency distribution of the genes will change in their relative proportions depending on how well the traits they undergrid contribute to the suitability of the species to that environment. Parallel to that an individual organism begins life with a limited subset of genes of their species and the trait potentials they subserve. In time the prominence of these trait potentials, not the proportion of the genes themselves, will become differentially prominent as

the organism interacts with the environment. The organism then 'learns' from these experiences which traits 'fit' best, that is, which are optimally suited to the ecosystem. Therefore in ontogenesis, it is the prominence of gene- based traits that changes as adaptive learning takes place. A parallel evolutionary process takes place, one within the life of a species and the other within the life of the individual organism. The organism shapes latent potentials into adaptive and manifest styles of perceiving, feeling, thinking and acting. These unique ways of adaption, reinforced by the interaction of biologic endowment and social experience, compromise the elements of what we call a personality style, which is a formative process within a single organism's lifetime (Davis, 1999; Millon, 1996, Millon, 2000). Disorders of personality would represent unique styles of maladaptive functioning that can be traced to deficiencies, imbalances or conflicts in the capacity of a species to relate to the environment(s) it faces.

Four spheres or domains in which evolutionary and ecological principles are demonstrated were labelled by Millon, these provide a conceptual background from the adjacent sciences and furnish a rough model concerning the styles of personality disorder. These four domains are existence, adaption, replication and abstraction (Davis, 1999; Millon, 1996, Millon, 2000).

Existence refers to the transformation of random or less organised states into those possessing distinct and durable structures of greater survivability. In other words the aims of existence relate to life enhancement and life preservation. Millon termed this the *pleasure- pain* polarity. Two intertwined strategies are required for survival: one to achieve existence and the other to preserve it. The aim of the first is the enhancement of life; that is creating ecologically survivable organisms. The aim of the second is the preservation of life; that is, avoiding events that might terminate it. A shifting balance between the two aims makes up the pleasure- pain bipolarity and

typifies normality

With regards to modes of adaption, for an organism to maintain its unique composition, differentiated from the larger ecosystem of which it is a part, requires good fortune and effective modes of functioning. Millon termed these adaptive modes; *ecological accommodation* and *ecological modification*, or what he also termed as the *passive- active* polarity. The modes of adaption fit into the two- part polarity. The first mode, ecological accommodation, implies an inclination to 'fit in' to the environment, to locate and remain securely anchored in a niche, being subjected to the unpredictablilities and whims of the environment. Underlying this mode is the expectation that the environment will furnish both the nourishment and protection needed to sustain existence. This is the evolutionary process employed by the plant kingdom, a passive, stationary, rooted, yet essentially pliant and dependant survival mode. The second of the two adaptive modes is that of the animal kingdom. This represents a primary inclination to towards modifying the ecosystem, arranging or changing the elements constituting the larger milieu. Optimal functioning amongst humans requires a flexible balance that involves both adaptive polarities (Choca, 1999; Davis, 1999; Millon, 1996; Millon, 2000).

The third ecological principle refers to strategies of replication. The polarity here is between reproductive individuation and reproductive nurturance, Millon termed this the *self- other* polarity. Recombinant (def: incorporated into chromosome other than its original one) replication requires the partnership of two parents, each contributing genetic material in a distinctive and species- characteristic manner. Similarly, the attention and care given to the offspring of a species is also species distinctive. Noteworthy is the difference between the contributing parents degree to which they protect and nourish joint offspring. Although this might be balanced and

complementary, it is rarely identical or comparable in devotion or determination. This difference in reproductive investment strategies underlies the evolution of the male and female genders, the foundation for the third polarity Millon proposes to account for the procession of evolution. This differentiation undergrids what he terms the *self- other* orientation polarity, individuals can be both self- actualising and other- encouraging, usually leaning more to one or the other (Davis, 1999; Millon, 1996, Millon, 2000).

The fourth polarity refers to the processes of abstraction, or the capacity to symbolize one's world. This polarity is less central to his personality studies, but more relevant to his cognitive-neuroscience formulations. It is therefore bypassed in his personality- orientated version of his theories.

4.9.1 Taxonomy

From this evolutionary model Millon developed theoretical concepts that describe normal personalities and personality disorders. He developed a classification scheme that combined in a matrix what he termed *dependant, independent, ambivalent, discordant* and *detached* styles with an activity- passivity dimension. As it evolved these generated 11 basic types and 3 severe variants, for a total of 14 personality prototypes. These were conceived as prototypal and heuristic constructs, not as diagnostic entities, even though they have a close correspondence to the DSM-IV personality disorders. The following outline the 11 basic pathological patterns and the 3 deemed to be severe patterns.

1) Schizoid Prototype: comprises of the *passive- detached* personality style. This individual has developed a prominent deficiency in the capacity to experience both elements of the first polarity,

pleasure and pain. Most obvious is the person's social passivity, with affectional needs and emotional feelings being minimal. The individual functions as an indifferent, passive observer, detached from the rewards and demands of human relationships (Millon, 2000; Millon & Davis, 1996).

2) Avoidant Prototype: displays an *active- detached* style. This individual experiences an encompassing fear and mistrust of others, preoccupying them with attempts to distance themselves from psychic pain. It is only through active withdrawal that they can protect themselves. Therefore, despite their desire to relate, they have learned it best to deny these feelings and keep an interpersonal distance (Millon, 2000; Millon & Davis, 1996).

3) Depressive Prototype: these individuals are seen as possessing a *pain- passive* personality style, in which there is an acceptance of pain as inevitable and a consequent adoption of passive accommodation. Individuals are noted by a long- standing pattern of glumness, pessimism, and inability to experience pleasure. There is also prominent self- devaluation and a loss of hope that 'normality' can ever be achieved (Millon, 2000; Millon & Davis, 1996).

4) Dependant Prototype: these individuals display a *passive- dependant* style, noted by a constant search for relationships in which one can lean on others for affection, security and leadership. This lack of autonomy is often a result of parental overprotection, as a result they learn the benefits of assuming a passive role in interpersonal relations, accepting support and willingly submitting themselves to the wishes of others to maintain their continued support and affection (Millon, 2000; Millon & Davis, 1996).

5) Histrionic Prototype: this prototype possesses an *active- dependant* style. The person is motivated by an almost insatiable, indiscriminate, search for approval and affection from others. The nature of the behaviour may give the false impression of self- assurance and independence, but beneath lies a fear of autonomy and need for social acceptance and approval from others. Affection needs to be replenished constantly and is sought in almost every source of interpersonal contact (Millon, 2000; Millon & Davis, 1996).

6) Narcissistic Prototype: exhibits a *passive- independent* style, primarily noted by egotistic self-involvement. From early experience these individuals have learned to overvalue their self- worth, expecting good things to happen to them with little effort on their part. Their confidence is however mainly based on false premises. They assume others will recognise their specialness and will maintain an air of arrogance and self- assurance, an exploit others to their own advantage (Millon, 2000; Millon & Davis, 1996).

7) Antisocial Prototype: this type displays an *active- independent* style. It is noted by a learned mistrust of others and consequent desire for autonomy and retribution. Many engage in deceitful and illegal behaviour designed to exploit the environment. A significant proportion are irresponsible and impulsive, although others may artfully evade detection, while engaging in activities that appear socially commendable, unless their life is examined carefully (Millon, 2000; Millon & Davis, 1996).

8) Sadistic Prototype: this type is described by Millon as an *actively discordant* style due to the person's self- focus and a reversal of the pain- pleasure polarity, that being, they enjoy giving pain to significant others. They may feel pleased or indifferent to the destructive consequences

of their cruel behaviour. Many are hypersensitive to humiliation and therefore adopt a hostile attitude to counter these feelings, their actions are seen by them as being justified because people are seen as unreliable and deceitful. Autonomy and hostility are considered the only means to head of deceit and betrayal (Millon, 2000; Millon & Davis, 1996).

9) Obsessive- Compulsive Prototype: Millon sees this prototype as having a *passive- ambivalent* style, this means that they exhibit a conflict between hostility towards others and a fear of social disapproval. They evidence an ambivalence between self and other. By suppressing resentment and over conforming and over complying in their surface behaviours they attempt to resolve the conflict. Underneath this front, however, are anger and intense oppositional feelings that can, at times, break through their controls (Millon, 2000; Millon & Davis, 1996).

10) Negativistic Prototype: this prototype possesses an *active - ambivalent* style. They display an inability to resolve the self- other conflict similar to those in the obsessive- compulsive prototype, however, their ambivalence remains close to consciousness and intrudes into everyday life. These individuals find themselves in endless difficulties and disappointments as they vacillate between deference and conformity at one time, and oppositional aggressiveness to others the next time. Their behaviour therefore displays an erratic pattern of explosive anger or stubbornness intermingled with moments of guilt and shame (Millon, 2000; Millon & Davis, 1996).

11) Masochistic Prototype: This is also known as the self- defeating type, it is described by Millon as a *passive- discordant* style. It is a pattern of giving into the abuses and suffering of life, but also often of self- sacrificing. These people may even encourage others to take advantage of

them, hoping thereby to ultimately experience the lesser of more severe evils they anticipate. Some exaggerate their deficits and place themselves in inferior positions to avoid more troubling abuses (Millon, 2000; Millon & Davis, 1996).

The following prototypes in the classification system described by Millon are those deemed to be among the more severely dysfunctional. Their differentiation from the other 11 is made by several criteria, mainly deficits in social competence and periodic psychotic episodes.

12) Schizotypal Prototype: this reflects a constellation of behaviours that reflect poorly integrated or unusually dysfunctional schizoid or avoidant personality patterns. Most of these individuals prefer isolation with minimal personal attachments or obligations. Others may perceive them as strange or different due to behavioural eccentricities and cognitive dysfunctions (Millon, 2000; Millon & Davis, 1996).

13) Millon's Borderline Prototype (originally termed cycloid): this prototype represents a severely dysfunctional self- versus- other orientation. These individuals can experience intense endogenous moods, with recurring periods of dejection and apathy mixed with periods of anger, anxiety, or euphoria. Many engage in self- mutilating behaviour and suicidal thoughts, appear preoccupied with securing affection, have difficulty maintaining a clear- sense of identity, and display a cognitive- affective ambivalence, as expressed in simultaneous feelings of rage, love, and guilt towards significant others (Millon, 2000; Millon & Davis, 1996).

14) Paranoid Prototype: these individuals are described by Millon as exhibiting a dysfunctional independent (self- orientated) personality style. They display a strong mistrust of others and

defensiveness against anticipated criticism and deception (Choca, 1999; Millon, 2000).

4.9.2 Instrumentation

Millon began with the question, 'do psychological syndromes, such as personality prototypes, have signs and symptoms that cluster together as do medical syndromes?' (Davis, 1999). He felt that the observation of these personality prototypes by clinicians may be connected to the fact that people possess enduring biophysical dispositions that consistently colour their experiences and that the range of experiences to which people are exposed throughout their lives is limited and repetitive. Once several components of a particular cluster are identified, knowledgeable observers should be able to infer the likely presence of other, unobserved, yet frequently correlated features comprising that cluster. Instrumentation can play a role in helping determine the presence of such symptom clusters (Craig, 1999a; Davis, 1999; Millon, 2000).

Like the DSM classification system, Millon identifies certain criteria for each personality disorder, but these are encompass a broader set of diagnostic domains (Millon, 1996; 2000; Millon & Davis, 1996). The domain model illustrates that categorical (qualitative distinction) and dimensional (quantitative distinction) approaches need not be in opposition or considered mutually exclusive. Millon discerns between the relatively stable and organised clinical domains (structures) from those that represent processing and modulating domains (functions)

4.9.2.1 Functional domains

Functional characteristics represent dynamic processes that transpire within the intrapsychic world and between the individual and his or her psychosocial environment. They represent expressive modes of regulatory action: behaviours, cognitions, perceptions, affect and

mechanisms that manage, adjust, transform, coordinate, balance, discharge, and control the give and take of inner and outer life. Specific modalities and expressive variations characterise certain personalities best but even the most distinct personalities will display variations throughout the individual's life. The following are four functional diagnostic domains relevant to personality; expressive behaviour, interpersonal conduct, cognitive style, regulatory mechanisms (Davis, 1999; Millon & Davis, 1996)

4.9.2.2 Structural domains

These can be defined as cognitive- affective substrates and action dispositions of a quasi permanent nature. These attributes represent an embedded and enduring template of imprinted memories, attitudes, needs, fears, conflicts that guide the experience and transform the nature of ongoing life events. These structures have an orienting and preemptive effect in that they alter the character of action and the impact of subsequent experiences in line with preformed inclinations and expectancies. By temporal precedence they guide the character of current events. Four structural attributes relevant to personality have been described: self- image, object relationships, morphologic organization, mood- temperament (Davis, 1999; Millon & Davis, 2000).

The MCMI-III is a diagnostic test aligned with the Diagnostic and Statistical Manual fourth edition, diagnostic criteria. While not encompassing all the diagnostic categories in the DSM-IV, it does include almost all the Axis II personality disorders and a number of Axis I disorders. The scales included are; on Axis II: Schizoid, Avoidant, Depressive, Dependant, Histrionic, Narcissistic, Antisocial, Aggressive (Sadistic), Compulsive, Passive- Aggressive (Negativistic), Self- Defeating, Schizotypal, Borderline, and Paranoid. On Axis I the following are included;

Anxiety, Somatoform, Bipolar: Manic, Dysthymia, Alcohol Dependence, Drug Dependence, Post- Traumatic Stress Disorder, Thought Disorder, Major Depression, Delusional Disorder (Millon, 1994). The test is in a true- false format, and as with any self- report inventory, the testee is required to know something about his or her personality, behaviour, and symptoms and also be willing to report them honestly on the test.

Interest in the test is far reaching with only research on the Rorschach and MMPI-2 having generated more published literature (Craig, 1999a; Weiner, 2000). Since the test's introduction in 1977 over 500 published article have appeared on the topic. The test has also been translated into various foreign languages (Craig, 1999a; Millon, 2000). In developing the test Millon used Loevinger's three- step test construction and validation, in which validation occurs throughout the test development process (Loevinger, 1957). At stage 1 theoretical- substantive items were constructed based on how well their content corresponded with Millon's theory. During stage two, known as internal validation, 289 items were prepared for stage three, external validation. With the MCMI-II this process was continued with an experimental version of 368 items, the introduction of an item- weighting system, and validity scales and various adjustments were added and fine tuned, increasing the test to four validity scales and thirteen personality disorder scales. The MCMI-III made further changes (Millon, 1994). Almost 50% of the items from the MCMI-II were changed and the scales reduced in length. Two new scales were added, PTSD and Depressive. Noteworthy response items dealing with eating disorders and child abuse were added but not scored on any scale, and the item- weighting scoring system was changed from a 3- point to a 2- point scale.

Millon introduced the concept of base rate scores (BR), this is a transformed score that selects that point in the distribution of scores whereby the patient has all of the features of the disorder or syndrome at the diagnostic level. This approach was used because personality disorders and clinical syndromes are not normally distributed and a T score type of transformation would therefore not be appropriate (Craig, 1999a). BR scores of 85 or more on the personality scales are said to be diagnostic, but scores between 75 and 84 reflect some of the behaviours and traits of that disorder but not necessarily at a diagnostic level, however, it is not possible to tell which behaviours or traits (Millon, 1994).

4.9.2.3 Profile invalidity

Computer adjustments are made to MCMI scores on all scales which could be affected by under- or over reporting of symptoms. Scales Y (Desirability) and Z (Debasement) are used to detect and correct fake- good and fake- bad responses. Results are considered invalid when respondents endorse two or three of the unusual items on the three- item Validity Index, or obtain scores above or below a certain level on the Disclosure index (scale X) (Millon, 1994). Most studies indicate that the MCMI has been able to detect fake- bad response sets with better efficiency than a fake- good response set (Craig, 1999a).

4.9.2.4 Effects of demographic variables

In the United States of America the following differences based on gender and race were noted. Men score higher on Scale 6A (Antisocial); women higher on Scales H and CC (Somatoform Disorder and Major Depression respectively). No gender differences were consistently noted on Scales 2A and 8A (Avoidant and Negativistic respectively). No other conclusions were able to be drawn from the data available regarding gender.

With regards to race the following differences were noted; African Americans score consistently higher on Scales 5 (Narcissistic), 6A (Antisocial), P (paranoid), T (Drug Dependance) and PP (Delusional Disorder). No racial differences were noted between blacks and whites on Scales 3 (Dependent), 7 (Compulsive), 8A (Negativistic) and A (Anxiety Disorder). No data are available for comparisons between whites and other ethnic groups on the MCMI scales (Craig, 1999a).

4.9.2.5 Strengths and weaknesses

The MCMI is unique in that it is one of the few assessment instruments in the field of psychology that was derived from a comprehensive theory. It is increasingly coordinated with the American Psychiatric Association's multiaxial diagnostic system, in the DSM. It enhances diagnostic efficiency by taking into account the base rates of the disorders it measures. It is also a short test to administer taking on average 20- 30 minutes. Interpretation is made easy if one is familiar with the DSMs terminology and criteria. It is however, susceptible to respondents with an acquiescent response set because most of the items are keyed true. It has difficulty in assessing patients with minor personality pathology and patients with severe personality dysfunction, such as psychotic disorders.

It cannot be used as a broad screening instrument since it is only designed for people experiencing problems, and may therefore over- score people who are 'normal' (Millon, 1994; Retzlaff, 1995). Furthermore, interpretation of personality scales where the BR score falls between 75 and 84 is a problem (Craig, 1999a). MCMI-III is not a general personality instrument to be used for 'normal' populations or for any purpose other than diagnostic screening or clinical assessment. Normative data and transformation scores are based entirely on clinical samples and

only applicable to individuals who display psychological problems or who are engaged in a program of professional psychotherapy or psychodiagnostic evaluation. Assessment for forensic purposes is appropriate since many such cases were included in the normative sample. A further limitation, as with all self- report methods of data collection, is the tendency of similar patients to interpret questions differently, the patient's emotional state at the time of testing, and the possibility of patients to create false impressions.

4.9.2.6 Clinical and research uses

a) Primary intent is to provide information to clinicians who must make assessment and treatment decisions about individuals with emotional and interpersonal difficulties

b) Can be used in following settings: psychiatric outpatients, community agencies, university settings, general and psychiatric hospitals, court and private practice.

c) Cut- off scores can be used to make diagnoses.

d) Research uses: scale scores and profile patterns can be used to make and test a variety of clinical, experimental and demographic hypotheses.

4.10 The Minnesota Multiphasic Personality Inventory 2 (MMPI-2)

4.10.1 Introduction

The Minnesota Multiphasic Personality Inventory-2 is a broad band test intended to assess a number of personality patterns and emotional disorders (Butcher, Dahlstrom, Graham, Tellegen & Kaemmer; 1989). An eighth- grade (standard 6) level of reading comprehension and participant cooperation are necessary for successful administration. The test itself provides internal mechanisms in the event that these requirements have not been met (Butcher et al, 1989). The MMPI-2 can be used in a wide variety of settings and the tester can make use of a wide range

of computer- based interpretive services providing diagnostic and assessment hypotheses.

4.10.2 Administering the MMPI-2

The ease with which the MMPI-2 can be administered and scored may lull some individuals into using the MMPI-2 in ways that may be unsuitable and compromise the ethical and professional requirements which all psychological assessment methods require. The testee needs to be assured of privacy, freedom from distraction and intrusions, and assurance that the results will be respected, safeguarded and used for the sole intention of his/ her benefit or treatment. If the administration of the test is not carried out by a fully qualified professional then supervision of the administrator by such a person is essential.

4.10.3 Testability of the subject

The usefulness of the data obtained via the test relies on the subject's ability to understand and comply with test instructions and with the requirements of the task, comprehension and interpretation of the content of the items as they relate to him or her, and to record these in a way required by the form of the test being administered. Certain conditions and emotional states may impair this ability: visual impairments, learning disorders, chemical intoxication, toxic reactions, delirium, post- seizure confusion due to an epileptic disorder, hallucinations, profound psychomotor retardation due to a major depressive disorder or extreme mania (Butcher et al, 1989). Also the subject must be able to read the content and interpret the meaning in the cultural context from which they have been derived. Although there are validational methods built into the test itself which can help determine the acceptability of an administration, it is better for the person administering the test to try and determine these for himself prior to testing. It is necessary that the subject have a sixth- grade (standard 4) or higher reading ability to adequately understand

the item content. Based on contemporary reading proficiency levels, it would now require an eighth-grade (standard 6) reading level to comprehend the content of all the MMPI-2 items and respond to them appropriately.

4.10.4 International adaptions of the MMPI-2

As of yet the MMPI-2 has not been adapted to the South African context. The original MMPI, however, has been widely used amongst white South African population groups for many years. The MMPI-2 has been adapted to many other foreign contexts since its creation. So far the test has been or is being adapted to the following countries: Japan, Korea, China (Hong Kong and Mainland People's Republic of China), Thailand, Vietnam, Chile, Argentina, Mexico, Nicaragua, Puerto Rico, Spain, Belgium, Netherlands, Norway, Iceland, Russia, France, Italy, Greece, Turkey, an Arabic Translation, Hebrew translation, and a Persian version (Butcher, 1996). This indicates the popularity of the test worldwide and its adaptability to foreign contexts. An Butcher (1996) states that the international scene for personality assessment has become increasingly more active over the past two decades, especially since the publication of the MMPI-2 in 1989.

Butcher (1996) states there are many factors for the extensive development of the MMPI-2 in international contexts. Firstly, a fair number of countries have undergone rapid political-economic changes and have become more open to adapting Western technology to their situations. Countries not traditionally open to psychological testing are now more receptive to assessment methods developed in the West. Countries without the financial and professional resources to develop new instruments could now adapt clinical tests to their own situations.

Secondly, communication between mental- health professionals from various countries have

continued to broaden thus increasing ideas regarding procedures and models of practice. Thirdly, linked to the second point, advances in technology have facilitated the rapid communication of professionals, allowing for more efficient collaboration with regards to research. Such tools as FAX machines, the Internet, and express mail allows researchers to communicate even on an hourly basis. As Butcher states:

> When Pancheri and I were working on our handbook we had great difficulty communicating because the mail between the United States and Italy was so unreliable that correspondence and data were routinely lost between Minneapolis and Rome. Telephone calls, though more reliable, were prohibitively expensive and had to be very brief.
>
> (1996: xxviii)

Finally, the publication of two new MMPI instruments, the MMPI-2 for adults in 1989 and the MMPI-A for adolescents in 1992, made translation and adaption much easier and immediately rewarding for foreign psychologists. The revised items were much easier to translate and the new norms based on a more diverse sample of Americans proved to be a closer match to normals from other countries.

4.10.5 The validity scales

For the test to yield the most accurate information the test subject needs to approach the test-taking task in accordance with the test instructions. Subjects need to read the test item, consider its content and respond in an as honest and accurate as possible manner within the true- false format. When excessive deviations from this procedure occurs the protocol should be considered

invalid and cannot be interpreted any further. But this does not mean that the exercise has been fruitless, test- taking attitude can also aid in evaluating an individual, such as a person who is applying for medical pension or has some other secondary gain, also certain personality disorders might be more likely than others to manipulate test responses.

Hathaway and McKinley hoped that such distortions would be less likely with the MMPI due to the empirical keying procedure used in the development of the MMPI, as opposed to earlier face-valid inventories. However, they recognised the importance of assessing test- taking altitudes. In the original MMPI four validity indicators were developed and are still used in the MMPI-2, in addition, three new validity indicators were developed specifically for the MMPI-2 (Butcher et al, 1989: Graham, 1987; Graham, 1993). These seven indicators are:

i) Cannot say (?) score

ii) L- scale

iii) F- scale

iv) K- scale

v) Back- page infrequency (Fb) scale

vi) Variable response inconsistency scale (VRIN)

vii) True response inconsistency scale (TRIN)

4.10.5.1 Cannot say (?) score

This scale is simply the number of omitted items, including those answered as both true and false. Reasons may vary as to why subjects omit items on the test. Sometimes, it is due to carelessness or confusion. Alternatively, omissions can be as a result of an attempt to avoid admitting undesirable things about oneself without actively lying by answering incorrectly on the

test item. Indecisive people who cannot decide between responses may leave items unanswered. Sometimes responses are omitted due to a lack of information or experience necessary for a meaningful response (Graham, 1993).

Regardless of the reason for the omission(s) a large number of them can lead to lowered scores on other scales, this then affects the validity of the protocol. The MMPI- 2 manual suggests that protocols with thirty or more items omitted must be regarded as highly suspect, if not completely invalid (Butcher et al, 1989; Graham, 1993). Graham (1993) however, feels that an amount of thirty or more omissions is too liberal and says it is his own practice to interpret with great caution protocols with over 10 items missing and to not interpret at all protocols with more than 30 items missing.

4.10.5.2 The L- scale

The L- scale was originally constructed to detect an intentional and rather unsophisticated attempt on behalf of the subject to present him/ herself in a favourable light. All fifteen items in the original L-scale have been maintained in the MMPI-2. The items deal with minor flaws and weaknesses to which most people are willing to admit, for example, "I do not like everyone I know". Individuals who are intentionally trying to present themselves in a favourable light are not willing to admit to even such minor 'flaws'. These subjects will produce high L-scale scores. The average number of 'true' endorsed responses in the normative sample was approximately three.

The following are summaries of hypotheses made from either high or low L-scale scores, it should be noted that these descriptions are modal ones and that all descriptions will not

necessarily apply to all individuals with a given score. The hypotheses must be validated by referring to other test and non- test data (Graham, 1993).

According to the MMPI-2 manual, the following can be regarded as rough cut- off boundaries regarding implications for the scale elevations:

Table 4: Cut- off points for the L- scale

T-Score Level	Usefulness of Profile	Sources of Elevation	Interpretive Possibilities
Very High (80 & above)	Probably invalid	Faking well-adjusted	Test resistance or naivete
High (70- 79)	Questionable validity	Random responding, denial of faults	Confusional state, Repressive style, Lacks insight
Moderate (60- 69)	Probably valid	Defensive set	Over- conventional and conforming, Moralistic, Rigidly virtuous
Modal (50- 59)	Valid	Typical test- taking approach	Comfortable with own self- image
Low (49 & below)	Possibly faking-bad	"Plus- getting" set, All True responding	Over- emphasizing pathology, Self-confident and independent, Cynical, sarcastic

(From Butcher et al., 1989:25)

4.10.5.2.1 Summary of the descriptors for the L- scale

High L-scale scores are indicative of persons who:

a) are trying to create a favourable impression of themselves by not responding honestly to items

b) may be defensive, denying or repressing

c) may be confused

d) manifest little or no insight into their own motivations

e) show little awareness of consequences to other people of their behaviour

f) over evaluate their own worth

g) tend to be conventional and socially conforming

h) are unoriginal in thinking and inflexible in problem solving

i) are rigid and moralistic

j) have poor tolerance for stress and pressure

Low L-scale scores are indicative of persons who:

a) probably respond frankly to items

b) are confident enough about themselves to be able to admit minor faults and shortcomings

c) in some cases may be exaggerating negative characteristics

d) are perceptive and socially reliant

e) are seen as strong, natural and relaxed

f) are self- reliant and independent

g) function effectively in leadership roles

h) communicate ideas effectively

i) may be described by others as cynical and sarcastic

4.10.5.3 The F- Scale

The F- scale was originally developed to assess deviant or atypical ways of responding to test items. In the new MMPI-2 certain items were dropped because of objectionable content, leaving the scale with 60 items. The F-scale serves three important functions. Firstly, it is an index of test- taking attitude and is useful in detecting deviant response sets. Second, if one can rule out profile invalidity, the F- scale is a reliable indicator of degree of psychopathology, with higher scores implying greater psychopathology. Thirdly, scores on this scale can be used to generate inferences about other extra- test characteristics and behaviours (Graham, 1993).

Table 5: Cut- off points for the F- scale

T- Score Level	Usefulness of Profile	Sources of Elevation	Interpretive Possibilities
Very High (91 and above)	Probably invalid	Random responding, Scoring errors, severe dyslexia	Uncooperative, faking bad, Marginal reading ability, Test resistance
High (71- 90)	Questionable validity	Malingering, Psychotic processes, All true responding	Plea for help, Adolescent identity crisis, Confusional state

Moderate (56- 70)	Probably valid	Desire to be unconventional, Strong political or social or religious comments, Lagging attention, Extreme honesty in answering, Agitation in midst of crisis	Risk of aggressive acting- out, Moody, restless, unstable, Moderately severe psychopathology, Self-critical, Agitated, distractible
Modal (45- 55)	Acceptable record	A few deviant beliefs	Well- functioning Typical test responding
Low (44 and below)	Acceptable record	Conformity Possibly faking good	Conventional, Sincere, Socially conforming

(From Butcher et al., 1989:26)

4.10.5.3.1 Summary of the descriptors for the F- scale

Graham (1993) has slightly different cut off points regarding hypotheses made from scale scores and more detailed commentary on the implications of these scores. He summarises the high and low scores as follows:

T- scores equal or greater than 100 are indicative of persons who:

a) may have responded randomly to MMPI-2 items

b) may have responded true to all of the MMPI-2 items or false to all of the items

c) may have been "faking bad" when taking the MMPI-2

d) if hospitalised psychiatric patients, may present with:

i. delusions

ii. visual and/ or auditory hallucinations

iii. reduced speech

iv. withdrawal

v. poor judgement

vi. short attention span

vii. Lack of knowledge of reasons for hospitalization

viii. psychotic diagnosis

ix. some extra- test signs of organicity

T- scores in a range of 80- 99 are indicative of persons who:

a) may be malingering

b) may be exaggerating symptoms and problems as a plea for help

c) may be quite resistant to the testing procedure

d) may be clearly psychotic

T scores in a range of 65 to 79 are indicative of persons who:

a) may have very deviant social, political, or religious beliefs

b) may manifest clinically severe neurotic or psychotic disorders

c) if relatively free of psychopathology, are described as:

i. moody

ii. restless

iii. dissatisfied

iv. changeable, unstable

v. curious and complex

vi. opinionated

vii. opportunistic

T scores between 50 and 65 are indicative of persons who:

a) have endorsed items relevant to a particular problem area

b) typically function adequately in most aspects of their life situations

T scores that are below 50 can indicate the following:

a) answered items as most normal people do

b) are likely to be free of disabling psychopathology

c) are socially conforming

d) may have "faked good" in responding to the MMPI-2 items

4.10.5.4 The K- Scale

The K- scale is a more subtle and effective index of attempts by testees to deny psychopathology and present themselves in a favourable light, or to exaggerate psychopathology and appear in an unfavourable light. It was thus thought that high scores on the scale indicated a defensive approach to the test whereas low scores were thought to indicate unusual frankness and self-critical attitudes. A statistical procedure was also developed for correcting scores on some of the clinical scales, the K- correction (Graham, 1993; Butcher et al, 1989).

The items in the K- scale cover several different content areas in which a person can deny problems, such as hostility, suspiciousness, excessive worry. This scale's items tend to be much more subtle than items on the L- scale, it is therefore less likely that a defensive person will

recognise the purpose of the items and manipulate his responses (Graham, 1993). Although above- average scores on the K- scale usually represent defensiveness, moderate elevations sometimes reflect ego strength and psychological resources. There is no clear way to determine when elevated scores indicate clinical defensiveness or more positive characteristics. A rule of thumb may be that if the person does not appear to be psychologically disturbed and appears to be functioning relatively well, an elevated score may reflect positive characteristics rather than defensiveness (Graham, 1993).

Table 6: Cut- off points for the K- scale

T- Score Level	Sources of Elevation	Interpretive Possibilities
High (71 and above)	Marked defensiveness Faking good All false responding Guardedness in employment situations	Shy, inhibited, lacking emotional involvement Reliance on denial Lacks insight
Moderate (56- 70)	Moderate defensiveness No acknowledgement of distress	Adaptive Self- reliant Unwilling to seek help
Modal (41- 55)	Balance between self-protectedness and self- disclosure	Sufficient resources for intervention
Low (40 and below)	Faking bad responding All true responding Plea for help Inadequate defences	Cynical, sceptical Panic state Poor self- concept Critical of self and others

(From Butcher et al., 1989)

4.10.5.4.1. Summary of descriptors for the K- scale

Graham (1993) makes the following hypotheses surrounding the different scores. Very high scores are indicative of persons who:

a) may have responded false to most of the items

b) may have tried to "fake good" in responding to items

Moderately high scores are indicative of persons who:

a) may have approached the test- taking task defensively

b) may be trying to give an appearance of adequacy, control, and effectiveness

c) are shy and inhibited

d) are hesitant about becoming emotionally involved with people

e) are intolerant, unaccepting of unconventional attitudes and beliefs in others

f) lack self- insight and self- understanding

g) are not likely to display overt delinquent behaviour

h) if clinical scales are also elevated, may be seriously disturbed psychologically but have little awareness of this

i) if not seriously disturbed psychologically, may have above- average ego strength and other positive characteristics

Average scores on the K- scale are indicative of persons who:

a) maintain a healthy balance between positive self- evaluation and self- criticism in responding to items

b) are psychologically well adjusted

c) show few overt signs of emotional disturbance

d) are independent and self- reliant

e) are capable of dealing with problems in daily life

f) exhibit wide interests

g) are ingenious, enterprising, versatile, and resourceful

h) think clearly and approach problems in reasonable and systematic ways

i) mix well socially

j) are enthusiastic and verbally fluent

k) take an ascendant role in relationships

Low K- scores are indicative of persons who:

a) may have responded true to most of the items

b) may have tried to "fake bad" when responding

c) may be exaggerating problems as a plea for help

d) may exhibit acute psychotic or organic confusion

e) are critical of self and others and are self- dissatisfied

f) are ineffective in dealing with the problems of daily life

g) show little insight into their own motives and behaviour

h) are socially conforming

i) are overly compliant with authority

j) have a slow personal tempo

k) are inhibited, retiring, and shallow

l) are socially awkward

m) are blunt and harsh in social situations

n) are cynical, sceptical, caustic, and disbelieving

o) are suspicious about the motivations of other people

4.10.5.5 Back- page infrequency (Fb) scale

In a protocol where the F- scale score is valid, an elevated Fb- score could indicate that the subject responded to items in the second half of the test in an invalid manner. In this situation, one could make hypotheses regarding the scales whose items occur early in the test, but scales that are based on items that occur later in the test should not be interpreted. Because of the newness of this scale extensive research is lacking regarding optimal cut- off scores for identifying invalid records. Until such research has been conducted it is possibly best practice to use the same T-score cut- offs for the Fb- scale as for the F- scale. Persons who randomly respond to items throughout the test will have very elevated Fb- scale scores and elevated scores on the VRIN scale (above 80). Testees that respond 'true' to most items or who "fake bad" will most likely produce very elevated scores on the Fb- scale. In a 'true' response bias, the high Fb- score will be accompanied by a TRIN- scale T- score greater than 80 in the true direction (Graham, 1993).

4.10.5.6 Variable Response Inconsistency Scale (VRIN) and True Response Inconsistency Scale (TRIN)

Both of these scales are new additions and complement traditional MMPI validity indicators. Both provide an index of the tendency of a subject to respond to items in ways that are inconsistent or contradictory, thus resembling the Carelessness scale. They both consist of pairs of specially selected items.

The members of each VRIN item pair have either similar or opposite content, each pair is scored for the occurrence of an inconsistency in the responses to the two items. The score on the VRIN scale is the total number of items pairs answered inconsistently. A high VRIN score is a warning that a testee may have been answering items in an indiscriminate manner, and may raise possibility that the profile may be invalid and essentially uninterpretable.

The TRIN scale consists solely of pairs that are opposite in content. Inconsistency therefore occurs when a testee responds 'true' to both items of the pair, when this occurs one point is added to the TRIN score. If the testee responds by answering 'false' to certain item pairs, one point is subtracted. Therefore high TRIN scores indicates someone who gives 'true' answers indiscriminately and low TRIN scores indicates someone who answers 'false' indiscriminately. Thus either very high or very low scores may indicate indiscriminate answering and may render the profile invalid.

TRIN and VRIN are intended to complement L, F, and K scales in unique ways.

A high F score and high VRIN score can indicate a profile that is uninterpretable due to carelessness or confusion. A high F and low VRIN could reflect either true psychopathology or deliberate efforts to fake bad. A high K score and low TRIN is most likely to reflect indiscriminate False- responding. The use of TRIN and VRIN is currently experimental and caution should be exercised when using them for interpretive purposes, but in the mean time the following rough guidelines can be used to determine significant inconsistency: VRIN raw scores of 13 or greater and TRIN raw scores of 5 or less or 13 of greater (Butcher et al, 1989).

4.10.5.7 The clinical scales

The clinical scales of the MMPI-2 are basically the same as those found in the original MMPI. Some items were deleted from some of the scales because they had become dated or deemed to have objectionable content, usually to do with religious beliefs or bowel or bladder function. Some items were modified slightly to modernize them, eliminate sexist references, or to improve readability (Graham, 1993).

The definition of a high score on a scale has differed greatly in literature and from one scale to another. Low scores have also been defined in different ways in literature. Several studies with the MMPI-2 have attempted to clarify the meaning of low scores on the clinical scales. Keiller and Graham (1993) concluded in their research that low scores convey important information but not as much as high scores. The exceptions were scales 5 and 0 for which limited inferences can be made about low scorers.

In general T- scores greater than 65 are considered to be high. It must be taken into account that T- score levels that are used have been established some what arbitrarily and clinical judgement is necessary in deciding which inferences should be applied to scores at or near the cut- off scores for the levels. It should also be taken into account that not every inference presented will apply to every person who has a T- score at that level (Graham, 1993).

4.10.5.7.1 Scale 1: Hypochondriasis

This scale was developed to identify persons who manifested a pattern of symptoms associated with the label hypochondriasis. This label is characterised by a preoccupation with the body and constant fears of disease and illness. Although not delusional they are persistent. Patients with

real physical complaints may show somewhat elevated T scores on this scale (approximately 60). The elderly may also have elevated scores when compared to the general adult population possibly due to a deterioration in health.

High scores may be summarised as follows. Extremely high scores, over 80, may be indicative of dramatic and sometimes bizarre somatic concerns. If scale 3 is also elevated the possibility of a conversion disorder may be considered. If scale 8 is also elevated with scale 1 then somatic delusions may be present.

Moderate elevations (T=60-80) tend to present vague, nonspecific complaints. If complaints are specific they may be epigastric in nature, also, chronic weakness, lack of energy, and sleep disturbance tend to be common in this range of scores. When medical patients present with scores over 60 there may be a strong psychological component to the illness.

High scale 1 scorers in both psychiatric and non- psychiatric samples tend to have rather specific personality attributes. They tend to be selfish, self- centred, and narcissistic. Their outlook on life tends to be pessimistic, defeatist and cynical. They are generally dissatisfied and unhappy and are likely to make those around them miserable. They may be demanding and critical. Extremely high and moderate scorers tend to see themselves as physically ill and seeking medical explanations and treatment for their symptoms. They tend to lack insight into the causes of their complaints and deny any psychological interpretations. This and their cynical outlook tend to make them generally poor candidates for psychotherapy.

4.10.5.7.2 Scale 2: Depression

This scale was developed to assess symptomatic depression which is primarily characterised by poor morale, lack of hope for the future, and general dissatisfaction with one's life situation. Scale 2 appears to be a good indicator of testee's dissatisfaction and discomfort with their life situations. While elevated scores may be indicative of clinical depression, moderate scores tend to be indicative of a general attitude/ lifestyle characterised by poor morale and lack of involvement.

High scores on scale 2 can be summarised as follows. People with scores exceeding 70 often display depressive symptoms. They tend to be pessimistic about the future and about the possibility of overcoming problems, they may talk about suicide and self- deprecation and guilt feelings are common. Such scorers often receive a diagnoses of a depressive nature. They show a marked lack of self- confidence. Their lifestyle may be characterised by withdrawal and lack of intimate involvement with other people, they may be introverted or aloof to maintain psychological distance from others. Because high scale 2 scores are suggestive of great personal distress, they may indicate a good prognosis for psychotherapy (Graham, 1993).

4.10.5.7.3 Scale 3: Conversion hysteria

This scale was constructed on patients who exhibited some form of sensory or motor disorder for which no organic basis could be established. 60 items comprise this scale reflecting physical specific complaints or troubling disorders, but some items involve a denial of problems or lack of social anxiety often seen in individuals with these defences (Butcher et al, 1989). This scale would help to identify patients who were having hysterical reactions to stress situations. Scale 3 scores are related to intellectual ability, with brighter persons scoring higher. As with scale 1,

patients with bona fide medical problems for whom there are no psychological components tend to obtain scores in the region of 60 on this scale (Graham, 1993).

Generally high scores indicate someone who reacts to stress and avoid responsibility by developing physical symptoms. These symptoms do not fit the picture of any known organic disorder. The symptoms may include: headaches, stomach discomfort, chest pain, weakness and tachycardia. These people may be symptom- free most of the time but symptoms may appear when under stress and disappear when the stress subsides. The most frequent diagnoses for such patients are conversion disorder and psychogenic pain disorder. These individuals often posses little insight and may be infantile in manner (Graham, 1993).

4.10.5.7.4 Scale 4: Psychopathic deviate

This scale was developed on individuals who were referred for psychiatric assessment for clarification of why they continued to have conflict with the law even though they suffered no cultural deprivation and despite possessing normal intelligence and the absence of any serious neurotic or psychotic disorders (Butcher et al., 1989). Subjects included in the original sample were characterised by lying, stealing, sexual promiscuity, excessive drinking and the like but no major criminal types were included. There are 50 items comprising this scale (Graham, 1993).

Extremely high T- scores, over 75, tend to be associated with individuals who have difficulty incorporating the values and standards of society. These individuals may engage in asocial, antisocial and criminal activities. High scorers tend to be rebellious towards authority figures, have stormy relations with family members, underachieve at school, have poor work histories, and marital problems. They strive for immediate gratification of needs and therefore act

impulsively having a low frustration tolerance. Their relationships tend to be superficial. They may tend to be aggressive with women being more expressing their aggression in more passive, indirect ways. They are generally unable to accept responsibility for their actions and may be problematic in psychotherapy (Graham, 1993).

4.10.5.7.5 Scale 5: Masculinity- femininity

This scale was comprised on men who sought psychiatric help in their efforts to control homoerotic feelings and cope with the painful confusion surrounding their gender role. Scale 5 is essentially reverse for the two sexes, since the T-score tabulations for females run in the opposite direction from those for males (Butcher et al., 1989). The result is that high T- scores for both genders indicates deviation from one's own gender role. Most of the items are non-sexual in nature covering topics like work and recreational interests, worries and fears, excessive sensitivity and family relationships. Education level does have an influence on this scale. More educated men tend to obtain slightly *higher* T scores on scale 5 than less educated men. More educated women tend to obtain slightly *lower* T scores on scale 5 than less educated women.

Very high scores, T- score over 65, for both men and women suggests the possibility of sexual concerns and problems. These may be associated with homoerotic trends or homosexual behaviour, but may also centre around sexual problems and behaviours of other kinds.

In men high scores, over 60, are indicative of a lack of stereotypical masculine interests. These individuals tend to have aesthetic and artistic interests, are likely to participate in housekeeping and child- rearing activities to a greater extent than do most men. Men with low scores present themselves in a stereo typically masculine light, this reflects in their masculine preferences in

choice of work, hobbies and other activities.

In women high scores are more uncommon. When encountered they usually reflect a rejection of traditional female roles (Graham, 1993).

4.10.5.7.6 Scale 6: Paranoia

This scale was developed on patients showing primarily some form of paranoid condition or state. All forty of the original items were retained (Butcher et al., 1989). The paranoid symptoms include ideas of reference, feelings of persecution, grandiose self- concepts, suspiciousness, excessive sensitivity, and rigid opinions and attitudes. It is possible to obtain high T-scores, greater than 65, without endorsing any of the psychotic items (Graham, 1993).

Extremely high elevations, greater than 70, indicate people who may exhibit psychotic behaviour, disturbed thinking, delusions of persecution or grandeur, ideas of reference, feel angry or resentful, utilize projection as a defence mechanism. In a psychiatric setting may receive diagnoses of schizophrenia or a paranoid disorder. Moderate elevations, between 60 and 70, can indicate people who have a paranoid predisposition, overly sensitive and responsive to others, rationalize and blame others for their misfortunes, appear moralistic and rigid in their opinions, have poor prognosis for therapy, in therapy reveal hostility and resentment toward family members (Graham, 1993).

4.10.5.7.7 Scale 7: Psychasthenia

This scale was constructed primarily on patients displaying obsessive worries, compulsive rituals, or exaggerated fears of the neurotic group described at the time as suffering from psychasthenia (a weakening of one's mental control over thoughts and actions) but which

corresponds to the current diagnostic category of obsessive- compulsive disorder. No subscales have been developed for this scale (Butcher et al., 1989). Common symptoms include thinking characterised by excessive doubts, compulsions, obsessions, and unreasonable fears. This symptom cluster is more commonly found in out- patients instead of hospitalised patients.

High scores indicate someone who is experiencing psychological discomfort, is feeling anxious, tense and agitated, is very worryful, have obsessive thinking, compulsive and ritualistic behaviour, ruminations, plagued by self- doubts, are perfectionistic, overreact to stressful situations, are described as dependent, unassertive, immature, may have physical complaints centering around the heart, genitourinary system, gastrointestinal system, fatigue, exhaustion, insomnia, and bad dreams. These people may be motivated for psychotherapy due to the inner turmoil, and may make slow but steady progress in therapy (Graham, 1993).

4.10.5.7.8 Scale 8: Schizophrenia

This scale was developed using patients who were manifesting various forms of schizophrenia. Initial attempts to construct separate measures of the various forms of schizophrenia were unsuccessful therefore the item content covers a wide range of strange beliefs, unusual experiences, social alienation, impulse control, fears, worries and dissatisfaction. Scores are influenced by age and race. University students commonly obtain scores in a range of 50 to 60, perhaps reflecting the turmoil associated with that period of life. African- American, Native-American, and Hispanic subjects scored higher than Caucasian subjects. This may purely as a result of alienation and social estrangement experienced by minority members. Some elevations can be attributed to the use of prescription and non- prescription medication. Also Epileptics and stroke sufferers may endorse some of the items that could cause an elevated scale score (Graham,

1993).

T- scores in the range of 75- 90 may indicate a psychotic disorder. High scores may also reflect a schizoid lifestyle. They also have a great deal of apprehension and general anxiety, often reporting bad dreams. High scorers may have self- doubt, feel inferior and incompetent (Graham, 1993).

4.10.5.7.9 Scale 9: Hypomania

This scale was developed to reflect patients displaying hypomanic symptoms which are characterised by elevated mood, accelerated speech and motor activity, irritability, flight of ideas, and brief periods of depression. Scores on scale 9 are related to age and race. Younger subjects typically obtain scores in a T- score range of 50- 60 while older subjects often score below 50. African- American, Native- American, and Hispanic subjects in the normative samples scored slightly higher, 5- 10 T- score points, than Caucasian subjects. Overall, this scale can be viewed as a measure of psychological and physical energy. If the scale score is high then one would expect that characteristics of other elevated scales on the profile will be acted out. In other words, if high scores on scale 4, Psychopathic Deviate, are seen in conjunction with high scores on scale 9, Hypomanic, then it is likely that the antisocial behaviour would be overtly expressed.

Extremely high scores, T- score over 80, may be suggestive of a manic episode. Subjects with more moderate scores are not likely to exhibit psychotic symptoms, but there is a definite tendency toward overactivity and unrealistic self- appraisal. These individuals tend to be talkative, energetic, prefer action over thought, but do not utilize energy wisely and often do not complete tasks they begin. They may display periodic episodes of irritability, hostility, and

aggressive outbursts. They often have grandiose aspirations, with an exaggerated feeling of self-worth and self- importance. They also have a greater than average likelihood of using non-prescription medications and contact with the legal system. Therapeutically these individuals are resistant to interpretations, are irregular in attendance of sessions, likely to terminate therapy prematurely, and engage in intellectualisation. They do not become dependent on the therapist, and may target the therapist for hostility and aggression (Graham, 1993).

4.10.5.7.10 Scale 0: Social introversion

This scale was designed to assess a subject's tendency to withdraw from social contact and responsibility. Female subjects comprised the sample group, but this scale is also used on males. The items are of two general types: one group deals with social participation, whereas the other group deals with general neurotic maladjustment and self- deprecation. Scores on this scale are quite stable over time.

High scorers are most obviously characterised by social introversion. They tend to be very insecure and uncomfortable in social situations, feeling more comfortable when alone or with a few close friends. They may be especially uncomfortable around members of the opposite sex. High scorers tend to lack self- confidence and be self- effacing. Others describe them as being cold and distant and difficult to get to know. They tend to be very sensitive about what others say and think. Their lack of involvement with others tends to bother them. In interpersonal relationships they tend to be submissive and compliant and overly accepting of authority. They approach problems in a cautious, conventional and unoriginal manner and may give up easily. Guilt feelings and periods of depression may occur.

Low scorers tend to be social and extroverted, being outgoing, gregarious, friendly and talkative. They have a strong need to be around other people and mix well with others. Others see them as verbally fluent and expressive. They are active, energetic and vigorous. They may be interested in power, status and recognition and seek out competitive situations (Graham, 1993).

4.11 The 16 Personality Factor Questionnaire

The 16PF is one of the most widely used and researched personality inventories. If all the primary and second- order factors are made use of, it can evaluate many aspects of the personality regardless of the field of application. Norms for males and females were established after research indicated gender differences on the profiles. Separate formulae for the second- order factors were based on factor analyses computed separately for males and females (Eeden & Prinsloo, 1997).

4.12 Conclusion

This research intends on using a qualitative approach to understanding the behaviour of persons who committed serial murder. This approach is intended to explore and discover that which was previously unknown, and many of the goals are uncovered as the research develops. This approach hopes to uncover one of many 'truths' regarding serial murder, a 'truth' that will hopefully allow people to see the person involved in this phenomenon in a new light and therefore develop new approaches to the phenomenon of serial murder.

While different psychometric tests are derived from varied backgrounds and are based on what at times may seem as opposing theories, they all have certain elements in common. Ultimately they have to communicate their results. This is done using language. What the researcher does

is group 'language' together that is similar. Common to most tests is that they describe behavioural or interpersonal aspects of the individual, diagnostic aspects and language regarding the testee's approach to the test itself. These seem, at least amongst the tests used in this research, to be the common denominators. With qualitative research its data are the words and actions people use, a convergence of major themes or patterns lends strong credibility to the findings. With each test, words are sought that fit under the headings mentioned above; profile considerations, interpersonal considerations and diagnostic considerations. Once this is done the tests and interactional analysis are compared to each other to see if there are common words under each of the three headings. This reflects a macro to micro process. Looking at each test individually to see what themes/ headings arise, then seeing which themes/ headings are common in each of the research tools, then grouping words under each heading for each test. Finally, seeing if the words under the headings in each test are similar or dissimilar.

Chapter 5

Results

5.1 Introduction

The results are presented in the following order: brief history and background, clinical impressions, test behaviour, medical investigations previously conducted, intelligence level, interactional analysis, Thematic Apperception Test, Millon Clinical Multiaxial Inventory, the Minnesota Multiphasic Personality Inventory and finally the 16 Personality Factor Questionnaire. The brief history and background, clinical impressions, test behaviour, medical investigations and intelligence level appear first to help place the individual in a context in which the ensuing test results can be better understood. The interactional analysis, TAT, MCMI-III, MMPI-2 and 16PF therefore follow after this information.

5.2 Individual number 1

5.2.1 Brief history and background

This individual is a white Afrikaans- speaking male in his mid- thirties. At the time of the murders he was in his early- twenties. He was previously engaged but has never been married. He is an only child and his biological parents are still married. He reports no history of physical or sexual abuse. He completed a primary and secondary education of ten years and was gainfully employed after the completion of his secondary- education.

The crimes for which he was charged, rape and murder, occurred over a three- year period. There were no reports of a history of watching violent pornography nor sexual fetishes. His victims were black and white females. He had no previous convictions.

5.2.2 Clinical impressions

The first impression of this person was one of aloofness. He came across as being emotionally 'cold'. This person was well dressed in his prison greens. He spoke well. He asked for a cigarette from the interviewer's pocket and offered one to each of the researchers. This can imply a high level of confidence on the part of the person. Both interviewers, the researcher and his colleague, a qualified clinical psychologist, felt that the individual was very confident during the interview. He seemed to take control of the situation and sat where he wanted to. He expressed his concern that the video- taped material was not to be used for media purposes.

5.2.3 Test behaviour

Individual number 1 was cooperative during the testing process. He seemed to cope well with the languages in which the testing was conducted. During the Thematic Apperception Test he seemed slightly uncomfortable about the test situation and sought the testers approval for his responses, upon not receiving any guiding feedback he seemed to become more anxious. During the more structured tests such as the 16PF, MMPI and MCMI and to a lesser degree the SAWAIS he seemed more comfortable.

5.2.4 Medical investigations previously conducted

Before being able to make any psychological conclusions it is necessary to determine if any medical problems, such as epilepsy, brain injury, thyroid problems, can be the cause of the manifested behaviours of the individual. With individual number 1 there were no medical problems detected during the forensic observation for the court proceedings. Furthermore the individual was determined fit to stand trial. These investigations involved routine blood work

(not specified on the available ward- round notes), CT scan and EEG were normal. There was also no medical history mentioned that was linked to the current context.

This individual's forensic observation file created during his evaluation of competency to stand trial, was destroyed during a fire at the institution where the observation took place. The only source of information from that time are case discussion notes from the forensic ward-round taken by one of the team members. The following are the details regarding the information available.

Developmental Problems: None reported

Medical of Psychiatric Illness: None reported

CT Scan: Normal

EEG: Normal

5.2.5 Intelligence level

This individual's intelligence level was measured by the South African Wechsler Adult Intelligence Scale. His full- scale IQ was in the normal range. His IQ, as measured by the same instrument at the time of his forensic evaluation of competency to stand trial was also in the normal range. This also corresponds with the researcher's clinical impression of his level of intelligence. For the full profile see appendix 2.

5.2.6 Interactional analysis

5.2.6.1 How does he speak?

Haltingly: the individual's language was quite broken and it seemed he didn't have an elaborate vocabulary.

Willingly/ Easily: he was not hesitant in describing the murders or other facts related to his life- circumstances.

Humoured: at certain points throughout the interviews he would have a slight smile on his face as if amused by something he was saying.

Abrupt: when discussing certain topics like his family.

Insincere

5.2.6.2 How does he speak about the problem?

Easily: he has no problem discussing any aspect of the murders.

Matter- of- Fact/ Casually: he seems to have the attitude that he committed the crimes and there is nothing he can do about it now so there is no need to be remorseful about something he cannot change. He often says things like "ek het dit gedoen" (I did it) in a matter- of- fact way.

Smilingly: often during his account of what happened, on various occasions, he would be speaking about a certain incident with a slight smile on his face. When questioned about this he replied that even though he knows the crimes were terrible there were certain things that occurred that he finds humorous in retrospect.

Accepting: he accepts that he committed the crimes and even before he was apprehended had decided that should anyone question him about the murders he would admit to them. Even with regards to his incarceration he accepts that he will be in prison for many years. He often stated that he is the kind of person that isn't bothered by much, even the circumstances in prison.

Feelingless: he didn't display any verbal or non- verbal signs of emotion during any of the interviews. He often used the phrase "dit was niks" (it was nothing) when discussing the crimes.

Incongruently: he would often verbally comment on how a crime was cruel but the non-verbal communication that came across was incongruent with what he was saying.

He would say "dit was wreed" (it was cruel) or, "ek wil my self verbeter" (I want to better myself) unconvincingly.

5.2.6.3 In what context does the problem appear?

Serial murders seemed to happen when he was bored and he sought a challenge to break the monotony. This involved risk- taking behaviour in the way of entering a flat and not knowing who or what awaited him. The murders always took place in a nearby urban area and the victims were always strangers.

5.2.6.4 What has been done to solve the problem?

Before he was apprehended no action was taken to resolve the problem. He stated that the only way he could have stopped was if someone caught him. Perhaps it can be said that his attempt to solve the problem was to allow himself to be caught. After his incarceration he had requested psychotherapeutic help.

5.2.6.5 Nature of person's relationships with people

Distant: His relationships with the researchers and with other people appear to be distant and therefore uninvolved.

Unemotional: There also seems to be little emotional involvement in any of his relationships. He seems to dislike the amount of effort necessary to maintain a relationship of give and take.

Non- Committal: This creates a non- committal and detached relationship.

Civil: In his interaction with the researchers he was civil and expressed his commitment to the research process, often saying "as ek iets begin dan maak ek hom klaar" (If I start something I

always finish it) but this can be attributed to the prison context where good behaviour can have a secondary gain for privileges and perhaps later for parole.

5.2.6.6 Context of the interview

Correctional Service Facility: Maximum Security

2 interviewers in the dual role of psychologist and researcher.

Voluntary participation.

Prison official's office.

Video camera.

5.2.6.7 Strong points of person

Artfully deceitful.

Makes researchers feel comfortable.

5.2.6.8 Negative points

Unemotional: this can make it difficult for him to make meaningful relationships in which he could do reality testing.

Broken way of speaking: this can make it difficult to follow and maintain a conversation also the possibility that he may be unable to bring across the message he wants to when speaking.

5.2.6.9 Effect of person on researchers

Interest: it was interesting to listen to this person.

At ease/ comfortable: his manner of interacting made one feel at ease when listening and conversing with this person.

Unemotional: it felt like a working relationship throughout the whole research process.

5.2.6.10 Summary of interactional analysis results

The following important aspects were taken from the interactional analysis. The individual spoke reasonably comfortably during the interviews, although he seemed to struggle for words at times as if he has a limited vocabulary to describe complex events, especially those emotional in nature. At times he appeared slightly amused, he was seen to have a slight smile or smirk during some of the discussions. At times he became fairly abrupt, especially when speaking about his family. This gave the impression that he, as with most interpersonal relations, had little insight into his family relations, and almost lacked the words to describe the relationship between two people.

In terms of how he spoke about the problem, the murders, he spoke quite easily about the events. This created almost a casualness about the discussion. His attitude was that he had committed the murders, therefore there was no sense in not being candid about them. This did not come across as bravado, or bragging however, the attitude could also be described as that of accepting in nature. The events were often described in an emotionless manner, although at times he would appear amused at what he was saying, when queried he would say that he was just thinking about something that, in retrospect, seemed amusing, for example when he asked an elderly lady if she had AIDS just before he raped her. He also spoke in an incongruent manner, verbally he would say that his crimes were cruel, but non- verbally there was no correspondence.

The nature of his relationships are distant and unemotional. At times he appears very non-committal about whether or not people maintain contact. He would often have pen- pal relationships yet when a pen- pal failed to continue to write to him in prison he seemed not to

be bothered by it. The impression was often created that he was trying to behave as he thought he should behave, as if following a 'manual', and lacked the backing insight to be able to explain for himself how a relationship should be maintained. He lacks the emotional connectedness that guides most 'normal' people in helping them determine how to behave in a relationship.

In terms of what contexts the problem appeared, it was usually when he was bored, and sought a challenge, there appeared to be a risk- taking element to his behaviour as he was often not sure if there were people in the homes he was breaking into. There seemed to be an escalation in the severity of the crimes, as a child he would steal money from his mother or mother's guests handbags, later, before the murders, he would break into homes to either steal small items, or just for the adventure, this was how the first murder took place, when the domestic helper found him in the house and he killed her (specific details of the event cannot be discussed due to confidentiality). Eventually the break- ins included rape and shortly thereafter rape and murder. The final escalation was rather rapid and the murders took place over a two year span.

5.2.7 Thematic Apperception Test (for full protocol see appendix 3)

5.2.7.1 Card 1

Approach to the test

As a rule (with every card, not only Card 1), the subject plays for time at the beginning, with comments like "OK" and "uhum". This may indicate a little anxiety or insecurity as regards the various stimuli of the cards.

The demands of his world

These are observed, but his inabilities are also clear - he tried to play the violin, but was not very successful, and now it is broken. It cannot be fixed and he is not going to try again either - he gives up.

Self- Concept

Appears to be insecure, poor self- concept.

The role of other people

They are also involved, but are not very supportive.

Observation

I observe that there is already a pattern which may be seen throughout: he knows what should be happening on the card, but his response style is full of insecurity as if he wants the tester to reassure him. (This is primarily seen in the use of words like "maybe" and "if".)

5.2.7.2 Card 2

The approach

As per Card 1.

Interpersonal relationships

He first says that it looks as if each is busy with his [sic] own things, thus they are isolated from one another. Then he does bring them into contact with one another after all: he first suggests a tenuous link between the pregnant woman and the man, then says that they have

come from home, and that the older people are the parents of the girl in the foreground. This is a good sign: in his world, people can be in supportive relationships with one another. However, there is a theme of sadness and hopelessness which appears in this card (I think that Card 1 also already indicates hopelessness.) The theme of relationships being destroyed (the young girl is going away) also comes to the fore.

5.2.7.3 Card 3BM

The theme of sadness (and loss as well) continues here. Here the relationship is also destroyed by someone and the central figure (with whom the subject identifies) suffers as a result. The suggestion of a car is interesting here. Although this card is concerned with frustrations and (self-directed) aggression, I would not interpret the car as a negative instrument whereby frustration will manifest as self-directed aggression. Rather, I would see it as a source of hope, that the subject thinks it possible to get up and go on with life, despite emotional pain. In the process, however, there is a moment where the subject becomes scared and struggles to restore calm - he sees the possibility of a firearm, with all its negative, hopeless, self-directed, destructive possibilities. The tester/ researcher's "As you wish" response was a good remark in this situation.

5.2.7.4 Card 4

On this card, which shows a heterosexual relationship, without focusing on the tender intimacy of Card 10 or the sexual intimacy of Card 13MF, it is not unusual to see conflict between the man and the woman. The subject initially observes conflict, but this upsets him to such a degree that he tries to avoid this by making the contact softer and more jovial. In this rather artificial way, he also tries to indicate that the friendly relationship will continue. Here I would like to put forward the hypothesis of an interpersonal conflict which is very

painful to him, and which came sharply to the fore here, and which he unsuccessfully tried to avoid.

5.2.7.5 Card 6BM

The theme which appears here harks back to Card 2. There the main figure with whom the subject identified had the experience of being unable to speak to the mother figure. On this card, the young man experiences a sad situation and he wants to speak to his mother, but she is totally inaccessible. With projective techniques, it is always important to note what is read into a card without the card having suggested it. With this card, for instance, the father was brought in. I suspect that the subject has a better relationship with his father than with his mother, but that he is scared that he will lose his father in some way, or has already actually lost him.

5.2.7.6 Card 7BM

Although there is more contact between the father and son than between the mother and the son, there are still communication problems between them. The theme of loss comes to the fore once again, this time with a faint suggestion that something went wrong between the person and a girlfriend. By the end, the response became unclear and uncontained. What stands out is that the subject has little hope that interpersonal problems will be solved.

5.2.7.7 Card 8BM

Traditionally, this is the card in which more overt aggression can be lived out. However, the theme of self-directed aggression (Card 3BM) came to the fore with the subject. It is almost as if the firearm which frightened the subject in Card 3BM has now actually become a suicide weapon. Only after the deed has been done, do people come forward to try and help. He distances himself from the situation through fantasy. He stands apathetically outside his body. "Are they going to save my life or not? It doesn't really matter" - he just waits to see what is going to happen.

5.2.7.8 Card 10

The idea of conflict, which is not suggested by this card, is read into the card. Tender intimacy follows. Different to the other cards, here the subject feels that it is possible for people to move closer together after conflict. I wonder if this is not wish-fulfillment for him, and if he did not really experience this. The fact that he then says that they have been married for 50 years already also suggests fantasy and wish-fulfillment.

5.2.7.9 Card 13MF

The sexual meaning of the card is denied. However, the fact that the woman is dead and the man finds her suggests that a sexual relationship with a woman has died for him. It is not very clear whether these were the subject's words or not, or if he is only playing with the idea that the man killed the woman, and then suppresses it (I am thinking of the words "the old hell" which he used).

5.2.7.10 Summary of the TAT

Profile Considerations: This person responded in slightly anxious manner. He sought direction from the tester but when he didn't receive it he became more anxious. He did however, cooperate with the test instructions.

Interpersonal Considerations: Relationships are noted but there is no emotional involvement between role- players. Others are not perceived as being supportive. This may be due to an insecure, poor self- concept on his part. While able to see interpersonal demands he is unable to effectively react to them, and may seek reassurance. People are seen as being isolated from each other, and what few relationships he does perceive are plagued by sadness and destruction. What few interpersonal relations he may perceive seem to filled with disappointment. Interpersonal conflict is experienced painfully for this person. Communication problems seem to be a common factor in interpersonal relations. It appears that interpersonal problems are perceived as unsolvable and therefore abandoned or avoided.

Diagnostic Considerations: A difficulty in dealing with life's demands creates anxiety for this individual. There are pervasive indications of sadness, possibly a depressed mood. A poor self- concept could be an integral part of this. Aggression can be seen as self- directed in certain instances, this can represent his bottling- up of emotions instead of expressing them through interpersonal means. There is a possibility that sexual concerns can be repressed by this individual.

5.2.8 Millon Clinical Multiaxial Inventory III Edition: Interpretive Report

5.2.8.1 Capsule summary

MCMI-III reports are normed on patients who were in the early phases of assessment or psychotherapy for emotional discomfort or social difficulties. Respondents who do not fit this normative population or who have inappropriately taken MCMI-III for non- clinical purposes may have distorted reports. The MCMI-III report cannot be considered definitive. It should be evaluated in conjunction with additional clinical data. The report should be evaluated by a mental health clinician trained in the use of psychological tests. The report should not be shown to inmates or their relatives.

Interpretive Considerations

The client is currently being seen as a correctional inmate, and he did not identify specific problems and difficulties of an Axis I nature in the demographic portion of this test.

Profile Severity

On the basis of the test data (assuming denial is not present), it may be reasonable to assume that the inmate is exhibiting psychological dysfunction of mild to moderate severity. The text of the following interpretive report may need to be modulated slightly downward given this probably level of severity.

Possible Diagnoses

He appears to fit the following Axis II classification best: Avoidant Personality Traits, Dependent Personality Traits, Schizoid Personality Features, and Borderline Personality Features. The major complaints expressed by the client's MCMI-III responses do not take the form of distinct Axis I symptoms.

Therapeutic Considerations

The shy and awkward demeanor of this inmate may cloak his resentment towards others, which is the result of feeling repeatedly rejected. Socially isolated and possessing a poor self-image, the inmate spends much of the time in quiet rumination. The prospect of psychotherapy may not be well- received. Fear of humiliation may lead to resistance. Although the advent of a therapeutic relationship may increase pre- existent anxiety and a desire for social isolation, compliance may be achieved with a treatment regimen that focuses on symptom relief and the acquisition of social skills.

Figure 1: MCMI-III Profile

ID NUMBER:
PERSONALITY CODE: - ** 2A 3 * 1 2B 8B 6A + 4 5 7 " 8A 6B ' ' // - ** - * //
SYNDROME CODE: - ** - * // - ** - * //
DEMOGRAPHIC: /CI/M/33/W/N/10/--/--/-----/--/-----/

Valid Profile

CATEGORY		SCORE RAW	SCORE BR	PROFILE OF BR SCORES 0 60 75 85 115	DIAGNOSTIC SCALES
MODIFYING INDICES	X	77	50		DISCLOSURE
	Y	11	51		DESIRABILITY
	Z	3	42		DEBASEMENT
CLINICAL PERSONALITY PATTERNS	1	9	74		SCHIZOID
	2A	7	75		AVOIDANT
	2B	5	68		DEPRESSIVE
	3	9	75		DEPENDENT
	4	12	42		HISTRIONIC
	5	9	42		NARCISSISTIC
	6A	8	60		ANTISOCIAL
	6B	3	26		SADISTIC
	7	10	39		COMPULSIVE
	8A	4	30		NEGATIVISTIC
	8B	4	68		MASOCHISTIC
SEVERE PERSONALITY PATHOLOGY	S	2	40		SCHIZOTYPAL
	C	9	68		BORDERLINE
	P	2	24		PARANOID
CLINICAL SYNDROMES	A	2	40		ANXIETY DISORDER
	H	1	30		SOMATOFORM DISORDER
	N	3	36		BIPOLAR: MANIC DISORDER
	D	5	68		DYSTHYMIC DISORDER
	B	4	60		ALCOHOL DEPENDENCE
	T	3	45		DRUG DEPENDENCE
	R	3	45		POST-TRAUMATIC STRESS
SEVERE CLINICAL SYNDROMES	SS	4	60		THOUGHT DISORDER
	CC	2	40		MAJOR DEPRESSION
	PP	0	0		DELUSIONAL DISORDER

5.2.8.2 Response tendencies

No adjustments were made to the Base Rate (BR) scores of this individual to account for any undesirable response tendencies. The response style of this inmate showed no unusual test-taking attitude that would distort MCMI-III results.

5.2.8.3 Axis II: personality patterns

The following paragraphs refer to those enduring and pervasive personality traits that underlie this man's emotional, cognitive, and interpersonal difficulties. Rather than focus on the largely transitory symptoms that make up Axis I clinical syndromes, this section concentrates on his more habitual and maladaptive methods of relating, behaving, thinking, and feeling.

Most significant on the MCMI-III of this inmate are suggestions of a self- protective aloofness from others, a tendency to deprecate his self- worth, a general emotional sluggishness, a lack of positive affect, a social awkwardness, and an inclination to feel uncomfortable on most interpersonal relationships. Although he may want a measure of closeness and affection, he protectively denies this desire. He is likely to be a rather sad man who experiences a pervasive dysthymia with recurring periods of anxiety. His thinking may frequently be over controlled, although occasionally distracted by an upsurge of disruptive ideas. Fearing abandonment, he is overly concerned about social rebuff; this is often intensified by his tendency to anticipate- and thereby elicit- rejection.

Other significant traits may include a lack of initiative and competitiveness, persistent deprecation of his aptitudes, and a general avoidance of autonomous behaviour. He may evince a conciliatory submission to others and a dependent search for supportive persons or institutions. Yet he often denies this desire for independence, choosing instead to maintain a safe measure of interpersonal distance. Among the MCMI-III items he is likely to endorse is "In social groups, I am almost always very self- conscious and tense". He may typically assume a passive role in social relationships, willingly submitting to the demands of others to fulfill his dependency needs.

Given his apparent self- image of weakness and fragility and his frequent depressive mood, ordinary stresses and responsibilities may often seem excessively demanding. His passive and aloof lifestyle stems not only from a general depressive fatigability but also from a protective effort to dampen feelings of anxiety and to deaden excess sensitivity. Hence, his depressive blandness may be deceptive, overlying a deep dysphoric mix of inhibited anger, anxiety, and resentment. Careful probing of these denied feelings may be usefully pursued by his clinician.

This man may often be self- absorbed, lost in daydreams that may at times confuse fantasy with reality. Cognitively, he may report being distracted by inner thoughts that intrude on his normal social communications. To counteract these, he may seek to avoid emotional experiences and may attempt to suppress events that stir disturbing memories and feelings. These defensive efforts preclude a socially rewarding lifestyle, and together with his affective restraining and withdrawal behaviour, fail to elicit favourable attention and interest from others. As a consequence, he may drift further into his detached, socially anxious, depressive, and ineffectual life pattern.

5.2.8.4 Axis I: clinical syndromes

No distinctive Axis I clinical syndrome appears in this man's MCMI-III diagnostic picture (other than the general personality characteristics described previously). If denial tendencies are present, he may be covering up significant symptoms.

5.2.8.5 Noteworthy responses

The client answered the following statements in the direction noted in parentheses. These items suggest specific problem areas that the clinician may wish to investigate.

Health Preoccupation

No items endorsed.

Interpersonal Alienation

10. What few feelings I seem to have I rarely show to the outside world. (True)

27. When I have a choice, I prefer to do things alone. (True)

Emotional Dyscontrol

22. I'm a very erratic person, changing my mind and feelings all the time. (True)

Self- destructive Potential

24. I began to feel like a failure some years ago. (True)

142. I frequently feel there's nothing inside me, like I'm empty and hollow. (True)

Childhood Abuse

No items endorsed.

Eating Disorder

No items endorsed.

5.2.8.6 Possible DSM-IV multiaxial diagnoses

The following diagnostic assignments should be considered judgements of personality and clinical prototypes that correspond conceptually to formal diagnostic categories. The diagnostic criteria and items used in the MCMI-III differ somewhat from those in the DSM-IV, but there are sufficient parallels in the MCMI-III items to recommend consideration of the following assignments. It should be noted that several DSM-IV Axis I syndromes are not assessed in the MCMI-III. Definitive diagnoses must draw on biographical, observational, and interview data in addition to self- report inventories such as the MCMI-III.

Axis I: Clinical Syndrome

The major complaints expressed by the inmate do not take the form of distinct or isolated symptoms but rather appear to reflect pervasive difficulties.

Axis II: Personality Disorders

The following personality prototypes correspond to the most probable DSM-IV diagnose (Disorders, Traits, Features) that characterise this inmate.

Personality configuration composed of the following:

Avoidant Personality Traits

Dependent Personality Traits

Schizoid Personality Features

Borderline Personality Features

Course: The major personality features described previously reflect long- term or chronic traits that are likely to have persisted for several years prior to the present assessment.

Axis IV: Psychosocial and Environmental Problems

In completing the MCMI-III, this individual identified the following problems that may be complicating or exacerbating his present emotional state. They are listed in order of importance as indicated by the client. This information should be viewed as a guide for further investigation by the clinician.

None Identified

5.2.8.7 Summary of the MCMI- III

Profile Considerations: The MCMI was valid and indicates a mild to moderate psychological problem in this individual. The problems appear to be more on Axis II of the DSM-IV Multiaxial Classification System, and not on Axis I. Therefore the main focus is on the personality of the individual.

Interpersonal Considerations: Axis II Personality Patterns are this individuals enduring and pervasive personality traits that underlie his emotional, cognitive and interpersonal difficulties. Most significant are the suggestions of a self- protective aloofness from others, tendency to deprecate his self- worth, general emotional sluggishness, lack of positive affect, social awkwardness, and inclination to feel uncomfortable in most interpersonal relationships. Although he may want a measure of closeness and affection, he protectively denies this desire. Fearing abandonment, he is overly concerned about social rebuff, this is often intensified by his tendency to

anticipate, and thereby elicit, rejection. He may interpersonally display a lack of initiative and competitiveness, and a general avoidance of autonomous behaviour, showing a conciliatory submission to others and a dependent search for supportive persons or institutions. He, however, will deny such a desire for dependence, choosing instead to maintain a safe interpersonal distance. He may typically therefore adopt a passive role in social relationships, willingly submitting to the demands of others to fulfill his dependency needs. Having a weak self- image and at times depressed mood leads him to struggle to deal with ordinary responsibilities, thus his passive and aloof lifestyle stems not only from a depressive position, but also functions as a protective measure to damped feelings of anxiety. At times he may be self- absorbed and appear 'lost' in daydreams. Avoiding stressful situations acts as a defensive measure which precludes a socially rewarding lifestyle. This, together with affective restraining and withdrawal, prevents him from eliciting favourable attention and interest from others. This leads to a vicious cycle where he drifts further into a detached, socially anxious, depressive and ineffectual life pattern.

Diagnostic Considerations: He is likely to be a sad man, experiencing pervasive dysthymia with recurring periods of anxiety. Linked with this, a low self- esteem leads to a deprecation of his aptitudes, and a general passivity. Certain ordinary situations will elicit anxiety and appear to be unsurmountable. His depressive 'blandness' may be deceiving, covering up a deep dysphoric mix of inhibited anger, anxiety and resentment. The following diagnostic labels can be used to try and describe this person:

Axis I: No clear syndrome, that which does appear seems linked to his pervasive difficulties.

Axis II: A personality configuration composed of the following: Avoidant Personality Traits, Dependent Personality Traits, Schizoid Personality Features, and Borderline Personality Features.

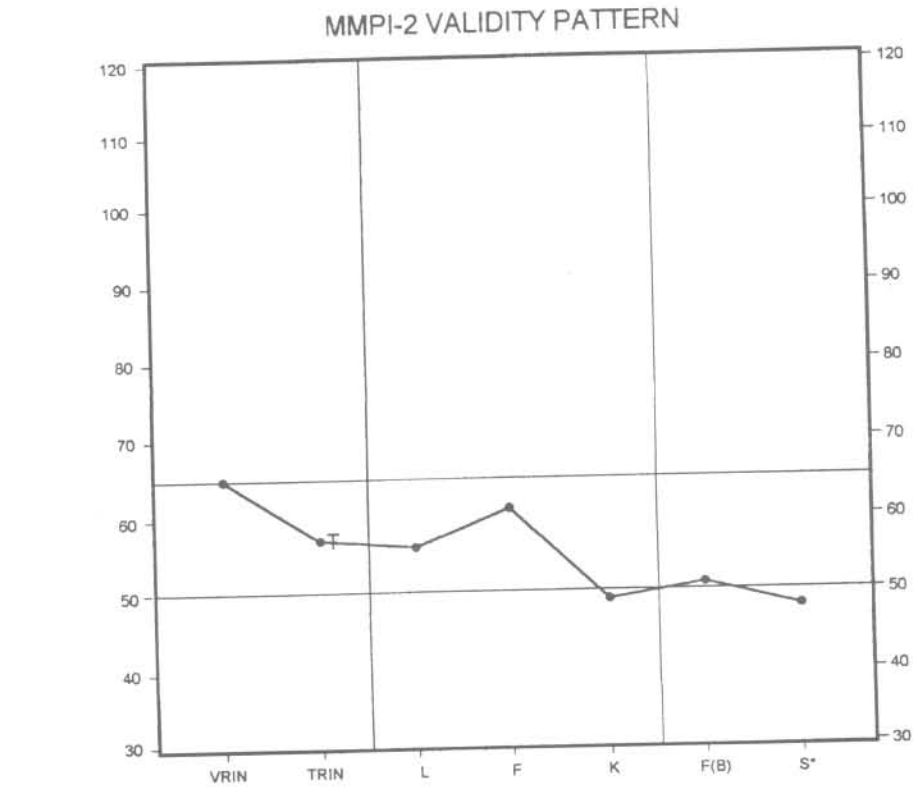
5.2.9 Minnesota Multiphasic Personality Inventory 2nd Edition (MMPI-2)

5.2.9.1 Profile validity

His MMPI-2 clinical profile is probably valid. The client's responses to the MMPI-2 validity items suggest that he cooperated with the evaluation enough to provide useful interpretive information. The resulting clinical profile is an adequate indication of his present personality functioning.

He has not indicated the highest level of education he has attained. The Minnesota Report has been processed as though he has completed a 12- year high school education. If the education level is actually different from high school, then the Minnesota Report, particularly interpretations related to educational background such as those based on the Mf scale, should be carefully evaluated and modified accordingly.

Figure 2



	VRIN	TRIN	L	F	K	F(B)	S*
Raw Score:	9	10	5	8	15	2	23
T Score:	65	57	56	61	49	51	48
Response %:	100	100	100	100	100	100	98

Cannot Say (Raw): 1

F(p) (Raw)*: 3

Percent True: 38

Percent False: 62

F(p) (T-score)*: 63

*Experimental

5.2.9.2 Symptomatic pattern

The MMPI-2 clinical profile type that includes Scales D, Pd, and Sc was employed as the prototype to develop this report. This profile type shows very high definition. The behavioural descriptions provided in the following narrative are likely to be an accurate portrayal of the client's personality and symptoms because his profile closely matches the profile characteristics on which the correlates are based. Acute distress,

depression, and tension are characteristic symptoms expressed in this MMPI-2 pattern. The client is likely to be moody, angry, distrustful, and quite resentful of others, possibly because he feels extremely insecure and inadequate and tends to blame others for his problems. Behavioural deterioration under stress is characteristic of individuals with this profile; however, persistent personality problems are also probably part of his clinical picture.

He probably has a very poor achievement or work history, and he may be having severe family problems. Acting- out behaviour and sexual maladjustment are characteristic problems for individuals with this profile.

In addition, the following description is suggested by the content of the client's item responses. He has difficulty managing routine affairs, and the items he endorsed suggest a poor memory, concentration problems, and an inability to make decisions. He appears to be immobilized and withdrawn and has no energy for life. He views his physical health as failing and reports numerous somatic concerns. He feels that life is no longer worthwhile and that he is losing control of his thought processes. He reports some antisocial beliefs and attitudes, admits to rule violations, and acknowledges antisocial behavior in the past.

5.2.9.3 Profile frequency

Profile interpretation can be greatly facilitated by examining the relative frequency of clinical scale patterns in various settings. The client's high- point clinical scale score (Pd) occurs in 9.1% of the MMPI-2 normative sample of men. However, only 3.3% of the normative men have Pd as the peak score equal to or greater than a T score of 65,

and only 1.9% have well- defined Pd spikes. This elevated MMPI-2 profile configuration (2-4/4-2) is very rare in samples of normals, occurring in less than 1% of the MMPI-2 normative sample of men.

The relative frequency of his profile in various correctional settings is informative. Megargee (1993) reported that this high- point clinical scale score (Pd) occurred in 36.8% of men in a state prison and 21.5% of men in a federal prison. Moreover, a large number of state prisoners (28.8%) and federal prisoners (11.7%) had a Pd spike equal to or greater than a T score of 65.

5.2.9.4 Profile stability

The relative elevation of the highest scales in his clinical profile shows very high profile definition. His peak scores on this testing are likely to be very prominent in his profile pattern if he is retested as a later date. His high- point score on Pd is likely to remain stable over time. Short- term test- retest studies have shown a correlation of 0.81 for this high- point score. Spiro, Butcher, Levenson, Aldwin, and Bosse (1993) reported a moderate test- retest stability index of 0.62 in a large study of normals over a five- year test- retest period.

5.2.9.5 Interpersonal relations

Poor social skills and disturbance in interpersonal relationships are hallmarks of such clients. He is overly sensitive and resistant to the demands of others, and he may be quite argumentative and obnoxious. He tries to stay aloof but may show dependency feelings and an exaggerated need for affection. He is very suspicious of others and rejects emotional ties. Many individuals with this profile never marry.

He is somewhat shy, with some social concerns and inhibitions. He is a bit hypersensitive about what others think of him and is occasionally concerned about his relationships with others. He appears to be somewhat inhibited in personal relationships and social situations, and he may have some difficulty expressing his feelings towards others.

5.2.9.6 Diagnostic considerations

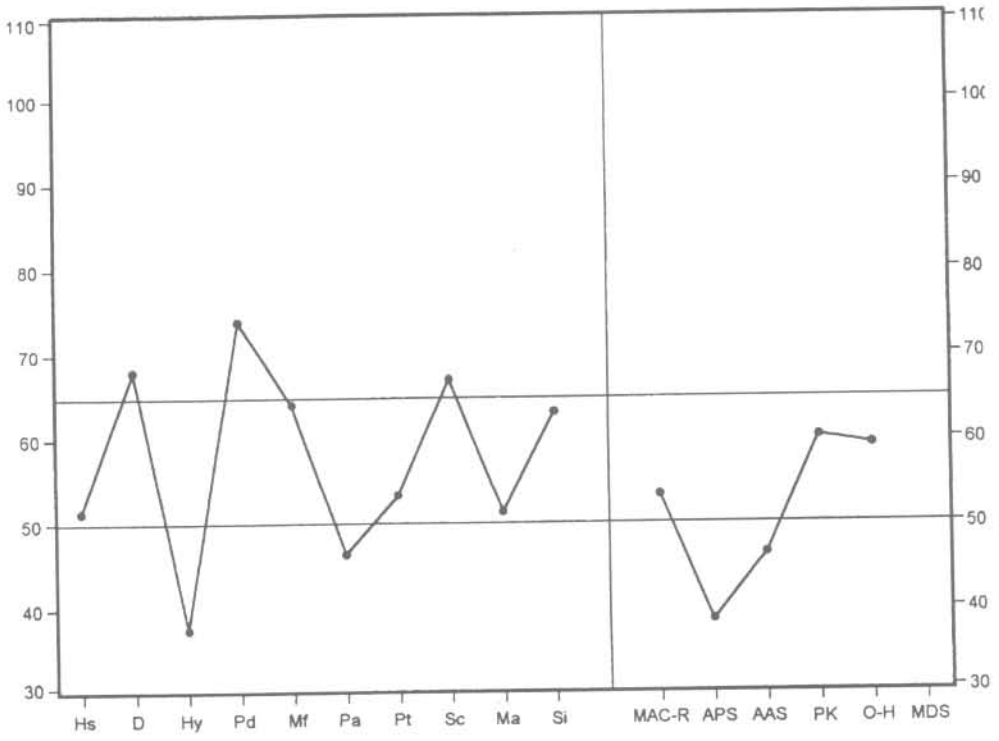
This individual's clinical profile indicates severe psychological disorder as well as antisocial features. His antisocial behavior may be a primary consideration. However, the possibility of a schizophrenic process should be evaluated. His response content is consistent with the antisocial features in his history. These factors should be taken into consideration in arriving at a clinical diagnosis.

The Megargee system for classifying criminal offenders (Megargee, 1993) has often been found to be a useful typology for individuals facing incarceration. There is considerable research support for the view that the Megargee types are found in both men and women across a wide range of correctional facilities. The Megargee system allows for the classification of about two- thirds of the offender population. However, successful classification rates and the retest stability of an inmate's type have been found to vary across settings and for men and women.

This client fits equally well into more than one classification according to the Megargee classification rules. People with multiple classifications probably share characteristics associated with each of these groups.

Figure 3

MMPI-2 BASIC AND SUPPLEMENTARY SCALES PROFILE



	Hs	D	Hy	Pd	Mf	Pa	Pt	Sc	Ma	Si	MAC-R	APS	AAS	PK	O-H	MDS
Raw Score:	5	27	14	27	33	9	13	21	18	36	22	19	2	14	15	*
K Correction:	8			6			15	15	3							
T Score:	51	68	37	74	64	46	53	67	51	63	53	38	46	60	59	*
Response %:	100	98	100	100	100	100	100	100	98	100	100	100	100	100	96	*

Welsh Code (new): 4'28+50-719/6:3# F-L/K:

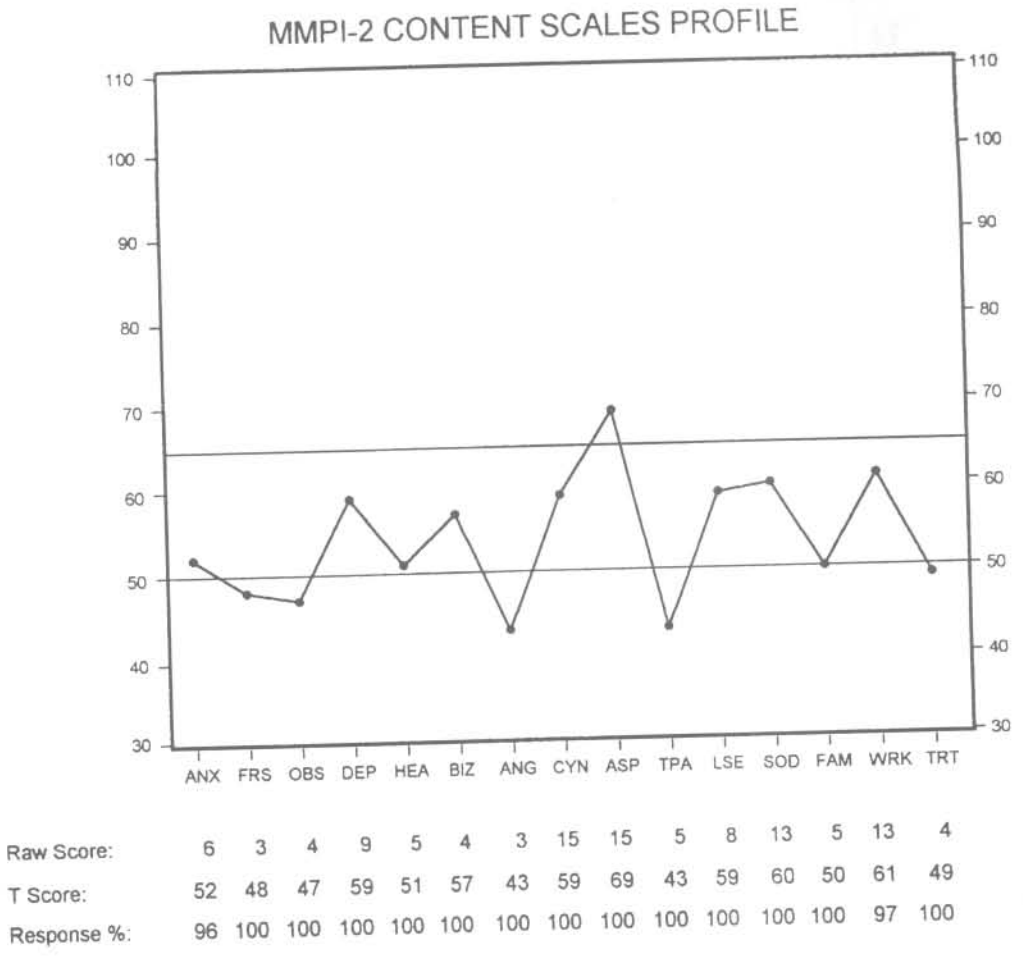
Welsh Code (old): 42"58'079-16/3: F-KL/?:

Profile Elevation: 55.90

Megargee Classification (Rev.): Multiply Classified*

*MDS scores are reported only for clients who indicate that they are married or separated.

Figure 4



5.2.9.7 Supplementary score report

Table 7

	Raw Score	T Score	Resp %
Anxiety (A)	12	53	100
Repression (R)	24	69	100

Ego Strength (Es)	33	40	100
Dominance (Do)	14	41	100
Social Responsibility (Re)	18	45	100
Post- Traumatic Stress Disorder- Schlenger (PS)	15	56	100
Depression Subscales (Harris- Lingoes)			
Subjective Depression (D1)	14	69	100
Psychomotor Retardation (D2)	9	70	100
Physical Malfunctioning (D3)	5	67	100
Mental Dullness (D4)	6	67	93
Brooding (D5)	2	51	100
Hysteria Subscales (Harris- Lingoes)			
Denial of Social Anxiety (Hy1)	3	45	100
Need for Affection (Hy2)	4	40	100
Lassitude- Malaise (Hy3)	3	52	100
Somatic Complaints (Hy4)	1	43	100
Inhibition of Aggression (Hy5)	1	33	100
Psychopathic Deviate Subscales (Harris- Lingoes)			
Familial Discord (Pd1)	2	51	100
Authority Problems (Pd2)	7	73	100
Social Imperturbability (Pd3)	4	51	100
Social Alienation (Pd4)	7	66	100
Self- Alienation (Pd5)	7	67	100
Paranoia Subscales (Harris- Lingoes)			
Persecutory Ideas (Pa1)	4	64	100

Poignancy (Pa2)	2	48	100
Naivete (Pa3)	0	30	100
Schizophrenia Subscales (Harris- Lingoes)			
Social Alienation (Sc1)	6	64	100
Emotional Alienation (Sc2)	3	69	100
Lack of Ego Mastery, Cognitive (Sc3)	4	66	100
Lack of Ego Mastery, Conative (Sc4)	6	71	100
Lack of Ego Mastery, Defective Inhibition (Sc5)	1	47	100
Bizarre Sensory Experiences (Sc6)	1	46	100
Hypomania Subscales (Harris- Lingoes)			
Amorality (Ma1)	2	50	100
Psychomotor Acceleration (Ma2)	5	49	91
Imperturbability (Ma3)	3	47	100
Ego Inflation (Ma4)	4	56	100
Social Introversion Subscales (Ben- Porath, Hostetler, Butcher, & Graham)			
Shyness/ Self- Consciousness (Si1)	7	56	100
Social Avoidance (Si2)	5	58	100
Alienation- Self and Others (Si3)	9	62	100

Uniform T scores are used for Hs, D, Hy, Pd, Pa, Pt, Sc, Ma and the Content Scales; all other MMPI-2 scales use linear T scores.

5.2.9.8 Experimental content component scales (Ben- Porath & Sherwood)

Table 8

	Raw Score	T Score	Resp %
Fears Subscale			
Generalised Fearfulness (FRS1)	0	44	100
Multiple Fears (FRS2)	3	47	100
Depression Subscales			
Lack of Drive (DEP1)	5	68	100
Dysphoria (DEP2)	0	42	100
Self- Deprecation (DEP3)	3	62	100
Suicidal Ideation (DEP4)	0	45	100
Health Concerns Subscales			
Gastrointestinal Symptoms (HEA1)	1	57	100
Neurological Symptoms (HEA2)	2	54	100
General Health Concerns (HEA3)	1	48	100
Bizarre Mentation Subscales			
Psychotic Symptomatology (BIZ1)	0	44	100
Schizotypal Characteristics (BIZ2)	2	54	100
Anger Subscales			
Explosive Behaviour (ANG1)	0	39	100
Irritability (ANG2)	1	41	100
Cynicism Subscales			
Misanthropic Beliefs (CYN1)	13	68	100
Interpersonal Suspiciousness (CYN2)	2	43	100

Antisocial Practices Subscales			
Antisocial Attitudes (ASP1)	12	66	100
Antisocial Behaviour (ASP2)	2	52	100
Type A Subscales			
Impatience (TPA1)	0	34	100
Competitive Drive (TPA2)	3	45	100
Low Self- Esteem Subscales			
Self- Doubt (LSE1)	4	59	100
Submissiveness (LSE2)	2	55	100
Social Discomfort Subscales			
Introversion (SOD1)	11	68	100
Shyness (SOD2)	2	47	100
Family Problems Subscales			
Family Discord (FAM1)	3	50	100
Familial Alienation (FAM2)	2	58	100
Negative Treatment Indicators Subscales			
Low Motivation (TRT1)	2	54	100
Inability to Disclose (TRT2)	1	45	100

5.2.9.9 Critical items

The following critical items have been found to have possible significance in analysing a client's problems situation. Although these items may serve as a source of hypotheses for further investigation, caution should be used in interpreting individual items because they may have been checked inadvertently.

The percentages of endorsement for each critical item are presented in brackets following the listing of the item. The percentage of the MMPI-2 normative sample of 1,238 men who endorsed the item in the scored direction is given.

5.2.9.9.1 Acute Anxiety Scale (Koss- Butcher Critical Items)

Of the 17 possible items in this section, 1 was endorsed in the scored direction:

208. I hardly ever notice my heart pounding and I am seldom short of breath. (False)

[N= 30.0]

5.2.9.9.2 Depressed Suicidal Ideation (Koss- Butcher Critical Items)

Of the 22 possible items in this section, 6 were endorsed in the scored direction:

9. My daily life is full of things that keep me interested. (False)

[N= 14.4]

71. These days I find it hard not to give up hope of amounting to something. (True)

[N= 30.7]

130. I certainly feel useless at times. (True)

[N= 34.3]

233. I have difficulty in starting to do things. (True)

[N= 35.2]

273. Life is a strain for me much of the time. (True)

[N= 16.0]

518. I have made lots of bad mistakes in my life. (True)

[N= 27.3]

5.2.9.9.3 Threatened Assault (Koss- Butcher Critical Items)

Of the 5 possible items in this section, 2 were endorsed in the scored direction:

85. At times I have a strong urge to do something harmful or shocking. (True)

[N= 18.5]

213. I get mad easily and then get over it soon. (True)

[N= 40.5]

5.2.9.9.4 Situational Stress Due to Alcoholism (Koss- Butcher Critical Items)

Of the 7 possible items in this section, 1 was endorsed in the scored direction:

518. I have made lots of bad mistakes in my life. (True)

[N= 27.3]

5.2.9.9.5 Mental Confusion

Of the 11 possible items in this section, 2 were endorsed in the scored direction:

31. I find it hard to keep my mind on a task or job. (True)

[N= 13.3]

316. I have strange and peculiar thoughts. (True)

[N= 14.9]

5.2.9.9.6 Persecutory Ideas (Koss- Butcher Critical Items)

Of the 16 possible items in this section, 3 were endorsed in the scored direction:

216. Someone has been trying to rob me. (True)

[N= 2.6]

259. I am sure I am being talked about. (True)

[N= 18.4]

314. I have no enemies who really wish to harm me. (False)

[N= 11.6]

5.2.9.9.7 Antisocial Attitude (Lachar- Wrobel Critical Items)

Of the 9 possible items in this section, 5 were endorsed in the scored direction:

35. Sometimes when I was young I stole things. (True)

[N= 58.0]

227. I don't blame people for trying to grab everything they can get in this world. (True)

[N= 39.9]

240. At times it has been impossible for me to keep from stealing or shoplifting something. (True)

[N= 6.6]

254. Most people make friends because friends are likely to be useful to them. (True)

[N= 23.8]

266. I have never been in trouble with the law. (False)

[N= 40.9]

5.2.9.9.8 Family Conflict (Lachar- Wrobel Critical Items)

Of the 4 possible items in this section, 1 was endorsed in the scored direction:

21. At times I have very much wanted to leave home. (True)

[N= 31.9]

5.2.9.9.9 Somatic Symptoms (Lachar- Wrobel Critical Items)

Of the 23 possible items in this section, 2 were endorsed in the scored direction:

53. Parts of my body often have feelings like burning, tingling, crawling, or like "going to sleep." (True)

[N= 18.8]

255. I do not often notice my ears ringing or buzzing. (False)

[N= 21.7]

5.2.9.9.10 Sexual Concern and Deviation (Lachar- Wrobel Critical Items)

Of the 6 possible items in this section, 3 were endorsed in the scored direction:

12. My sex life is satisfactory. (False)

[N= 26.7]

34. I have never been in trouble because of my sex behaviour. (False)

[N= 19.3]

166. I am worried about sex. (True)

[N= 15.1]

5.2.9.10 Omitted items

The following items were omitted by the client. It may be helpful to discuss these item omissions with this individual to determine the reason for noncompliance with the test instructions.

15. I work under a great deal of tension.

5.2.9.11 Summary of the MMPI-2

Profile Considerations: Individual number 1's MMPI profile is indicated as being probably valid. The scales used in compiling the test conclusions were scales D, Pd, and Sc. In terms of profile frequency, 3.3% of normative men have a Pd spike equal to and slightly above 65, and 1.9% have a Pd spike significantly elevated above 65. This particular profile occurs in less than 1% of the MMPI normative sample population. This high Pd scale is probably stable over time.

Interpersonal Considerations: This profile is characterised by poor social skills and marked disturbance in interpersonal relations. Such individuals tend to be overly sensitive and resistant to the demands of others. He tries to stay aloof but may show dependency feelings. He is often suspicious of others and rejects emotional ties. Many individuals with this type of profile never marry. Because this individual feels extremely insecure and inadequate and tends to blame others for his problems he is often moody, angry, distrustful and resentful of others. His behaviour may deteriorate under distress. He may display acting- out behaviour. Being somewhat shy, he has social concerns and inhibitions. He tends to be hypersensitive about what others think of him and is occasionally concerned about his relationship with others. Being inhibited in interpersonal relationships and social situations, he may have difficulty expressing feelings towards others.

Diagnostic Considerations: These could indicate primarily a severe psychological disorder with anti- social features. Furthermore, a schizophrenic process may be considered. In terms of the supplementary scales, significant scores were for Repression (69). For the Harris- Lingoes Depression Sub Scales a score of 69 for

Subjective Depression, 70 for Psychomotor Retardation, 67 for Physical Malfunctioning, and 67 for Mental Dullness. For the Psychopathic Deviate Subscale of the Harris- Lingoes, a score of 73 for Authority Problems, 66 for Social Alienation, 67 for Self Alienation was obtained. The Schizophrenia scale of the Harris- Lingoes, had the following elevated scales; 69 for Emotional Alienation, and 71 for Lack of Ego Mastery, Conative.

Acute distress, depression and tension characterise this person. He will tend to be moody, angry and resentful of others. People with sexual maladjustment are characteristic for this type of profile. He has difficulty managing routine affairs and displays poor memory and concentration. This can affect his ability to make decisions. At times he may withdraw and become immobilized. His distress may manifest itself in somatic complaints, perhaps due to his inability to respond on an emotional level and deal with difficulties on an interpersonal level. These difficulties lead to a decrease in self- worth. This type of profile indicates some anti- social beliefs and attitudes.

Therefore, the profile indicates a severe psychological disorder as well as antisocial features, with the antisocial features being the primary consideration. The possibility of a schizophrenic process should be evaluated.

Axis I: No clear syndrome, depressive mood and anxiety might better be explained by more pervasive difficulties.

Axis II: Antisocial Personality Features.

5.2.10 The 16 Personality Factor Questionnaire

Table 9

Low	1 2 3 4 5 6 7 8 9 10	High	Scale	Raw	STEN	Adjusted
Aloof	1 2 3 4 5 **6** 7 8 9 10	Warmhearted	A	10	6	6
Concrete	1 2 3 4 5 6 7 8 **9** 10	Abstract	B	11	9	9
Unstable	1 2 3 4 5 6 7 8 **9** 10	Stable	C	23	9	9
Humble	**1** 2 3 4 5 6 7 8 9 10	Assertive	E	6	1	1
Serious	1 **2** 3 4 5 6 7 8 9 10	Enthusiastic	F	7	2	2
Undependable	1 2 3 4 **5** 6 7 8 9 10	Conscientious	G	12	5	5
Shy	1 2 **3** 4 5 6 7 8 9 10	Adventurous	H	5	3	3
Tough Minded	1 2 3 4 5 **6** 7 8 9 10	Sensitive	I	9	6	6
Trusting	1 2 3 **4** 5 6 7 8 9 10	Suspicious	L	9	4	4
Practical	1 2 3 4 5 **6** 7 8 9 10	Imaginative	M	14	6	6
Unpretentious	1 2 **3** 4 5 6 7 8 9 10	Shrewd	N	8	3	3
Confident	1 2 3 **4** 5 6 7 8 9 10	Apprehensive	O	8	4	4
Conservative	1 2 3 4 5 **6** 7 8 9 10	Liberal	Q1	10	6	6
Group Dep.	1 2 3 4 5 6 7 **8** 9 10	Self-Sufficient	Q2	17	8	8
Uncontrolled	1 2 3 4 5 6 **7** 8 9 10	Self-Control.	Q3	14	7	7
Relaxed	1 2 3 4 5 6 **7** 8 9 10	Tense	Q4	12	6	7

5.2.10.1 Warnings

The first warning indicates that the respondent may have distorted some of his responses positively. The second warning indicates that he may have distorted some of his responses negatively.

5.2.10.2 Broad clinical dimensions

This report is based on the interplay between two factors, degree of adjustment and the degree of inner control.

Adjustment Factors: This individual appears to be adequately adjusted emotionally and will cope with life in a similarly adequate manner. This is not to say that occasional problems will not occur. In explaining this, his slightly elevated threat-sensitivity, expressed as slight shyness, suggests that he is likely to react somewhat fearfully to a wide range of situations. Secondly, he is rather self- confident and resilient, with little concern for the approval of other people. This suggests an adequate emotional armour. Thirdly, he is rather prone to stress and anxiety and is usually somewhat tense and over wrought. This indicates either poor coping abilities or the presence of an environmental stressor.

Control Factors: In this case, the general effectiveness of emotional control is seen to be somewhat above average which suggests some ability to exercise emotional restraint. More specifically, he has a very realistic outlook on life and is able to exercise an uncommon degree of restraint in emotionally- charged situations. This suggests a person who presents an almost emotionless front to the world. Secondly, showing an average regard for what is conventionally considered to be right or wrong

may provide him with a level of social restraint and compliance. Lastly, he is at least somewhat socially precise and careful about living up to normal expectations. This suggests that he will tend to have set standards for his behaviour and to restrain his emotional expression in accordance with such standards.

Patterns of Social Interaction: His somewhat introverted pattern on the high- order scale suggests some movement away from social interaction moderated by some degree of warmth toward other people, reduced interesting belonging to social groups, an introspective, very cautious and inhibited lack of communication, and shyness and a tendency toward emotional restraint and constricted affect.

By itself, average warmth toward other people merely suggests the ability to get on with others while retaining some degree of restraint in his emotional expression. This may allow him to be critical and aloof at times. Having mentioned his tendency to want to be independent of social groups, note that this also implies a "rugged individualism" and a tendency to reject social norms. He may value his independence substantially. His disregard for group affiliation may constitute a temperamental tendency to withdraw rather than a need for self- sufficiency. This is quite possibly the result of a range of pathological processes. As he is rather insightful and bright, he will listen to advice and apply it if it makes sense rather than consistently to do his "own thing". With a tendency to trust others, his low group affiliation is probably the result of a preference for a reliance on his own resources rather than generated by a paranoid fear of others. In any event, his relatively positive self- esteem suggests introversion as a preference rather than a compulsion.

It is likely that he will take life far too seriously and hardly ever "loosen up" or laugh. In such cases of "fearful inhibition", it is important to look for a history of punishment and failure. As he is somewhat socialised, this may enable him to lower his defences without fear of loss of self- control. With an elevated level of insight, inhibition is quite probably not a part of a strategy to prevent social blunders from occurring. Of interest, he will appear to be rather self- confident which, in the face of social inhibition, suggests a specific fear which he tries to deal with by immobilising himself.

As he has a strong need for security and certainty in his life, he will tend to establish obsessive routines for doing things and to have an extremely high concern that others approve of what he does. He will usually rehearse actions beforehand. It is possible that he has sufficient warmth towards others to lead him not to withdraw socially despite his intense security needs. This may be associated with alcoholism. Extreme submissiveness, in this context, further suggests that he will be totally independent on others for providing him with a secure routine. Suicide is not uncommon in cases like this. He is, however, not really suspicious and will tend, rather, to be somewhat tolerant of others as long as they do not directly threaten his safety. Lastly, he is very deeply conflicted as far as inhibition is concerned. More specifically, a very introspective aspect which clashes with a low degree of inhibition suggests some form of heroic fantasy existence verging on psychosis.

Identifiable Psychological Processes: Despite a high degree of emotional stability, there are pathological signs in this profile which require additional discussion. In the light of a fair degree of personal adequacy, this is not likely to be related to guilt as he

will be somewhat insensitive to the approval or disapproval of others. Furthermore this individual may lack a sense of self, as indicated by extremely low dominance, and move from encounter to encounter while never really expressing any opinions, thoughts or ideas. As he may not be inclined to express difficulties, a deeply internalised difficulty may be fuelling that aspect of pathology which is not visible on the surface. There is reason to believe that this individual will become depressed and even physically ill very easily and will approach interactions or events with extreme caution.

The following composite scales may clarify this profile:

Table 10: Composite scales

Depressive:	6
Obsessive:	6
Manic:	3
Anxious:	6
Socially Phobic:	7
Paranoid:	5
Antisocial:	5
Passive- Aggressive:	8
Socially Dependent:	5
Socially Avoidant:	6
Narcissistic:	3
General Pathology:	3

This socially phobic pattern is characterised by low emotional stability linked to extreme shyness. This may be found separately or linked to the socially avoidant pattern which is often used as a means of controlling the anxiety which is resultant and which is socially crippling. A number of primary factors can be used to determine the exact nature of this pattern.

The passive- aggressive pattern is identified by very low assertiveness and high suspicion. Anger builds up inside as it cannot be adequately expressed and suspicion and blaming of others then leads this to being expressed in ways which satisfy the need to punish the "wrong doers"while not directly involving him.

5.2.10.3 Summary of the 16-PF

Profile Considerations: There are indications that he may have distorted some responses in a negative way and some in positive way.

Interpersonal Considerations: He has a somewhat introverted pattern on the higher-order scales which suggest movement away from social interaction. This is moderated by a slight degree of warmth towards people, which could merely suggest an ability to get on with others, reduced interest in belonging to social groups, an introspective, cautious and inhibited lack of communication. This is coupled with a shyness and tendency toward emotional restraint and constricted affect. This may allow him to be critical and aloof at times. He rejects social norms and values his independence, with his independence suggesting a temperamental tendency to withdraw rather than a need for self- sufficiency. This withdrawal is also not out of a paranoid fear of others, but rather a preference instead of a compulsion.

Diagnostic Considerations: At times this person will become depressed and even physically ill. His socially avoidant pattern may be a means of controlling anxiety, which can at times become overwhelming. A passive- aggressive pattern can develop due to low assertiveness and possible suspicion. Anger may build up inside but cannot be adequately expressed, it is released in a manner that does not directly involve the targets of such anger. He may establish obsessive routines to deal with anxiety arising from a lack of certainty and security in his life.

5.3 Individual number 2

5.3.1 Brief history and background

This individual is a white Afrikaans- speaking male in his late- thirties. At the time of the murders he was in his late- twenties. He was previously married. He is the middle child of three children and his biological parents are still married. He reports having been sexually abused by his elder brother from the age of 10 until the age of 15. There is no history of family violence. There is no reported history of violent pornography nor sexual fetishes. He completed a primary and secondary education of ten years, is a tradesman and was gainfully employed for various periods after the completion of his education.

The murders for which he was charged occurred over a three- year period. The victims were white and black males. He had a previous conviction for theft.

5.3.2 Clinical impressions

This individual was meticulously dressed. He wore slip- on leather shoes, had seams sown into his prison green pants, cuffs on the bottom of his pants. His clothes were

well ironed, both his head and face were neatly shaved and he was wearing aftershave. He was cautious about trusting us and wanted to first consult with his lawyer, at one point he seemed to be testing us by asking who the other participants were. He was friendly when he entered and shook hands with us. He too asked for a cigarette out of my top pocket. He presented himself well in his appearance and in posture. He appeared emotionally distant and rather intellectual.

5.3.3 Test behaviour

This individual was cooperative throughout the testing process. He expressed no problems understanding any of the test instructions. He was very willing to partake in any process that he felt would help improve himself.

5.3.4 Medical investigations previously conducted

As with individual number 1 there were no medical problems detected during his forensic investigation. Some of the tests conducted were; thyroid function test, HIV Elisa, Urine- Cannabis, P- Glucose, Liver functions, Urea and electrolytes, Full blood count and platelets, chest examinations, and CT scan. There was no significant psychiatric history prior to the offences. There were two parasuicide attempts in 1981 and 1990. After the 1990 parasuicide he was comatose for two weeks, his age at this time was approximately 27. During the time of the offences a general practitioner had treated him for insomnia and "stress". He described two episodes of having lost consciousness following motor vehicle accidents in 1977 and 1984 at the ages of 14 and 21 respectively. There is no history of epilepsy. He had been treated for gastric ulcers since 1979 when he was approximately 16 years of age. He currently experiences stomach related problems. There was previously a long history of alcohol

abuse. There is also a intermittent history of cannabis and mandrax (methaqualone) abuse. This individual was deemed fit to stand trial.

Thyroid Function Test: results normal

HIV Elisa: Negative

Cannabis- Urine: Negative

Serum Chemistry

P- Glucose (Random): Within normal range

Liver Function Tests (Blood):

S- Bilirubin total: 26 umol/l

S- Bilirubin conjugated: 8 umol/l

S- Albumin: 69 g/l

Urea and Electrolytes

S- Carbon Dioxide: 29 mmol/l

Full Blood Count & Platelets

MCH: 33.7 pg

Differential Count

No flags

Erythrocyte Sedimentation Rate

No flags

Chest Examination

The heart is normal size, shape and position and there is no evidence of cardiac chamber enlargement. The aortic arch is left- sided and normal and the pulmonary outflow tract is within normal limits. Both lung fields are clear. The hila are normal

and there is no evidence of pleural reactions. No other lung pathology noted. No evidence of Koch's is noted.

CT Scan Brain

A normal pre and post contrast CT brain scan was obtained with a normal density of the brain tissue in the cerebral hemispheres and in the cerebellum with a normal size, shape and position of the ventricles. There is no evidence of intra- cranial haemorrhage, neither were there any mass of cystic lesions demonstrated. There are also no abnormal calcifications in the brain. No vascular abnormalities were noted.

5.3.5 Intelligence level

This individual's intelligence level was measured by the South African Wechsler Adult Intelligence Scale. His full- scale IQ was in the normal range. His IQ, as measured by the same instrument at the time of his forensic evaluation of competency to stand trial was also in the normal range. This also corresponds with the researcher's clinical impression of his level of intelligence. For the full- scale see appendix 2.

5.3.6 Interactional analysis

5.3.6.1 How does he speak?

Blaming: he seems to imply that others influenced him to do things he was against doing. One gets the feeling from the language he uses that this person has an external locus of control. This gives the impression that he tries to put himself in a good light.

Melodramatic: his tone of voice and mannerisms give the impression he an actor on a stage, this does not necessarily mean he is not telling the truth. Sometimes certain traumatic events he describes are casually discussed while others are given great detail, this can give the impression of inconsistency in his story.

Story- telling: when he speaks it seems like he is narrating a story. What he says seems to be logically told, he speaks in a manner that makes the listener feel like he is going through a process. This creates the impression that the interviewee wants the listener to fully understand his position and the circumstances surrounding the events.

Friendly: the speaker communicates in a friendly manner and makes the listener feel at ease, he has a very gentle way about him. He is polite and well mannered.

5.3.6.2 How does he speak about the problem?

Blaming: Blaming others in a subtle manner he often describes how people dominated him, from his father, brother to people with whom he had relationships.

Narrative: Again his manner of describing the crimes was one of a narrative, a story. He places all the crimes in a context before discussing them, this creates the impression that he wants people to be able to understand how and why the events occurred. This also gives the impression it is very important for him that people understand his involvement in what happened and how he became involved and to what degree. He gives the impression of an innocent victim, forced to participate involuntarily with threats if he didn't cooperate.

Ambiguity: the type of language he uses sometimes indicates that he is uninvolved and clueless about what happened and why, but other times he seems to know more about particular events than in comparison to his previous dialogue.

Helpless: he gives the impression of being a helpless, coerced victim in the events that took place.

5.3.6.3 In what context does the problem occur?

The problem occurred in the presence of a second individual with whom the subject was involved with romantically at the time. There was a strong emotional tie between the two individuals.

5.3.6.4 What has been done to solve the problem?

During the murders this individual pleaded with his partner to stop, he offered to support his partner financially and take care of his partner.

After the murders this individual became religious and has tried to improve himself through scholarly activities and teaching other inmates inside the correctional facility.

5.3.6.5 Nature of relationships with people

Symbiotic: he needs other people, especially romantically yet it would appear that in return for his emotional needs being satisfied the other people abuse him.

Authoritarian: his partner and other important people near him seem to dominate him.

Assimilation: he adjusts to fit in with the people he is with, whether it be in the workplace or casual relationships, or romantic relationships. This allows him to be manipulated easily.

Dependant: he appears to be dependant on others approval and sanction.

5.3.6.6 Context of interview

Correctional Service Facility: Maximum Security

Two interviewers in dual role of psychologists and researchers.

Voluntary participation.

Video camera.

5.3.6.7 Strong points

Motivated

Post school training

Humour

5.3.6.8 Negative

Very dependant on others therefore easily manipulated.

5.3.6.9 Effect of client on researcher

Likeable and elicits feeling of sorrow for the individual.

5.3.6.10 Summary of the interactional analysis

The following points are highlighted from the interactional analysis. His manner of speaking can be characterised as 'blaming'. He would imply that others had influenced his behaviours. His manner of describing events were in a slightly melodramatic fashion, as if he was narrating a story. He often created the impression that he was a helpless victim of others' manipulations. The murders occurred with another individual with whom this person was involved. In this relationship individual number 2 was described as being the more submissive one.

In terms of the nature of his relationships with others, they tend to be symbiotic in nature, him needing others to satisfy his emotional needs, but in return he was often emotionally abused. Relationships were perceived as authoritarian with him being the submissive partner. This ties up with a dependent stance, he would assimilate to others' behaviours, for example at a new workplace he would start to behave as his co- worker would. He admittedly needed the sanction and approval of others.

The problem would usually appear in the presence of a second individual, with whom the individual was romantically involved. There was a strong subjective bond between this individual and his partner.

5.3.7 Thematic Apperception Test (for full protocol see appendix 3)

5.3.7.1 Card 1

Approach to the Test and to Demands

The person's approach to the test is rather fast, 5 seconds. He plays for time as indicated by the "uh" but then launches into the test. He sees the young boy as a central figure, sees the violin, refers to it indirectly and what it is used for. But when the impact of it hits him he withdraws faster than he began and then starts to increasingly distance himself from the stimulus of the card to the point where he carefully places it in a display case (but doesn't play it) and the photos are placed somewhere and protected.

Outside World and its Demands

The fact that he initially acknowledges all the elements of the demands (the boy, the violin and the fact that it is supposed to be played) but later tries hard to distance himself from them, amongst others he tries to move to the past by saying it belongs to a person from the past. A hypothesis can be drawn that he is capable of determining demands, but realises he cannot fulfill them. He then makes use of inadequate defence mechanisms. When he describes the demands it seems as though he first intellectualises about them, using the word "think" and then wonders what the world expects of him "what must he play?". It is not about what he himself wants to do.

When the demands on himself become too much (before he has even attempted to deal with them) he uses the above mentioned techniques to place them outside of his reach. He continually puts it out of his reach: it is first a taboo (it belonged to his father or another important figure), then it is placed in a display case, eventually the whole situation becomes a photograph.

Self- Concept

The boy feels inferior to the person who owns the violin. If this appears on another card one can make a hypothesis of feelings of inferiority in relationships.

Attitude Towards Other People (and Authority) in His World

Although he says he must play the violin, implying that other people expect it of him, he doesn't involve anyone in a supportive role in the process. Although the authority figure is not physically present he still plays an important inhibiting role so the person almost doesn't dare play the violin.

Aspirations, Ambitions, Possibilities of Achieving Success

An hypothesis can be made that he is paralysed in the shadow of the authority figure from the past, he is therefore incapable of having ambitions or achieving success. A hypothesis of depression can also be considered, because the father/ authority figure is no longer present, but is a memory or reminder that must be preserved. But the opposite possibility also exists, perhaps he is there and the testee protects himself from him by trying to pack him away.

5.3.7.2 Card 2

Entrance to the Card

His entrance is much longer than on the other cards, 18 seconds. This can indicate feelings of insecurity in interpersonal relations.

Interpersonal Relations

Initially the two women, "twee vroumense", and the man are not seen in relation to each other. The link is only made later in the response. The hypothesis made here is that the person is not very content in his family situation, and feels isolated within it.

The word "vroumense", 'women' is a somewhat crude word, and it can be queried whether his attitude towards the prominent women in his life is not perhaps contemptuous. If he says that the woman "vertoon wragtig swanger" then his choice of words are again crude and again possibly in a despising manner. It can also indicate that he is fascinated by this. Just as in card 1 the authority figure is from the past. The main figure is more distanced from them than the card suggests. Two themes that appear in card 1 appear here also: the girl's emotions when she wants to look back and reminisce, while she is actually looking forward is one of heartache that also inhibits her since she wants to move on.

5.3.7.3 Card 3BM

The themes of heartache and depression appear again on this card. When this person is confronted with frustration he gives up all hope. To a degree the aggression is directed inwards by means inflicting pain on the self with an injection. He wants to make it a firearm but tones it down to a injection needle. A firearm would be a more

aggressive way to react towards the self. The term "verslaaf" (addict) indicates dependency. Dependency in the way that he cannot defend himself against prominent (inhibiting) authority figures, this had already appeared on cards 1 & 2. The fact that he calls the figure "dit" (it) and doesn't ascribe a sex to the figure can possibly indicate a uncertainty with regards to his own sexual identity.

5.3.7.4 Card 4

Although incidences appear here where the person seems to identify with the card, and from the use of the word "kinderjare" (childhood) can assume that the person is an adult, he projects the card onto his parents, and sees them here in a relationship. Hypotheses that can be made from this are: he himself is afraid of intimate relationships, or that his relationship with his parents inhibits him.

In the relationship he sees on the card the father is cold and inaccessible and aloof. He displays no heartache or sorrow. The mother pleads, speaks nicely, tries hard to make contact, but the father has completely severed contact.

5.3.7.5 Card 6BM

The test person easily sees the mother- child relationship. The theme in this card is the same as in card 4, with the difference that here it is the child that is pleading and the mother is inaccessible. The theme is that of rejection.

In one incident he does try to escape from the theme of rejection by talking about "slegte nuus" (bad news). He isn't completely successful and relapses with renewed zeal into the theme of rejection. His choice of words parallel those used on card 4:

Boy (mother in card 4) asks, pleads, begs, (hat in hand, 'please' in his eyes). The mother (father in card 4) is cold, aloof, bitter and not heart- sore. This heart- sore/ ache becomes a domineering theme in the cards. The 'good' people in the cards have it but the other people do not.

5.3.7.6 Card 7BM

Here he also easily sees the card's stimulus value of father- son relationship. When one looks at the testee's response one can hypothesize that this card is very important to him. The relationship is sketched as a good one. The father speaks while the son listens attentively, in the previous cards one person was always speaking, pleading, while the other was always cold, aloof and inaccessible. In this card where the testee identifies with the son, the communication problem is remedied by the son. In the previous two cards he was powerless- either the parents were speaking with each other and he cannot solve the problem, or the mother remains aloof when he wants to try and communicate with her.

Here the father speaks and the son can take the initiative to listen, to be with him. Then he comes loose, he becomes free to carry on, to continue with his life. Now his father is no longer in the past, in a cupboard or book (card 1)- he is next to him, and this empowers him to carry on.

There are two reservations with regards to the above mentioned interpretations:

i) The response seems very idealistic and this could possibly due to wish-fulfillment: perhaps his father is really unapproachable and his life really as it appears on the previous cards- his father's attitude still inhibiting him.

ii) Logically following the preceding, will the individual ever be able to shake himself loose from this inhibiting impact on his life?

5.3.7.7 Card 8BM

Traditionally this card was the overt- aggression card because there were many aggressive and violent responses offered by respondents. There are also opportunities for sublimation. In the response the person falls back upon themes of powerlessness and the inability to do something about bad circumstances, when he responds that he is being operated upon. He escapes by using fantasy and perhaps even death when he mentions the spirit or soul ('gees') which leaves the body. The thought that he wants to move on appears again here, but here it is in the form of a fantasy and even possibly a death- wish. Different to some of the previous cards he doesn't fall back upon the past which entraps him but rather makes use of an unrealistic method to escape it.

5.3.7.8 Card 10

The person's shortest responses appear on this card. A hypothesis around this can be that intense closeness or intimacy is an area of uncertainty for him, possibly even anxiety. His response contains uncertainty and this can support the above mentioned hypothesis; "...mekaar omhels, jy weet, blydskap, ... kan ook wees... dat die man die vrou probeer vertroos." But if one puts aside this hypothesis there is the possibility of signs of tenderness. If one compares it with other appropriate cards the following comes to light: the message is different in comparison to card 4 where the person is cold and inaccessible towards his wife. If one compares card 10 to card 7BM where the person the testee identifies with is capable of listening and caring (as opposed to

his father in card 4) it might be possible that the side of him that can care cautiously comes to light.

5.3.7.9 Card 13MF

The testee lingers first in the beginning, "Hier... wat ek sien is, ek sien uh..." this can indicate that he is uncomfortable with the impact of the card. He toys with two types of emotions in the context of sexuality:

* Remorse: because he did something wrong. This feeling overwhelms the first part of his response. Even if he has normal sexual relations it is wrong and he has remorse. He could have also progressively done worse, he could have raped or killed her.

* The second emotion is softer, it is grief, sorrow, a theme that has presented itself repeatedly throughout the test. Sorrow because she is dead and he discovered her. Strictly speaking in this card he is grieving over something he has done. He then tries to further excuse himself by saying it was a suicide.

5.3.7.10 Central themes in individual number 2's Thematic Apperception Test

1. Noticeably in many of the cards there are indications that this person's past interpersonal relations were emotionally traumatic and that he is continually drawn back to these when he actually wants to be free from them to carry on with his life. It is almost as if his past was so traumatic that it has a hold on him preventing his from creating a future. Twice it is indicated that the testee tries to escape the grip of the past, in card 7BM and card 10, except if 7BM is wish fulfilling, an option which cannot be discarded.

2. Hand in hand with the above- mentioned theme is the theme of sorrow and depression which he struggles to escape.

5.3.7.11 Summary of TAT

Profile Considerations: This individual was fairly comfortable with the cards, he did not seem to seek reassurance from the tester.

Interpersonal Considerations: This individual is able to notice the demands society places on him by tries to distance himself from them, via ineffective means, such as avoidance. There are also indications of feelings of inferiority. In terms of the demands placed on him he feels relatively alone, without any support in achieving those goals. Women are perhaps seen with slight contempt by this individual. Familial relations appear almost non- existent and very inhibited. Indications of dependency appear in the test responses. Themes of rejection in interpersonal relations are also common. The idea of the sanctioning of his behaviour by a more 'senior' person as being important, featured again in this test. His powerlessness in most interpersonal relations is noticed. Traumatic interpersonal relations seem to characterise this individual's history, these still play a strong role in the determining of his current relations.

Diagnostic Considerations: This individual tends to withdraw from responsibilities, especially of an interpersonal nature. These cause great anxiety for him which he has trouble controlling, this can leads to various somatic complaints. It is the very awareness coupled with the inability to effectively resolve the situation that creates the anxiety. Feelings of inferiority and depression are prevalent on the test responses. The

feelings of inferiority and the inability to deal with anxiety provoking situations can lead to him preferring a dependent position in relation to stronger figures, as a means of coping.

5.3.8 Millon Clinical Multiaxial Inventory IIIrd Edition

5.3.8.1 Capsule summary

MCMI-III reports are normed on patients who were in the early phases of assessment or psychotherapy for emotional discomfort or social difficulties. Respondents who do not fit this normative population or who have inappropriately taken the MCMI-III for non- clinical purposes may have distorted reports. The MCMI-III report cannot be considered definitive. It should be evaluated in conjunction with additional clinical data. The report should be evaluated by a mental health clinician trained in the use of psychological tests. The report should not be shown to inmates or their relatives.

Interpretive Considerations

The client is a 36- year- old divorced white male with 10 years of education. He is currently being seen as a correctional inmate, and he did not identify specific problems and difficulties of an Axis I nature in the demographic portion of his test.

Profile Severity

On the basis of the test data, it may be assumed that the inmate is experiencing a severe mental disorder, further professional observation and inpatient care may be appropriate. The text of the following interpretive report may need to be modulated upward given this probable level of severity.

Possible Diagnoses

He appears to fit the following Axis II classifications best: Paranoid Personality Disorder, with Avoidant Personality Traits, Depressive Personality Traits, and Schizotypal Personality Features. Axis I clinical syndromes are suggested by the client's MCMI-III profile in the areas of Delusional (Paranoid) Disorder, Generalized Anxiety Disorder, and Psychoactive Substance Abuse NOS.

Therapeutic Considerations

This inmate often feels misunderstood, tense, and depressed. Overly sensitive to how others react to him, he frequently overreacts, withdrawing or displaying self-derogating attitudes. He may be erratic in relating to therapists and may have been disappointed in or ambivalent about plans for his treatment. Calm expressions of genuine interest and attention may help moderate his discomfort and depressive feelings.

Figure 5: MCMI-III Profile

ID NUMBER: Valid Profile
PERSONALITY CODE: 2A 2B ** 1 * 3 8A 8B 6B + 7 6A 5 " 4 ' ' // P S ** - * //
SYNDROME CODE: - ** A T R * // - ** PP * //
DEMOGRAPHIC: ,/CI/M/36/W/D/10/--/--/----/--/----/

CATEGORY		SCORE RAW	SCORE BR	PROFILE OF BR SCORES 0 60 75 85 115	DIAGNOSTIC SCALES
MODIFYING INDICES	X	153	88		DISCLOSURE
	Y	11	51		DESIRABILITY
	Z	12	65		DEBASEMENT
CLINICAL PERSONALITY PATTERNS	1	17	84		SCHIZOID
	2A	21	97		AVOIDANT
	2B	17	94		DEPRESSIVE
	3	15	73		DEPENDENT
	4	0	0		HISTRIONIC
	5	12	39		NARCISSISTIC
	6A	8	48		ANTISOCIAL
	6B	16	64		SADISTIC
	7	22	51		COMPULSIVE
	8A	16	72		NEGATIVISTIC
	8B	13	70		MASOCHISTIC
SEVERE PERSONALITY PATHOLOGY	S	21	90		SCHIZOTYPAL
	C	12	67		BORDERLINE
	P	26	108		PARANOID
CLINICAL SYNDROMES	A	10	83		ANXIETY DISORDER
	H	2	53		SOMATOFORM DISORDER
	N	9	61		BIPOLAR: MANIC DISORDER
	D	8	69		DYSTHYMIC DISORDER
	B	6	63		ALCOHOL DEPENDENCE
	T	16	78		DRUG DEPENDENCE
	R	17	76		POST-TRAUMATIC STRESS
SEVERE CLINICAL SYNDROMES	SS	9	60		THOUGHT DISORDER
	CC	2	33		MAJOR DEPRESSION
	PP	11	76		DELUSIONAL DISORDER

5.3.8.2 Response tendencies

The BR scores reported for this individual have been modified to account for the high self- revealing inclinations indicated by the high raw score on Scale X (Disclosure) and the psychic tension indicated by the elevation on Scale A (Anxiety).

5.3.8.3 Axis II: personality patterns

The following paragraphs refer to those enduring and pervasive personality traits that underlie this man's emotional, cognitive, and interpersonal difficulties. Rather than focus on the largely transitory symptoms that make up Axis I clinical syndromes, this section concentrates on his more habitual and maladaptive methods of relating, behaving, thinking and feeling.

There is reason to believe that at least a moderate level of pathology characterises the overall personality organisation of this man. Defective psychic structures suggest a failure to develop adequate internal cohesion and a less than satisfactory hierarchy of coping strategies. This man's foundation for effective intrapsychic regulation and socially acceptable interpersonal conduct appears deficient or incompetent. He is subjected to the flux of his own enigmatic attitudes and contradictory behaviour, and his sense of psychic coherence in often precarious. He has probably had a checkered history of disappointments in his personal and family relationships. Deficits in his social attainments may also be notable as well as a tendency to precipitate self-defeating vicious circles. Earlier aspirations may have resulted in frustrating setbacks and efforts to achieve a consistent niche in life may have failed. Although he is usually able to function on a satisfactory basis, he may experience periods of marked emotional, cognitive, or behavioural dysfunction.

The MCMI-III profile of this man appears to reflect an intense conflict between his desire to withdraw from personal relationships, his fear of independence, and a growing sense of unworthiness and despondency. He would very much like to depend on friends and family, but he has learned to anticipate disillusionment and

discouragement in these relationships. His deflated sense of self- worth and his expectation of personal failure and social humiliation limit any efforts he might make to become autonomous or to overcome his dispirited feelings. Moreover, he believes that others have either deprecated or disapproved of his occasional attempts at confidence building or self- assertion. He sees no alternative but to give up hopelessly or to give in to his gloomy and sorrowful state. This restriction of choice stirs deep resentments within him. As a consequence, he may experience anxiety and dejection, interspersed occasionally with petulant, erratic, and passive- aggressive acts, and periodic criticism of others for their lack of support. The dependency security that he seeks, however, may be seriously jeopardized when he voices his discontent too strongly. To bind his resentments and thereby protect against further loss, he will characteristically withdraw, becoming even more anxiously depressed. The referring clinician may want to determine whether this man's moods change almost from day to day and whether he feels empty and hollow at times.

The erratic moodiness of this man may only add to the humiliating reactions he gets from others, which may serve to further reinforce his self- protective and depressive withdrawal. Every avenue of potential gratification seems full of conflict. He fears standing on his own because of his shaky sense of self- esteem. On the other hand, he cannot depend on others because of his fearful mistrust of them. Anticipating disillusionment, he may behave petulantly and irritably, thereby incurring the very rejection and disappointment he expects but seeks to avoid.

Unable to overcome the feeling that life is meaningless and empty, and unable to muster the skills to overcome the deficits he sees within himself, he is likely at times

to become cranky, if not explosive, but then to turn against himself, expressing self-pity and a deep sense of personal unworthiness and uselessness. Often feeling misunderstood, unappreciated, and demeaned by others, he may add to his dismay by turning ridicule and contempt on himself. He sees few of the attributes he admires in others within himself, and this awareness intrudes upon his thoughts and interferes with his behaviour, ultimately upsetting his sense of identity and his capacity to cope effectively with ordinary life tasks. Extended periods of exhaustion and chronic depression may be typical. Simple tasks may demand more energy than he can muster, What few efforts he can make may give way to emotional outbursts under the slightest of family or social pressures.

5.3.8.4 Axis I: clinical syndromes

The features and dynamics of the following Axis I clinical syndromes appear worthy of description and analysis. They may arise in response to external precipitants but are likely to reflect and accentuate several of the more enduring and pervasive aspects of this man's basic personality makeup.

A number of delusional facets to this man's thinking (eg. Transient ideas of reference, mixed jealousy, and persecutory beliefs) interweave with other features to constitute a mini- paranoid episode. He believes that he has been betrayed or forsaken by persons whose support he had hoped to gain. His previously repressed resentments have slipped through once- adequate controls, breaking through as irrational, but brief, expressions of anger and suspicion. Tensions are likely to accumulate, compelling him to be quite touchy and irritable.

That this aggrieved and unhappy man reports the symptomology of an anxiety disorder is not unexpected. Much of his run- of- the- mill existence may be fraught with discontent and suffering; hence, that he notes the diffuse fears, mental distractibility, and fatigue that typify the anxiety syndrome should not be surprising. Plagued by doubts, expecting the worst, and repeatedly undoing opportunities to better his circumstances, this man seems to create life stressors that promote the worries and anguish that characterise his general anxiety state.

This man's MCMI-III responses suggest that he has abused or is currently abusing drugs. Whether these agents are legal or illicit is not possible to determine from these test results, but whatever their origin, they have probably been maintained as instruments to help relieve the persistent tension and social inadequacies that this man experiences interpersonally. The drugs may embolden him, although more probably is their function in generating feelings and fantasies that supplant the alienation of his daily reality.

Related to but beyond his characteristic level of emotional responsivity, this man appears to have been confronted with an event or events in which he was exposed to a severe threat to his life, a traumatic experience that precipitated intense fear or horror on his part. Currently the residuals of this event appear to be persistently re-experienced with recurrent and distressing recollections, such as in cues that resemble or symbolise an aspect of the traumatic event. Where possible he seeks to avoid such cues and recollections. Where they cannot be anticipated and actively avoided, as in dreams or nightmares, he may become terrified, exhibiting a number of symptoms or intense anxiety. Other signs of distress might include difficulty falling asleep,

outbursts of anger, panic attacks, hypervigilence, exaggerated startle response, or a subjective sense of numbing and detachment.

5.3.8.5 Noteworthy response

The client answered the following statements in the direction noted in parentheses. These items suggest specific areas that the clinician may wish to investigate.

Health Preoccupation

No items endorsed

Interpersonal Alienation

10. What few feelings I seem to have I rarely show to the outside world. (True)

18. I'm afraid to get really close to another person because it may end up with my being ridiculed or shamed. (True)

27. When I have a choice, I prefer to do things alone. (True)

48. A long time ago, I decided it's best to have little to do with people. (True)

63. Many people have been spying into my private life for years. (True)

69. I avoid most social situations because I expect people to criticise or reject me. (True)

92. I'm alone most of the time and I prefer it that way. (True)

99. In social groups I am almost always very self- conscious and tense. (True)

105. I have little desire for close relationships. (True)

161. I seem to create situations with others in which I get hurt or feel rejected. (True)

165. Other than my family, I have no close friends. (True)

167. I take great care to keep my life a private matter so no one can take advantage of me. (True)

174. Although I'm afraid to make friendships, I wish I had more than I do. (True)

Emotional Dyscontrol

9. I often criticise people strongly if they annoy me. (True)

83. My moods seem to change a great deal from one day to the next. (True)

96. People have said in the past that I became too interested and too excited about too many things. (True)

116. I have had to be really rough with some people to keep them in line. (True)

134. I sometimes feel crazy- like or unreal when things start to go badly in my life. (True)

Self- Destructive Potential

24. I began to feel like a failure some years ago. (True)

154. I have tried to commit suicide. (True)

Childhood Abuse

81. I'm ashamed of some of the abuses I suffered when I was young. (True)

132. I hate to think about some of the ways I was abused as a child. (True)

Eating Disorder

121. I go on eating binges a couple times a week. (True)

163. People say I'm a thin person, but I feel that my thighs and backside are much too big. (True)

5.3.8.6 Possible DSM-IV multiaxial diagnoses

The following diagnostic assignments should be considered judgements of personality and clinical prototypes that correspond conceptually to formal diagnostic categories. The diagnostic criteria and items used in the MCMI-III differ somewhat from those in the DSM-IV, but there are sufficient parallels in the MCMI-III items to recommend consideration of the following assignments. It should be noted that several DSM-IV Axis I syndromes are not assessed in the MCMI-III. Definitive diagnoses must draw on biographical, observational, and interview data in addition to self- report inventories such as the MCMI-III.

Axis I: Clinical Syndrome

The major complaints and behaviours of the inmate parallel the following Axis I diagnoses, listed in order of their clinical significance and salience.

297.10 Delusional (Paranoid) Disorder

300.02 Generalised Anxiety Disorder

305.90 Psychoactive Substance Abuse NOS

Axis II: Personality Disorders

Deeply ingrained and pervasive patterns of maladaptive functioning underlie Axis I clinical syndromal pictures. The following personality prototypes correspond to the

most probable DSM-IV diagnoses (Disorders, Traits, Features) that characterise this inmate.

Personality configuration composed of the following:

301.00 Paranoid Personality Disorder with Avoidant Personality Traits

Depressive Personality Traits and Schizotypal Personality Features

Course: The major personality features described previously reflect long- term or chronic traits that are likely to have persisted for several years prior to the present assessment. The clinical syndromes described previously tend to be relatively transient, waxing and waning in their prominence and intensity depending on the presence of environmental stress.

Axis IV: Psychosocial and Environmental Problems

In completing the MCMI-III, this individual identified the following problems that may be complicating or exacerbating his present emotional state. They are listed in order of importance as indicated by the client. This information should be viewed as a guide for further investigation by the clinician.

None Identified.

5.3.8.7 Summary of the MCMI-III

Profile Considerations: The Base Rate scores for this profile were modified to account for the high self- revealing inclinations indicated by a high raw score on scale X (Disclosure) and the psychic tension indicated by the elevation on scale A (Anxiety). The profile was determined as being valid.

Interpersonal Considerations: There is a moderate level of pathology that characterises this individual's personality structure and therefore interpersonal behaviour. There are indications that he has failed to develop a satisfactory hierarchy of coping strategies, with his foundation for socially acceptable interpersonal conduct seems to be deficient or incompetent. His behaviour is influenced by the flux of his own enigmatic attitudes and is often contradictory. There is a history of disappointments in interpersonal relations, including familial relationships. His shortcomings in social attainments are noticeable as well as a tendency to precipitate self- fulfilling prophecies in terms if interpersonal failures. Earlier attempts at achieving social attainments may have resulted in frustrating setbacks, leading to him being unable to achieve a niche in life.

This individual experiences a conflict between his need to withdraw from interpersonal relationships, his fear of independence, and a growing sense of unworthiness and despondency. While he would like to be able to depend on friends and family, history has taught him to anticipate disillusionment and discouragement from these relationships. This low sense of self- worth and expectation of interpersonal failure and humiliation limit any attempts he might make to become autonomous or overcome dispirited feelings. In addition, he feels that others have thwarted or disapproved of his rare attempts at confidence building or self- assertion. This restriction in his available interpersonal choices stirs resentment in him, consequently he may experience anxiety and dejection, interspersed with occasional passive- aggressive attacks, and periodic criticism of others for lack of support. The dependency security he seeks, can be jeopardized when he voices strong criticism, to

bind his resentments and thereby protect himself from further loss he will tend to rather withdraw, leading to him becoming even more anxiously depressed.

His erratic moodiness adds to the humiliating reactions he gets from others, thus reinforcing his self- protective and depressive withdrawal. Every avenue of potential gratification seems full of conflict. While he fears standing alone because of his shaky sense of self- esteem, he cannot depend on others because of his fearful mistrust of them. Anticipating disillusionment, he may behave in a manner that incurs the very rejection and disappointment he expects yet paradoxically seeks to avoid. This pattern of interpersonal behaviour leads to him feeling that life is meaningless and empty, this coupled with his inability to effectively change the situation, leads him to become cranky, at times explosive, but then to turn the aggression onto himself, expressing self- pity and a deep sense of personal unworthiness and uselessness. This ridicule and contempt is turned onto himself. Simple tasks may demand more energy than he can muster, and what few efforts he can make give way to emotional outbursts under the slightest family or social pressure.

Diagnostic Considerations: As previously indicated the profile suggests that there is a mild level of pathology characterising the overall personality organisation of this man. His sense of self is often precarious and he often precipitates a self- defeating vicious circle in terms of interpersonal disappointments. Although he is usually able to function on a satisfactory basis, he may experience periods of emotional, cognitive, or behavioural dysfunction. As mentioned, this individual expresses an intense conflict between his desire to withdraw from others, a fear of independence, and an increasing sense of unworthiness and despondency as a result of this behaviour. This pattern stirs

deep resentments within him, resulting in him experiencing anxiety and dejection, with passive- aggressive behaviours as a result. His moodiness only adds to the negative reactions received by others, further enforcing a depressive withdrawal. He is often overcome by feelings of hopelessness and meaninglessness, leading him to become cranky and explosive, which is often turned against himself. Extended periods of exhaustion and chronic depression may be typical.

His thinking may have delusional facets to it in the form of transient ideas of reference, mixed jealousy, and persecutory beliefs, thus creating mini- paranoid episodes. He exhibits signs of heightened anxiety which are characterised by diffuse fears, mental distractibility, and fatigue. He is plagued by doubts, expecting the worst, and repeatedly sabotaging opportunities to better his circumstances. There are indications that he is or was previously abusing drugs. These can be used as means to help relieve persistent tension and social inadequacies. They may also serve to help relieve the anxiety surrounding traumatic events he has experienced. Residuals of this include persistent re- experiencing of the event, recurrent and distressing recollections such as cues that resemble or symbolise an aspect of the traumatic event. Avoidance behaviour is present to deal with such cues. When such cues come in the form of dreams or nightmares he may become terrified, experiencing intense anxiety. Other signs might include difficulty falling asleep, anger outbursts, panic attacks, hyper vigilance, exaggerated startle response, or a subjective sense of numbing and detachment.

The following possible DSM-IV diagnostic features were indicated by the test:

Axis I: Delusional (Paranoid) Disorder

Generalised Anxiety Disorder

Psychoactive Substance Abuse NOS

Axis II: Paranoid Personality Disorder

with Avoidant Personality Traits

Depressive Personality Traits

and Schizotypal Personality Features

5.3.9 The Minnesota Multiphasic Personality Inventory 2nd Edition

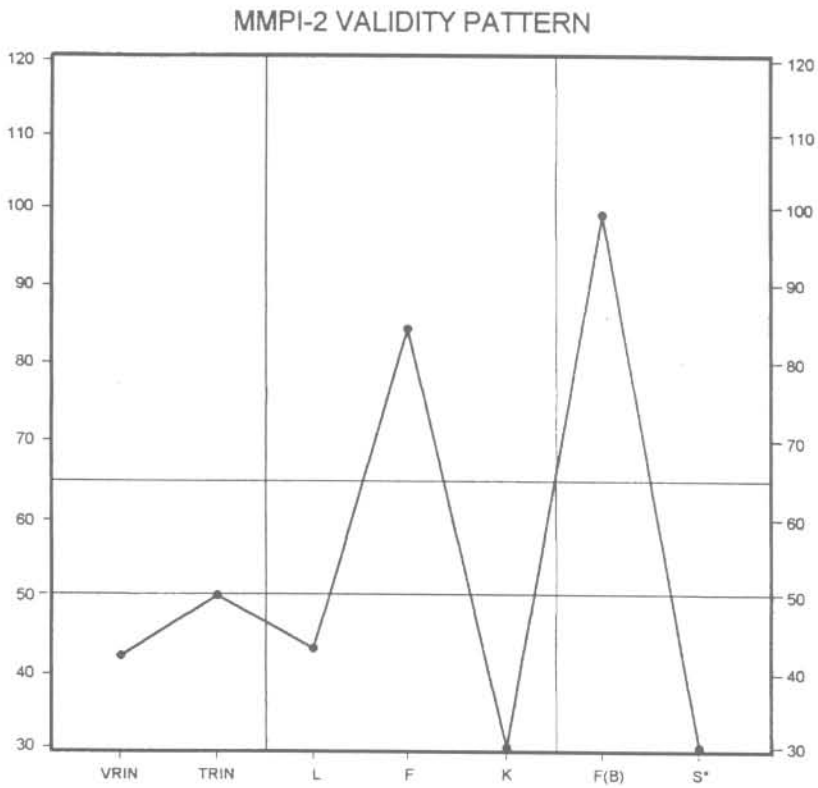
5.3.9.1 Profile validity

This MMPI-2 profile should be interpreted with caution. There is some possibility that the clinical report is an exaggerated picture of the client's present situation and problems. He is presenting an unusual number of psychological symptoms. This response set could result from poor reading ability, confusion, disorientation, stress, or a need to seek a great deal of attention for his problems.

His test- taking attitudes should be evaluated for the possibility that he has produced an invalid profile. He may be showing a lack of cooperation with the testing or he may be malingering by attempting to present a false claim of mental illness. Determining the sources of his confusion, whether conscious distortion of personality deterioration, is important because immediate attention may be required. Clinical patterns with this validity profile are often confused and distractible and have memory problems. Evidence of delusions and thought disorder may be present. He may be exhibiting a high degree of distress and personality deterioration.

The client's response to items in the latter portion of the MMPI-2 were somewhat exaggerated in comparison to his responses to earlier items. There is some possibility that he became more careless in responding to these latter items, thereby raising questions about that portion of the test. Although the standard validity and clinical scales are scored from items in the first two- thirds of the test, caution should be taken in interpreting the MMPI-2 Content Scales and supplementary scales, which include items found throughout the entire profile.

Figure 6



	VRIN	TRIN	L	F	K	F(B)	S*
Raw Score:	3	9	2	16	4	14	5
T Score:	42	50	43	85	30	100	30
Response %:	100	100	100	98	100	100	100

Cannot Say (Raw):	2	Percent True:	63
F-K (Raw):	12	Percent False:	37
F(p) (Raw)*:	6	F(p) (T-score)*:	84

5.3.9.2 Symptomatic patterns

This report was developed using the Pa and Sc scales as the prototype. The client appears to be quite confused and disorganised and is experiencing severe personality deterioration. His MMPI-2 clinical profile reflects and active, florid psychotic process, which includes a loss of contact with reality, inappropriate affect, and erratic, possibly assaultive, behaviour. He is preoccupied with bizarre ideas and abstract thoughts, and probably has delusions and hallucinations. He tends to project blame onto others and appears to withdraw into fantasy in an attempt to deal with his distress. In an interview, he is likely to be circumstantial, tangential, and disorganised. He may not be able to contribute to his own defence in a legal hearing because his behaviour is inappropriate and his thoughts are illogical.

5.3.9.3 Profile frequency

Profile interpretation can be greatly facilitated by examining the relative frequency of clinical scale patterns in various settings. The client's high- point clinical scale score (Pa) occurs in 9.6% of the MMPI-2 normative sample of men. However, only 3% of the sample have Pa as the peak score at or above a T score of 65, and only 2.2% have well- defined Pa spikes. This elevated profile configuration (6-8/8-6) is very rare in samples of normals, occurring in less than 1% of the MMPI-2 normative sample of men.

The relative frequency of his profile in various correctional settings is informative. Megargee (1993) reported that this high- point clinical scale score (Pa) occurred in 13.4% of men in a state prison and 16% of men in a federal prison. Moreover, 7.9% of the state prisoners and 11.7% of the federal prisoners had the Pa scale spike at or

above a T score of 65. Megargee (1993) reported that this elevated profile configuration (6-8/8-6) occurs with some frequency in prison samples (2.9% in a state prison and 6.8% in a federal prison).

5.3.9.4 Profile stability

The relative elevation of the highest scales in his clinical profile shows a very high profile definition. His peak scores on this testing are likely to be very prominent in his profile pattern if he is retested at a later date. His high- point score on Pa is likely to show moderate test- retest stability. Short- term test- retest studies have shown a correlation of 0.67 for this high- point score. Spiro, Butcher, Levenson, Aldwin, and Bosse (1993) reported a moderate test- retest stability of 0.55 in a large study of normals over a five- year test- retest period.

5.3.9.5 Interpersonal relations

Disturbed interpersonal relations are characteristic of individuals with this profile type. The client feels socially inadequate, has very poor social skills, avoids close relationships, and views others as unfriendly or threatening. He is fearful and suspicious of other people. He tends to feel insecure in personal relationships, is hypersensitive to rejection, and may become jealous at times. He tends to need a great deal of reassurance. Individuals with this profile are quite self- absorbed and find marital relationships problematic. Marital breakup is not uncommon.

He is a very introverted person who has difficulty meeting and interacting with other people. He is shy and emotionally distant. He tends to be very uneasy, rigid, and over controlled in social situations. His shyness is probably symptomatic of a broader

pattern of social withdrawal. Personality characteristics related to social introversion tend to be stable over time. His generally reclusive behaviour, introverted lifestyle, and tendency toward interpersonal avoidance may be prominent in any future test results.

5.3.9.6 Diagnostic considerations

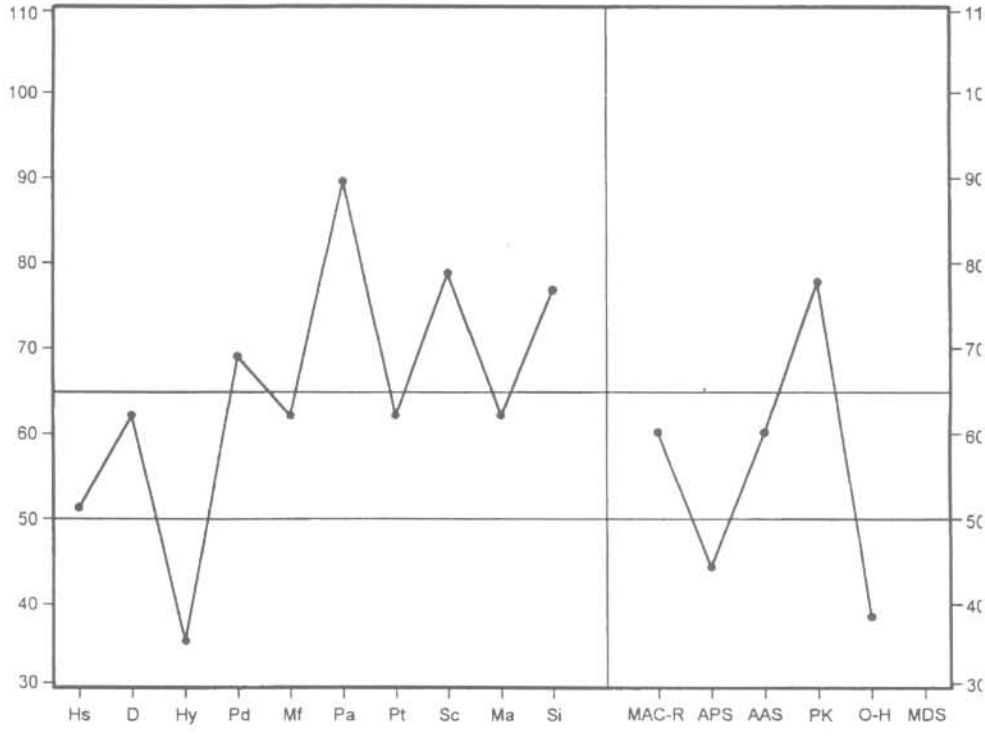
The most likely diagnosis is Schizophrenia, possibly Paranoid type, or a Paranoid Disorder. The Megargee system for classifying criminal offenders (Megargee, 1993) has often been found to be a useful typology for individuals facing incarceration. There is considerable research support for the view that the Megargee types are found in both men and women across a wide range of correctional facilities. The Megargee system allows for the classification of about two- thirds of the offender population. However, successful classification rates and the retest stability of an inmate's type have been found to vary across settings and for men and women.

The client fits the criteria for more than one classification according to the primary Megargee classification rules. However, the classification described in this report represents the best fit using the secondary rules. This client's profile matches those of Type C offenders in the Megargee typology. Individuals matching this profile type are among the most difficult criminal offenders. They are often viewed as distrustful, cold, irresponsible, and unstable. They tend to have antisocial, aggressive, and hostile attitudes towards others. They engage in violent crimes against other people and usually have an extensive criminal record. They tend to come from deviant and stressful home environment and typically have a great deal of difficulty adjusting to society. They are viewed by others as alienated, bitter, rigid, and dogmatic. Their

interpersonal relationships are quite disruptive; their suspicious attitudes and deep-seated hostility toward others make them a difficult case for rehabilitation. Research supports the view that Type C inmates typically have problems adjusting to prison life. It may be necessary to segregate them from weaker or more vulnerable inmates during incarceration.

Figure 7

MMPI-2 BASIC AND SUPPLEMENTARY SCALES PROFILE



	Hs	D	Hy	Pd	Mf	Pa	Pt	Sc	Ma	Si	MAC-R	APS	AAS	PK	O-H	MDS
Raw Score:	11	24	13	29	32	21	28	39	24	49	25	21	5	25	9	*
K Correction:	2			2			4	4	1							
T Score:	51	62	35	69	62	90	62	79	62	77	60	44	60	78	38	*
Response %:	97	100	98	100	100	100	100	100	100	100	100	100	100	100	100	*

Welsh Code (new): 6*"80'4+2579-1/:3# F'"+-/L:K#

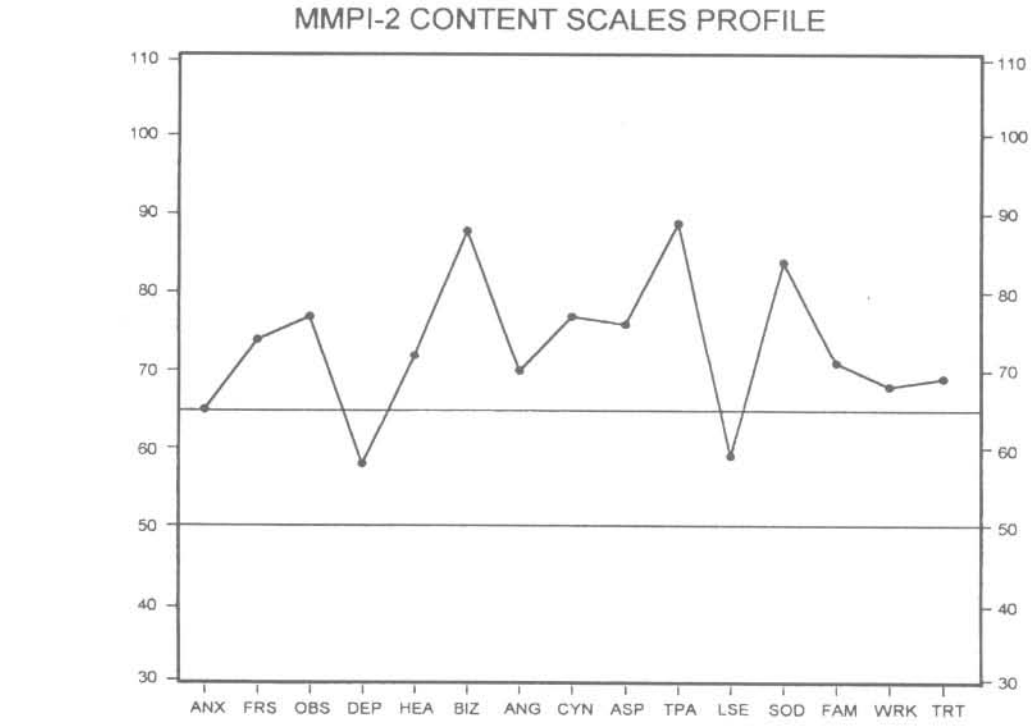
Welsh Code (old): 8*6"45029'7-1/3: F'"-/L?:K#

Profile Elevation: 63.80

Megargee Classification (Rev.): Charlie, High

*MDS scores are reported only for clients who indicate that they are married or separated.

Figure 8



	ANX	FRS	OBS	DEP	HEA	BIZ	ANG	CYN	ASP	TPA	LSE	SOD	FAM	WRK	TRT
Raw Score:	12	11	13	8	15	13	12	21	17	19	8	22	13	17	12
T Score:	65	74	77	58	72	88	70	77	76	89	59	84	71	68	69
Response %:	100	100	100	100	97	100	100	100	100	100	100	100	100	100	100

5.3.9.7 Supplementary score report

Table 11

	Raw Score	T Score	Resp %
Anxiety (A)	24	70	100
Repression (R)	15	50	100
Ego Strength (Es)	22	30	100

Dominance (Do)	11	31	100
Social Responsibility (Re)	13	32	100
Post- Traumatic Stress Disorder- Schlenger (PS)	27	71	100
Depression Subscales (Harris- Lingoes)			
Subjective Depression (D1)	12	64	100
Psychomotor Retardation (D2)	6	54	100
Physical Malfunctioning (D3)	5	67	100
Mental Dullness (D4)	2	48	100
Brooding (D5)	5	68	100
Hysteria Subscales (Harris- Lingoes)			
Denial of Social Anxiety (Hy1)	1	34	100
Need for Affection (Hy2)	0	30	100
Lassitude- Malaise (Hy3)	1	43	10
Somatic Complaints (Hy4)	5	62	94
Inhibition of Aggression (Hy5)	4	55	100
Psychopathic Deviate Subscales (Harris- Lingoes)			
Familial Discord (Pd1)	4	65	100
Authority Problems (Pd2)	5	60	100
Social Imperturbability (Pd3)	0	30	100
Social Alienation (Pd4)	10	82	100
Self- Alienation (Pd5)	9	77	100
Paranoia Subscales (Harris- Lingoes)			
Persecutory Ideas (Pa1)	11	106	100
Poignancy (Pa2)	6	76	100

Naivete (Pa3)	2	36	100
Schizophrenia Subscales (Harris- Lingoes)			
Social Alienation (Sc1)	12	88	100
Emotional Alienation (Sc2)	1	50	100
Lack of Ego Mastery, Cognitive (Sc3)	4	66	100
Lack of Ego Mastery, Conative (Sc4)	1	44	100
Lack of Ego Mastery, Defective Inhibition (Sc5)	8	96	100
Bizarre Sensory Experiences (Sc6)	11	95	100
Hypomania Subscales (Harris- Lingoes)			
Amorality (Ma1)	3	58	100
Psychomotor Acceleration (Ma2)	7	58	100
Imperturbability (Ma3)	0	30	100
Ego Inflation (Ma4)	9	89	100
Social Introversion Subscales (Ben- Porath, Hostetler, Butcher, & Graham)			
Shyness/ Self- Consciousness (Si1)	12	71	100
Social Avoidance (Si2)	7	67	100
Alienation- Self and Others (Si3)	12	71	100

Uniform T scores are used for Hs, D, Hy, Pd, Pa, Pt, Sc, Ma, and the Content Scales; all other MMPI-2 scales use linear T scores.

5.3.9.8 Experimental content component scales (Ben- Porath & Sherwood)

Table 12

	Raw Score	T Score	Resp %
Fears Subscales			
Generalised Fearfulness (FRS1)	6	98	100
Multiple Fears (FRS2)	5	56	100
Depression Subscales			
Lack of Drive (DEP1)	2	51	100
Dysphoria (DEP2)	3	68	100
Self- Depreciation (DEP3)	2	55	100
Suicidal Ideation (DEP4)	0	45	100
Health Concerns Subscales			
Gastrointestinal Symptoms (HEA1)	3	83	80
Neurological Symptoms (HEA2)	7	87	100
General Health Concerns (HEA3)	2	56	100
Bizarre Mentation Subscales			
Psychotic Symptomatology (BIZ1)	4	91	100
Schizotypal Characteristics (BIZ2)	7	86	100
Anger Subscales			
Explosive Behaviour (ANG1)	4	64	100
Irritability (ANG2)	7	72	100
Cynicism Subscales			
Misanthropic Beliefs (CYN1)	13	68	100

Interpersonal Suspiciousness (CYN2)	8	71	100
Antisocial Practices Subscales			
Antisocial Attitudes (ASP1)	13	69	100
Antisocial Behaviour (ASP2)	3	59	100
Type A Subscales			
Impatience (TPA1)	6	68	100
Competitive Drive (TPA2)	9	76	100
Low Self- Esteem Subscales			
Self- Doubt (LSE1)	2	49	100
Submissiveness (LSE2)	6	83	100
Social Discomfort Subscales			
Introversion (SOD1)	15	79	100
Shyness (SOD2)	6	68	100
Family Problems Subscales			
Family Discord (FAM1)	6	65	100
Familial Alienation (FAM2)	1	49	100
Negative Treatment Indicators Subscales			
Low Motivation (TRT1)	5	71	100
Inability to Disclose (TRT2)	5	75	100

5.3.9.9 Critical items

The following critical items have been found to have possible significance in analysing a client's problem situation. Although these items may serve as a source of

hypotheses for further investigation, caution should be used in interpreting individual items because they may have been checked inadvertently.

The percentages of endorsement for each critical item are presented in brackets following the listing of the item. The percentage of the MMPI-2 normative sample of 1,138 men who endorsed the item in the scored direction given.

5.3.9.9.1 Acute Anxiety State (Koss- Butcher Critical Items)

Of the 17 possible items in this section, 8 were endorsed in the scored direction:

5. I am easily awakened by noise. (True)

[N=41.4]

59. I am troubled by discomfort in the pit of my stomach every few days or oftener. (True)

[N= 6.7]

140. Most nights I go to sleep without thoughts or ideas bothering me. (False)

[N= 22.6]

218. I have periods of such great restlessness that I cannot sit long in a chair. (True)

[N= 30.1]

223. I believe I am no more nervous than most others. (False)

[N= 15.6]

301. I feel anxiety about something or someone almost all the time. (True)

[N= 14.8]

444. I am a high- strung person. (True)

[N= 21.9]

463. Several times a week I feel as if something dreadful is about to happen. (True)

[N= 4.4]

5.3.9.9.2 Depressed Suicidal Ideation. (Koss- Butcher Critical Items)

Of the possible items in this section, 6 were endorsed in the scored direction:

71. These days I find it hard not to give up hope of amounting to something. (True)

[N= 30.7]

146. I cry easily. (True)

[N= 12.9]

215. I brood a great deal. (True)

[N= 14.6]

233. I have difficulty in starting to do things. (True)

[N= 35.2]

518. I have made lots of bad mistakes in my life. (True)

[N= 27.3]

524. No one knows it but I have tried to kill myself. (True)

[N= 1.5]

5.3.9.9.3 Threatened Assault (Koss- Butcher Critical Items)

Of the 5 possible items in this section, 3 were endorsed in the scored direction:

37. At times I feel like smashing things. (True)

[N= 39.4]

213. I get mad easily and then get over it soon. (True)

[N= 0.45]

389. I am often said to be hotheaded. (True)

[N= 16.9]

5.3.9.9.4 Situational Stress Due to Alcoholism (Koss- Butcher Critical Items)

Of the 7 possible items in this section, 4 were endorsed in the scored direction:

264. I have used alcohol excessively. (True)

[N= 44.5]

487. I have enjoyed using marijuana. (True)

[N= 34.2]

502. I have some habits that are really harmful. (True)

[N= 27.8]

518. I have made lots of bad mistakes in my life. (True)

[N= 27.3]

5.3.9.9.5 Mental Confusion (Koss- Butcher Critical Items)

Of the 11 possible items in this section, 3 were endorsed in the scored direction:

32. I have had very peculiar and strange experiences. (True).

[N= 23.8]

311. I often feel as if things are not real. (True)

[N= 8.3]

316. I have strange and peculiar thoughts. (True)

[N= 14.9]

5.3.9.9.6 Persecutory Ideas (Koss- Butcher Critical Items)

Of the 16 possible items in this section, 13 were endorsed in the scored direction:

42. If people had not had it in for me, I would have been much more successful. (True)

[N= 4.1]

99. Someone has it in for me. (True)

[N= 5.0]

124. I often wonder what hidden reason another person may have for doing something nice for me. (True)

[N= 29.2]

138. I believe I am being plotted against. (True)

[N= 2.4]

145. I feel that I have often been punished without cause. (True)

[N= 9.1]

216. Someone has been trying to rob me. (True)

[N= 2.6]

228. There are persons who are trying to steal my thoughts and ideas. (True)

[N= 3.8]

241. It is safer to trust nobody. (True)

[N= 19.7]

251. I have often felt that strangers were looking at me critically. (True)

[N= 23.8]

259. I am sure I am being talked about. (True)

[N= 18.4]

314. I have no enemies who really wish to harm me. (False)

[N= 11.6]

333. People say insulting and vulgar things about me. (True)

[N= 6.2]

361. Someone has been trying to influence my mind. (True)

[N= 4.3]

5.3.9.9.7 Antisocial Attitude (Lachar- Wrobel Critical Items)

Of the 9 possible items in this section, 7 were endorsed in the scored direction:

27. When people do me wrong, I feel I should pay them back if I can, just for the principle of the thing. (True)

[N= 26.7]

35. Sometimes when I was young I stole things. (True)

[N= 58.0]

105. In school I was sometimes sent to the principle for bad behaviour. (True)

[N= 30.9]

227. I don't blame people for trying to grab everything they can get in this world. (True)

[N= 39.9]

240. At times it has been impossible for me to keep from stealing or shoplifting something. (True)

[N= 6.6]

254. Most people make friends because friends are likely to be useful to them. (True)

[N= 23.8]

266. I have never been in trouble with the law. (False)

[N= 40.9]

5.3.9.9.8 Family Conflict (Lachar- Wrobel Critical Items)

Of the 4 possible items in this section, 1 was endorsed in the scored direction:

21. At times I have very much wanted to leave home. (True)

[N= 31.9]

5.3.9.9.9 Somatic Complaints (Lachar- Wrobel Critical Items)

Of the 23 possible items in this section, 10 were endorsed in the scored direction:

33. I seldom worry about my health. (False)

[N= 37.1]

53. Parts of my body often have feelings like burning, tingling, crawling, or like "going to sleep". (True)

[N= 18.8]

59. I am troubled by discomfort in the pit of my stomach every few days or oftener. (True)

[N= 6.7]

111. I have a great deal of stomach trouble. (True)

[N= 6.1]

142. I have never had a fit or convulsion. (False)

[N= 7.2]

159. I have never had a fainting spell. (False)

[N= 27.0]

164. I seldom or ever have dizzy spells. (False)

[N= 9.2]

229. I have had blank spells in which my activities were interrupted and I did not know what was going on around me. (True)

[N= 7.5]

255. I do not often notice my ears ringing or buzzing. (False)

[N= 21.7]

295. I have never been paralysed or had any unusual weakness of any of my muscles. (False)

[N= 14.5]

5.3.9.9.10 Sexual Concern and Deviation (Lachar- Wrobel Critical Items)

Of the 6 possible items in this section, 5 were endorsed in the scored direction:

12. My sex life is satisfactory. (False)

[N= 26.7]

34. I have never been in trouble because of my sex behaviour. (False)

[N= 19.3]

121. I have never indulged in any unusual sex practices. (False)

[N= 36.9]

166. I am worried about sex. (True)

[N= 15.1]

268. I wish I were not bothered by thoughts about sex. (True)

[N= 21.0]

5.3.9.10 Omitted items

The following items were omitted by the client. It may be helpful to discuss these item omissions with this individual to determine the reason for noncompliance with the test instructions.

47. I am almost never bothered by pains over my heart or in my chest.

258. I can sleep during the day but not at night.

5.3.9.11 Summary of the MMPI-2

Profile Considerations: This profile should be interpreted with caution. There were some indications that the picture presented was an exaggeration of the individual's present situation and problems. His response style can indicate the following: poor reading ability, confusion, disorientation, stress, or a need to seek a great deal of attention for his problems. Clinical patients with this type of validity profile are often confused and distractible and have memory problems. Evidence of delusions and thought disorder may be present. He may be experiencing a high degree of distress and personality deterioration. This individual's high- point clinical scale score (Pa) occurs in 9.6% of the MMPI-2 normative sample of men, with only 2.2% having such well defined Pa spikes. This elevated profile configuration is very rare in samples of normals, occurring in less than 1% of the MMPI-2 normative sample of men. This profile is more common in prison samples, with 7.9% of state prisoners and 11.7% of federal prisoners having Pa scale spikes at or above a T score of 65. The elevated scales are likely to be prominent even if retested at a later date.

Interpersonal Considerations: People with a similar profile are most likely to have disturbed interpersonal relationships. He may feel socially inadequate, has poor social

skills, avoids close relationships and may view others as unfriendly or threatening. He tends to be very suspicious of others. In his interpersonal relationships he tends to feel insecure and is hypersensitive to rejection, becoming easily jealous at times. He would need a great deal of reassurance in his relationships. Due to such problems he may become self- absorbed and if married may find marital relationships problematic, with marital break ups common.

These difficulties make him a fairly introverted person who has difficulty meeting and interacting with others. He would tend to be shy and emotionally distant when in the presence of others. In social situations he will be uneasy, rigid, and over controlled.

Diagnostic Considerations: On this tests a possible diagnosis of schizophrenia should be investigated, possibly of a paranoid type, or a paranoid disorder. According to the Megargee typology, he falls into the Type C offender who is often seen as distrustful, cold, irresponsible, and unstable. They also tend to have antisocial, aggressive and hostile attitudes towards others. They tend to engage in violent crimes against other people and usually have an extensive criminal record. They also tend to come from deviant and stressful home environments and typically have a great deal of difficulty adjusting to society.

The following was indicated as a possible DSM-IV diagnosis for this individual:

Axis I: Schizophrenia, possible Paranoid type, or a Paranoid Disorder

5.3.10 The 16 Personality Factor Questionnaire

Table 13

Low	1 2 3 4 5 6 7 8 9 10	High	Scale	Raw	STEN	Adjusted
Aloof	1 2 **3** 4 5 6 7 8 9 10	Warmhearted	A	4	2	3
Concrete	1 2 3 4 5 **6** 7 8 9 10	Abstract	B	8	6	6
Unstable	1 2 3 4 5 **6** 7 8 9 10	Stable	C	13	4	6
Humble	1 2 **3** 4 5 6 7 8 9 10	Assertive	E	9	3	3
Serious	1 **2** 3 4 5 6 7 8 9 10	Enthusiastic	F	6	2	2
Undependable	1 2 3 4 5 6 **7** 8 9 10	Conscientious	G	16	7	7
Shy	1 2 **3** 4 5 6 7 8 9 10	Adventurous	H	4	2	3
Tough Minded	1 2 3 4 5 6 **7** 8 9 10	Sensitive	I	8	6	7
Trusting	1 2 3 4 **5** 6 7 8 9 10	Suspicious	L	12	6	5
Practical	1 2 3 4 5 6 7 **8** 9 10	Imaginative	M	18	8	8
Unpretentious	1 2 3 4 5 6 **7** 8 9 10	Shrewd	N	14	7	7
Confident	1 2 3 4 5 6 7 8 **9** 10	Apprehensive	O	20	10	9
Conservative	1 2 3 4 **5** 6 7 8 9 10	Liberal	Q1	8	5	5
Group Dep.	1 2 3 4 5 6 7 8 9 **10**	Self- Suff.	Q2	19	10	10
Uncontrolled	1 2 3 4 **5** 6 7 8 9 10	Self- Control.	Q3	8	4	5
Relaxed	1 2 3 4 5 6 7 8 **9** 10	Tense	Q4	22	10	9

5.3.10.1 Warnings

There is an indication that this respondent may have distorted some responses negatively. These results may be contaminated due to this subject having responded

randomly to the items. Deal with these results carefully, there is an indication of overall pathology which requires examination.

5.3.10.2 Broad clinical dimensions

This report is based on the interplay between two factors, degree of adjustment and the degree of inner control.

Adjustment Factors: Individual number 2 shows a very low level of emotional adjustment and is likely to have grave difficulties coping with life as he apparently lacks access to the appropriate emotional resources. In explaining this, his slightly elevated threat- sensitivity, expressed as slight shyness, suggests that he is likely to react somewhat fearfully to a wide range of situations. Secondly, he is apprehensive and prone to emotional disturbances as a result of poorly developed defence systems. This is evidenced by a limited ability to remain unaffected by pressure or criticism. Thirdly, he reports a high number of tension- related symptoms. This indicates either his poor ability to deal with environmental stress or that he is currently experiencing extreme pressure. In either case, he is pressure- sensitive.

Control Factors: In this case, an average level of overall emotional restraint is predicted. More specifically, he is somewhat realistic about life. This reflects an average ability to exercise emotional restraint and to draw on inner resources when confronted by emotionally charged situations. Secondly, he is rather well socialised and has a rather good ability to determine what is conventionally right and wrong in various situations. This suggests some level of social restraint over the expression of his emotions. Lastly, he has some set standards of conduct to which he conforms thus

showing an average level of internalised social norms. This may suggest an ability to reference his behaviour against these and so to exercise some degree of restraint.

Patterns of Social Interaction: His pronounced introversion on the high- order scale suggests a strong drive away from social interaction moderated by a somewhat cold or indifferent attitude toward other people, a strong preference for independence from social groups, an introspective, very cautious and inhibited lack of communication, and shyness and a tendency toward emotional restraint and constricted affect.

By itself, rather low warmth may be suggestive of some cynical distortion of reality and a rather pessimistic view of life. This is often found in people who have a history of dissatisfying or hurtful relationships. In the face of reduced emotional adjustment, the likelihood of social withdrawal is increased, as is a feeling of bitterness toward others. The possibility exists that he may project his own problems onto others. Furthermore, the possibility exists that he has been dominated in the past and has withdrawn to some degree as a result. This hints at feelings of helplessness and self-pity. His consistently very cautious approach to life further increases the tendency toward social withdrawal as a means of controlling his fear. This suggests that he is very afraid of making a fool of himself which, in turn, suggests low social competence. What is more, his need for safety and predictability has probably led him to become rather cautious as other people may introduce insecurity and danger to which he may prefer the relative safety of isolation. Lastly, a pronounced need to be socially independent strongly suggests withdrawal from any form of group interaction whenever possible.

Having mentioned his disregard of social groups and his need to be self- sufficient, note that this also implies a rejection of group norms and a tendency to be non-conforming in many areas of his life. His disregard for group affiliation constitutes a temperamental withdrawal response rather than a need for self- sufficiency. This is quite probably the result of a range of pathological processes. With moderate degree of insight, he will tend to listen to the advice of others (even of he doesn't always accept it) which may be of more value than resolutely doing his "own thing". With only an average level of interpersonal trust, the possibility that he will experience group involvement as threatening from time- to- time cannot be excluded. In any event, he has a very poor self- perception and avoids group membership out of a fear of rejection. This may be explained by his belief that he is unworthy of being part of a group and he may simply avoid being rejected.

It is likely that he will take life far too seriously and hardly ever "loosen up' or laugh. In such cases of "fearful inhibition", it is important to look for a history of punishment and failure. As he has an average control factor, this inhibition is possibly the result of his personal history. It is possible that such inhibition plays some part in the maintenance of self- control. With an average level of insight, however, he should be able to perceive social relationships without too much difficulty thus rarely making social blunders. As he is an extremely apprehensive person, the inhibition he displays may result from a very negative self- perception and the presence of guilt or shame. Inhibition could then result from a fear of exposure and retribution.

As he has a strong need for security and certainty in his life, he will tend to establish obsessive routines for doing things and to have an extremely high concern that others

approve of what he does. He will usually rehearse actions beforehand. It is likely that he is rather withdrawn and possibly shows paranoid tendencies. He will tend to avoid attention out of fear that others will disrupt his hard won security and safety. Clearly, this points to some feeling of insecurity. Rather high submissiveness in this context may indicate the presence of suicidal tendencies as he will feel unable to do anything about his insecurity. He is, however, neither particularly suspicious nor trusting of others but may be wary, watching for signs that they will violate his sense of security and safety. Such violations will prompt him to avoid dealing with people. Lastly, he is very deeply conflicted as far as inhibition is concerned. More specifically, a very introspective aspect which clashes with a low degree of inhibition suggests some form of heroic fantasy existence verging on psychosis. Again, poor adjustment moderates this entire analysis and suggests that his coping skills are severely compromised.

Identifiable Psychological Processes: With a slight degree of emotional instability, there are distinctly pathological signs in this profile which require additional discussion. In the light of extreme feelings of personal inadequacy, this is almost certainly related to self- reproach which will be associated with guilt. Phobic symptoms can be expected to emerge under these conditions. Furthermore, this individual may lack a sense of self because of low dominance and simply move from encounter to encounter while never really expressing any opinions or ideas. As he is rather insecure and intuitive, imagined problems are often created in the absence of any present difficulties. Often resultant from a highly protected childhood, this points to poorly developed defences and a tendency toward anxiety disorders. There is reason to believe that this individual will become depressed and even physically ill very easily and will approach interactions or events with extreme caution.

The following composite scales may clarify this profile:

Table 14: Composite scales

Depressive:	9
Obsessive:	6
Manic:	4
Anxious:	9
Socially Phobic:	8
Paranoid:	7
Antisocial:	3
Passive- Aggressive:	7
Socially Dependent:	3
Socially Avoidant:	8
Narcissistic:	4
General Pathology:	5

The depressive personality pattern is characterised by a low level of self- esteem and a consequent apprehensive view of the future, a tendency to be introspective and fearful of failure, and a strong cynical distortion of reality characterised by some degree of coldness towards other people. Classically, one would expect him to report a fatigued state accompanied by hypersomnia, poor concentration and feelings of hopelessness and despair. There are a number of factors which are of importance in this class of affective disorder and which provide guidelines in assessing a therapeutic process. Feelings of extreme failure and helplessness are likely to accompany depression and are quite possibly due to unexpressed anger or anger "turned inwards". An excessively

harsh socialisation process underlies feelings of worthlessness and extreme fear of failure. There is likely to be some evidence of bitterness towards the past which will require you to take a fairly extensive history. There is little doubt that this client is in a state of deep "psychological" pain and is likely to worry about problems to the point of exhaustion. Born of crippling self- doubt, feelings of shame, guilt and self-deprecation are quite likely. Here, a major focus will have to be the reframing this self- directed negativity if any therapeutic process is to be successful.

The Anxious personality pattern, characterised by a high level of apprehension and symptoms of tension, is complex in its associations as it can result from a wide range of factors and their interplay. Accompanied by significant indication of depression, agitated depression is suggested. In this case, the remarks pertaining to depression presented above will also apply. It would be advisable to examine this client for evidence of fearful paranoid fantasies as there is an indication that he is not always in touch with conventional reality. Also, examine the use of alcohol or narcotics in alleviating anxiety as an addictive personality is suggested here. Showing an extreme disaddiliation from society, he may be anxious as a result of an inability to form meaningful relationships with groups of people. Such personally enforced isolation is very uncommon and probably requires examination.

The socially phobic pattern is characterised by low emotional stability linked to extreme shyness. This may be found separately or linked to the socially avoidant pattern which is often used as a means of controlling anxiety which is resultant and which is socially crippling. A number of primary factors can be used to determine the exact nature of this pattern.

The paranoid personality profile is indicated by a cold, cynical attitude towards people and a very pronounced suspicion about their real intentions towards him. Characterised as jealous and often aggressive, he will avoid intimacy, resent criticism and rather blame others. This is often found to be associated with chronic CNS impairment, obsessive conditions and abuse of stimulants (amphetamines). Such people rarely seek treatment although they may be quite disturbed. As this client is somewhat detached from reality, it is likely that any revenge fantasies are quite elaborate and that this disorder assumes psychotic elements. Delusions of grandeur and a false sense of self- importance may be quite pronounced. As this is accompanied by a strong avoidance of group interaction, it is quite likely that groups are blamed and suspected of plotting against him.

The passive- aggressive pattern is identified by very low assertiveness and high suspicion. Anger builds up inside as it cannot be adequately expressed and suspicion and blaming of others then leads this to being expressed in ways which satisfy the need to punish the "wrong doers" while not directly involving him. This is significantly amplified by a tendency to loose touch with reality as this , once again, introduces some psychotic aspects into his behaviour as imagined events trigger the assault on the 'guilty' others.

Characterised by a profound shyness, hypersensitivity and low self- esteem, the socially avoidant pattern suggests a person who prefers to avoid social interaction rather than face social disapproval even though they have a great need for interpersonal involvement. This is often accompanied by high anxiety scores as a

result of the tension between the need to approach others on the one hand, and the need to avoid social rejection on the other.

5.3.10.3 Summary of the 16-PF

Profile Considerations: There were indications that this individual distorted some responses in a negative manner and some items were possibly answered randomly. There was a warning indicating a strong possibility of overall pathology.

Interpersonal Considerations: This individual shows a very low level of emotional adjustment and likely to have difficulty copping with life as he apparently lacks access to the appropriate emotional resources. What seems as slight shyness, suggests that he is likely to react fearfully to a wide range of situations. Due to poorly developed defence systems he will likely be prone to emotional disturbances. This is evidenced by a limited ability to remain unaffected by pressure or criticism from others. He also reports a wide range of tension- related symptoms possibly due to his inability to deal with such situations, or environmental stress.

He appears to have an average level of emotional restraint, he appears to be fairly well socialised and possesses an ability to determine what is conventionally right and wrong in various situations. He appears to have some set of internalised norms which guide his behaviour, this can suggest an ability to reference his behaviour against these and so to exercise some degree of restraint.

He is a pronounced introvert and moves away from social interaction, moderated by a somewhat cold and indifferent attitude towards other people. He has a strong

preference for independence from social groups, and an introspective, cautious and inhibited lack of communication. He tends to wards emotional restraint and constricted affect.

His low warmth and pessimistic view of life is often found in people who have a history of dissatisfying or hurtful relationships. He may project his own problems onto others. The possibility exists that he has been dominated in the past and has withdrawn to some degree as a result. This helps create a very cautious pattern of interpersonal interaction, him possibly fearing making a fool of himself, thus suggestive of low social competence.

His disregard for social groups and need to be self- sufficient also implies a rejection of group norms and tendency to be non- conforming in may areas of his life. This disregard for group affiliation constitutes a temperamental withdrawal response rather than a need for self- sufficiency. He avoids group membership out of fear for rejection. He has a strong need for security and certainty in his life and may tend to establish obsessive routines. He will avoid conflict that could threaten his safety and security, his submissiveness may indicate the presence of suicidal tendencies.

Diagnostic Considerations: Due to a low level of emotional adjustment he experiences a number of tension related symptoms. The may be a result of or causal factor in his pronounced introversion. Linked to this is a cynical distortion of reality and rather pessimistic view of life. This pessimism is linked to a bitterness towards others. Previous interpersonal disappointments lead him to experience feelings of helplessness and self- pity This causes him to avoid group membership out of fear of

rejection. These are closely linked to his negative self- perception. By projecting this onto his environment he adopts a paranoid outlook on the outside world. Due to his feelings of insecurity and submissiveness he is a prime candidate for suicidal tendencies. To transcend his position he may make use of some form of heroic fantasy existence which verges on psychosis.

Anxiety seems to play a strong role in this person's life, this can be possibly generated by the conflict between his history of disappointment with others and a need for reinforcement from others. Submissiveness can be a tool whereby he avoids conflict and therefore negative feedback, and also tries to obtain the approval of others. Accompanied with the anxiety in this whole process, is a strong depressive mood. He often expresses physical complaints which can be a result of the anxiety and depression sprouting from his ineffective interpersonal style. He may also experience fatigue, hypersomnia, poor concentration and feelings of despair. Any anger accompanying his depressed mood may be directed inwards, hence some of the somatic complaints and suicidal tendencies. Alcohol and narcotics can be a means to help him relieve anxiety, or as a means of facilitating his interpersonal interactions.

Chapter 6

Discussion of Results

6.1 Integration and summary of results for individual number 1

Individual number 1 is a single Afrikaans speaking South African male in his mid- thirties. From his competency to stand trial evaluation it was determined that he was not experiencing any medical problems that were related to his crime. He was deemed fit to stand trial and was processed by the justice system. He is currently incarcerated in a facility of the South African Department of Correctional Services. He is of average intelligence as determined by the South African Wechsler Adult Intelligence Scale, and had completed a high- school level education. Since leaving high- school he has been gainfully employed. He reports no familial conflict as a child, only that his mother was a more dominant figure than his father. His parents are still married and he is an only child.

Initial clinical impressions describe a neatly- dressed person, who was well groomed. He came across as reasonably confident during the interview process. One of the strongest initial impressions was that of 'aloofness' experienced by the interviewers, this creates the impression of emotional distance in the relationship. During the interviews that followed, no signs of thought content problems or thought process problems were detected. Nor did the individual ever express any subjective psychological problems. The prison system had also not received any complaints about his behaviour. He is aware of and able to recount the events surrounding his crimes.

Interpersonal considerations: Interpersonally he comes across as slightly distant and aloof. He appears to struggle for words at times, as if he lacks the vocabulary to express himself, especially

in the realm of emotions. At times he may even be abrupt, possibly due to the anxiety provoking nature of the questions, and this therefore acts as a protective mechanism from anxiety.

He perceives relationships as being distant and unemotional, the perception he creates is that he cannot really understand the purpose of relationships, and therefore at times seems to become easily bored by relationships. He seems void of any internal guideline for interpreting events and relationships, this creates the impression he tries to behave as though he thinks he is supposed to behave, as if he is following a 'manual' on how to behave, without the insight to support his actions. It is almost as if someone were to ask him why he was behaving a certain way he wouldn't be able to explain the social rationale for behaving in that manner. Due to this his social skills are poor. His aloofness may be a means to protect himself from the emotions he keeps under the surface. Since he can be overly sensitive and resistant to the demands of other, he tries to stay aloof, but can also deal with the situation by using a form of dependency as a means to avoid anxiety. It is almost as if there is no 'middle ground' in his relationships. There is either an avoidance of a relationship or a form of dependency where he will be submissive towards others authority, but not an emotional dependence. Being submissive, conceding authority to someone, helps him to avoid conflict and the accompanying anxieties. There is no 'emotional sharing' in this type of dependency, it is more like a protective mechanism. The focus in this type of dependency is not the relationship but rather what the behaviour helps him avoid, that being anxiety.

These behaviours in turn create a vicious circle where he prevents himself from learning and developing more appropriate social skills to deal with problems more effectively, this creates a game- without- end, as he must either avoid relationships or be in the shadow of a dominant

person, whose behaviour helps maintain this pattern. Group settings are largely avoided by this person, perhaps because he has not developed an effective coping mechanism for such settings, and most likely will not venture to do so unless forced into such a setting. In such a setting he would most likely take on the role of the passive, silent observer, whose only contributions would be safe social comments when directly approached, he will most likely go along with what the majority or leader(s) of the group decide. His overall pattern of withdrawal, by the two approaches discussed above, are either the result of, or the cause of his lack of his concern with societal norms. Without any involvement in 'society' by making contact with individuals, there is slight possibility of him developing and learning appropriate norms.

Diagnostic considerations: More diagnostically, there are no clear problems which can be discussed as distinct entities. At times antisocial traits seem present, such as mentioned on the MMPI-2, but from his history and the test material there are no clear indications. His emotionless manner and risk- taking behaviour surrounding the crimes, can be forced into an antisocial category, but this may be rather due to societal inclination to pathologise behaviour. The fact that he did commit the crimes can also be seen as antisocial behaviour, yet there is no clear historical pattern in this individual to make a definite conclusion regarding an antisocial personality disorder diagnosis and crime, even murder, is not necessarily an indication of personality pathology. It may be more accurate to say that his personality structure has certain antisocial features.

One test, the MMPI-2, did mention the possibility of a schizophrenic process, but at no times during the competency to stand trial evaluation, testing or interview process, which lasted over a period of 2 years, were any signs noted subjectively or objectively, therefore the possibility of

psychosis at the time of the crimes and during incarceration cannot be prominently regarded. The most distinct diagnostic features appear to be a pervasive depressive mood, possibly of a dysthymic type, with symptoms of anxiety. Whether these two are part of the personality structure or separate entities is unclear. It is also unclear if they are rather due to the prison environment or not. On the other hand, depression and anxiety are such common features in our society that the could not solely be used to explain the phenomenon of serial murder. It is the authors supposition that the depressive and anxiety signs are resultant of his ineffective interpersonal style, which could be heightened by the prison context, and should not be seen as separate diagnostic entities, independent of his interpersonal style. He at times experiences somatic complaints, which could linked to his inability to successfully deal with the sources of his interpersonal anxiety.

6.2 Integration and summary of results for individual number 2

Individual number 2 is a divorced Afrikaans speaking South African male in his late thirties. From his competency to stand trial evaluation it was determined that he was not experiencing any medical problems that were related to his crime. He was deemed fit to stand trial and was processed by the justice system. He is currently incarcerated in a facility of the South African Department of Correctional Services. He is of average intelligence as determined by the South African Wechsler Adult Intelligence Scale, and had completed a high- school education plus three years of post- school technical training. Since leaving high school he was employed in various positions on a full- time basis. Since leaving school he has had four jobs averaging a duration of 3 years per job. The only family conflict experienced as a child, was being sexually abused by his brother and his brother's friends from the age of 10 until the age of 15. His parents are still married. He has a reported history of alcohol, cannabis and methaqualone (mandrax)

abuse.

Initial clinical impressions describe a meticulously dressed individual, who came across as confident, yet cautious in his interaction. During the initial contact interview both observers experienced the confident image as a facade, and began to sense a more dependent stance. During the contact interview and the interviews that followed, there were no signs of thought process or content disturbances. There were no problems indicated by Department of Correctional Services personnel and he had the highest level of privileges available to prisoners.

Interpersonal considerations: Interpersonally he comes across as a person who is easily influenced by others, this pattern repeated itself in his interpersonal relations before and after his incarceration. It seems as if he is aware that he lacks the interpersonal skills to assert himself in interpersonal relations, and hence has to try and regulate it by withdrawing socially. This social withdrawal is in itself a source of anxiety since he has an emotional need to be with others. It is as if he has two poles of influence, his family on the one hand who represent a positive influence, and other prisoners and other criminal elements before incarceration, on the other hand. Depending on which pole he is leaning to, he thrives on the 'positive' attention he receives. It is as if he must receive 'positive- regard' from some source, like an addiction, and it doesn't matter from which source it comes from when the 'craving' arrives. When he is satisfying his 'craving' from a negative source, such as a person with less than honest intent, it often is accompanied by emotional and sometimes physical abuse, much like a battered spouse pattern of behaviour. When he is receiving his attention from a 'positive' source he is quite able to function in a socially acceptable manner. This individual is currently functioning very well in the prison structure, where he receives regular praise from wardens and the pupils he teaches.

This pattern of behaviour has led to many interpersonal disappointments in the past. It seems as if he has learnt to perceive most relationships in this manner, this also causes his to withdraw, thus preventing him from learning the necessary social skills to effectively develop a relationship. The repeated failures appears to have fostered a paranoid perception of people's motivations. He tends to be very insecure and hypersensitive in relation to others. He has already had one failed marriage. The interpersonal withdrawal has also hampered the development of effective coping skills, thus furthering his already present anxiety. Substances may have been a means to controlling his anxiety and to boost his interpersonal functioning. His expectation of interpersonal failure often precipitates the cycle, thus encouraging him to further withdraw. Any aggression he may experience could be expressed in passive- aggressive means, or directed inwards, fostering self- pity and a sense of personal unworthiness.

Diagnostic considerations: Diagnostically, there are no clear problems which can be discussed as distinct entities. While the possibility of schizophrenia was mentioned on one test, the MMPI-2, there were never any thought process or content disorders detected. Upon enquiry as to the experiencing auditory hallucinations the individual mentioned that he had once experienced what could best be described as a hypnagogic hallucination, when he would hear someone call his name just before falling asleep. It is possible that his strong paranoid ideas with regards to relationships, could have elevated this scale. Depression and anxiety seem to be strong themes, there is also a history of two suicide attempts in his past, and treatment for what he termed as "stress" and "insomnia". The anxiety he experiences seems to be chronic, it is quite possible that he reacts to his anxiety with somatic complaints, having been treated for ulcers since the age of 16. It is unclear whether the anxiety is a diagnostic entity separate from his depression or not. It is also unclear whether the depression and anxiety would exist in the absence of his poor

interpersonal skills, as one test, the MCMI-III, succinctly mentions "anxiety seems to play a strong role in this person's life, this can be possibly generated by the conflict between his history of disappointment with others and a need for reinforcement from others". There also appears to be mention of a traumatic incident, separate to his overall anxiety, that could still be having residual effects, although this was never specifically mentioned in the interviews held. It therefore appears as if the main thrust of any diagnostic considerations lie in the realm of personality, characterised by social withdrawal as a means of coping, not choice, suspicion of others, and long standing depressive outlook. Alcohol and narcotics have been used in the past, these may have been with the intention of moderating anxiety, or providing him with the feeling of control in interpersonal relations that he lack when not under the influence of a substance.

6.3 Case similarities and literature comparison

It is not the intention of this research to generalise its results, but to rather act as a starting point in compiling interactional data on individuals who commit serial murder, and to begin making descriptions with a scientific reference point in the form of standardised research tools in the form of psychometric tests and interviews. There do however appear to be certain strong similarities between the two individuals described here. While most literature seems to focus on psychosis or psychopathy as a means of describing serial murder, these may not be the only avenues to explore. Both these individuals seem to be troubled by depressive moods and anxiety. Also, restricted patterns of interpersonal behaviour appear to be prevalent in both individuals. While the motivation may differ, they both seem to be highly ineffective in interpersonal situations, and withdrawal acts as a means of trying to cope with the difficulties experienced when faced with, or when trying to avoid, such situations. This is hampered by dependency needs experienced by both individuals. While feeling inadequate, they both desire some form of

acceptance from an outside source, and may therefore enter into a submissive type of relationship. While individual number 1 may do so to avoid the conflict and anxiety accompanying interpersonal relations, individual number 2 may enter a dependent position to obtain the emotional 'connection' he needs. Therefore the reduction of anxiety seems to govern a large part of these individuals' interpersonal behaviour.

While both have elements that can be a criteria for the description of antisocial personality disorder, there are other criteria that are not 'present'. There is also no strong evidence, in these two individuals, of any form of psychosis. Perhaps it would be more accurate to say that, much like with any population in our society- male, female, black, white, young and old- one would have an incidence of mental disorders, yet not all members of that class will have a mental disorder. One should therefore be careful about trying to ascribe labels that appear in one individual, to all individuals, as if there is only one 'right' or accurate explanation. Human behaviour is far too complex and our environment far diverse to accurately pinpoint criteria to define who or what a serial murderer is.

There are certain characteristics that are shared with the literature on serial murder. Similar to McElroy (1999) who stated that amongst the psychological features of 36 men convicted of sexual offences, 81% had substance abuse histories, 61% mood disorders, and 36% anxiety disorders, out of these two individuals both had mood disorders in the form of depressions of varying degrees and anxiety was a strong feature in both. Wallace et al. (1998) also states that substance abuse is closely associated with violence. Only one of the two individuals here reported having a history of substance abuse. Milton (1997) reports that individuals who commit sexual homicide experience lifelong isolation and a lack of heterosexual relationships, in this study both

experienced interpersonal isolation. Meloy (2000) and Myers and Blashfield (1997) indicate that most individuals who commit serial murder experience cluster A traits- schizoid, paranoid, schizotypal being more common. These two individuals experienced traits that could be best described as avoidant, schizoid, and paranoid, thus overlapping with Meloy and Myers & Blashfield's statements. Meloy also states that most weren't sexually abused, which is the case with one of the individuals in this study. Myers and Blashfield also say that of 14 juveniles who committed sexual homicide under the age of 18, twelve had displayed Axis I pathology such as substance abuse, anxiety and dysthymia. In this study both experienced anxiety and depressive symptoms, and one experienced substance problems. Furthermore, most experience psychotic features but not consistently enough or seriously enough to warrant a diagnosis of a psychotic disorder, a similar pattern was experienced here with both individual's having schizophrenia being mentioned on at least one of their tests, but no clear consistent psychotic features being reported in the other tests and interview situation. Furthermore, in contrast to much of the literature, catathymia was not reported, there were no violent fantasies reported, no reports of animals being tortured or killed, and no history of a conduct disorder during childhood nor adolescence.

Similar to Ansevics and Doweiko's (1991) findings, both were in their late twenties when the murders began, both had approximately 13 years of education, and both individuals had IQs falling in the normal range. What was dissimilar to their findings were, both were NG- Church members, as opposed to Roman Catholic and Born Again in their study, neither had a history of family violence, one had a history of sexual abuse where Ansevics and Doweiko reported that 9% had a history of sexual abuse. Neither reported using violent pornography, and neither had a sexual fetish.

Meloy (2000) states that most victims are not consensual sexual partners but in one case in this research one victim was. Furthermore he reports that victims tend to be of the same race, where these individuals both had people of different races as their victims.

6.4 An interactional conceptualisation of serial murder

6.4.1 Reciprocal causality

Because each behaviour in an interaction functions as both cause and effect, linear relationships are difficult to pinpoint and may be arbitrary. They are primarily a matter of how the interactants perceive or punctuate their interaction. Therefore, how the serial murderer and the investigator, or profiler punctuate the interaction will determine what they see. A cyclic pattern has been described in certain serial murder cases, whereby a build up of anxiety leads to a catathymic condition whereby the anxiety is released through the murder. While cyclic in nature it only relates to two factors; anxiety and murder. What events take place in between, the perceptions and interactions and other behvaviours are largely ignored. While sounding like a very plausable explanation it does not however address the situation where, after arrest, serial murderers stop killing. If one replies that the fact that there are no women present in prison so therefore the opportunity to kill is denied, then one is implying that the situation has an impact on the person and the outcome of his behaviour, that is, the environment can help or hinder in the creation of a murder. If the concept of catathymia implies an uncontrollable build up of anxiety then what happens to that anxiety in prison? Does it not exist, is it not acted upon, is it displaced? If it can be displaced, or not acted upon then are we as researchers missing key factors in our understanding of serial murder. Is it because of the way that researchers punctuate serial murder that only certain explanations become plausable?

6.4.2 Communicational concepts

All behaviour is a message. A victim would perceive the serial murderer's behaviour as meaning one thing while an investigator, society or academic would perceive it as meaning another. Depending how one defines the system one may determine different messages from the murder. The serial murderer may receive a certain message determined by how he or she punctuates the interaction. With the killing of the victim he may receive the message "I am powerful" or "I am successful", this is reinforced by any benefits he or she receives from committing the murder. These benefits may be intrapsychically in the form of reduced anxiety, increased anxiety that relieves boredom, or sexually, or by the gratification received from notoriety in media reports.

If one expands the system to include the criminal justice system the message can include one of a meta- commentary of "the criminal justice system is ineffective". An even larger system would include society where the message may be one of "what state is society in that such murders can take place".

If one looks at the roles that each individual plays in serial murder, each is only defined by the actions of the other. A 'killer' without a victim is not a killer, likewise, a victim is only a victim if there is an attacker. To further illustrate this point here is an example. In a hostage situation there are two factions; the hostage takers and the hostages. The relationship is defined as such because one group (the hostage takers) wants to forcefully retain another group (the hostages) against their will. The relationship and therefore definition would change dramatically if the hostages all threatened to commit suicide. The hostage takers would have to change their roles to caretakers to ensure that the hostages survive, since without hostages they cannot be hostage takers. These changes in the relationship change the definition of the relationship. In relation to

serial murder, the victim must be unwilling to die, and the killer must kill, otherwise the role-players haven't played their part. These roles therefore form certain interactional patterns of behaviour, in accordance with the 'rules' of that relationship.

If one looks at these interactional patterns, one can begin to define them in terms of complementary and supplementary relationships, of which there appear to be elements of both. By continual exchanging of messages the relationship is defined, as one member tries to gain control over the definition and therefore the relationship. In terms of serial murder the killer gains control over the relationship by means of force that leads to the violent capitulation of the victim. This is complementary in that the killer is in a one- up position over the victim who is in a one-down position. It is only through the overt use of force that the killer creates this definition. This definition is complementary in nature. It can be hypothesised that this indicates a rigidity of the killer's system.

The murders may seem in contrast to the interpersonal behaviour described in this research. Where this research describes an almost dependent person in interpersonal interaction, thus placing the killer in a one- down position in his or her normal interpersonal interactions, the murders forcefully alter that position, by means of, and resulting in, the death of the victim. This can indicate an inability to allow new information, the victim, and his or her effect on the killer, to be integrated into the system of the killer. This leads to an ineffective interpersonal style where the killer makes use of an ineffective attempted solution to solve his 'problems'.

6.5 Ideas regarding serial murder as part of man's social order

One of the aims of the research, as mentioned in chapter 4, was to "investigate the findings and formulate ideas of possible theoretical explanations of serial murder as part of man's 'social order'" (Haley, 1967).

To arrive at a more definite conclusion for this statement, it seems essential that the total social system needs scientific investigation and scrutiny, rather than concentrating on 'parts of the whole' that is, certain elements within the system, such as the crime or the perpetrator's behaviour. From an interactional point of view the question needs to be answered in order to arrive at an understanding of serial murder and society, that is, what function does serial murder serve in society, not only in its immediate environment, but in society as a whole.

This study's literature survey and research endeavour suggests certain links between serial murder and society. Some of these are the fact of the psychological impact (anxiety, depression, phobias, interpersonal problems and post- traumatic stress disorders) on society; that the perpetrators are most often males and the victims in society are most often females; that the relationship between victim and assailant is usually that of a stranger.

Without specific support to arrive at definite conclusions on these points, one can say that in general:

i) The effect of serial murder can not be ignored; that it has major psychological effects, and even a pathological impact on society;

ii) the murderer has a voice, which is generated by the media and its tools of communication, written word (newspapers) the spoken word (radio) and visually,

as means of interaction, and

iii) that it is not only the serial murderer as an individual, or his or her family which is pathogenic, but that the whole social system, where serious crimes are committed regularly, that is pathological.

6.6 Critique and recommendations on the research

This research, like many other in the field of serial murder, is hampered by certain limitations. Firstly, the limited size of the research sample prevents generalisation of the results. Secondly, the context of the correctional facility can play a role in the way that information is shared between the researcher and participant.

In terms of recommendations, similar studies using the actual individuals who commit serial murder should be conducted to help determine if these are patterns of behaviour that occur frequently in other such individuals. Secondly, comparison between different population groups would be necessary since serial murder is committed by people of various racial backgrounds. These results should then be compared to determine if there are any universal patterns of behaviour.

6.7 Recommendations regarding the field of serial murder

A more thorough investigation into the interpersonal background of these individuals could shed new light on this phenomenon. Examining these individuals family interaction could also prove to be fruitful by placing the individual's behaviour in a broader context. This would also allow researchers to determine if there are any patterns of interaction unique to the development of a person who commits serial murder. Such an approach would ideally involve members of a multi-

disciplinary team including psychologists, social workers, psychiatrists, anthropologists and sociologists. It is suggested that each team member then focus on viewing the problem from their unique viewpoint, since the researcher's experience is that if one person tries to juggle these roles it makes integrating the collected information extremely difficult.

6.8 Conclusion

Durkheim (British Centre for Durkheim Studies, 1994) states that as society becomes more diverse and parameters become broader, as is the case with rapidly changing societies, it becomes more susceptible to crime. This has been evidenced in South Africa in the move from an apartheid to post- apartheid society. The overall increase in crime and possible ineffectiveness of government services to manage the problem had made boundaries become blurred. This helps create a sense of anonymity which makes a ripe playing field for serial murder. Thus a change in the ecosystem leads to new phenomenon appearing or mutating. Furthermore, serial murder, according to Jenkins (1994) has become politically, emotionally and financially important. The label of serial murderer supersedes any other labels a person might have, creating a mythological image, an image which cannot 'die'. This mythological image, in a capitalist society, becomes very useful: it sells newspapers, movie tickets, books and even contributes to academia in such 'noble' causes as Doctoral research. It becomes even more useful in self development for the researcher if he or she publishes articles in scientific journals. Clearly serial murder has become too powerful to ever die, its usefulness extends beyond individuals until it creates a life of its own. So, although its face may change, all involved contribute to its existence. Thus with our noble facades we too become predators for our own benefit.

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Appendix 1

Research Agreement

Ek, die ondergetekende (meld volle voorname en van)

_____

'n Meederjarige persoon, verklaar hiermee myself bereidwillig on vrywillig en sonder vergoeding deel te neem aan die voorgenome navorsingsprogram oor die verskynsel van moord, onderneem deur Mnr GN Labuschagne.

Die onderneming is onderhewig aan die voorwaarde dat alle inligting as vertroulik hanteer sal word en dat my identiteit te alle tye beskerm sal word. Ek is bewus dat die navorsings program sal uit psigometriese toetse en onderhoude bestaan.

Derhalwe onderneem ek om geen aksies, regsgedinge, eiese, skade vergoeding, kostes en uitgawes van watter aard ookal teen bogenoemde persoon in te stel of te verhaal indien hy die voorwaardes hierin vermeld, nakom.

Geteken _____ op hede dag van _____ 199____

As Getuies

1. _____

2. _____ _____

Handtekening van Deelnemer

Appendix 2

South African Wechsler Adult Intelligence Scale Results

Individual number 1

Verbal Tests			Practical Tests		
	Raw Score	Scale Score		Raw Score	Scale Score
1. Information	10	8,8	1. Picture Completion	14	12,5
2. Comprehension	12	10,5	2. Object Assembly	18	10
3. Arithmetic	3	6,5	3. Block Design	30	12
4(a) Digits Forward	5	-	4(a)Digit Symbol 90"	50	12,5
4(b) Digits Backward	4	-	4(b) Digit Symbol 120"	-	-
4(c) Digits Combined	9	8,5	5. Picture Arrangement	12	11,5
5. Similarities	9	7,5	TOTAL PRACTICAL	-	58,5
TOTAL VERBAL	-	41,5	PRACTICAL IQ	-	117-1 **(116)**
VERBAL IQ	-	83-1 **(84)**	CATEGORY	-	Above Ave.
CATEGORY	-	Below Ave.	***FULL SCALE***	-	***100***
Vocabulary	-	N/A	***CATEGORY***	-	***Normal***

Individual number 2

Verbal Tests			Practical Tests		
	Raw Scores	Scale Scores		Raw Scores	Scale Scores
1. Information	12	9,0	1. Picture Completion	15	14,5
2. Comprehension	7	7,5	2. Object Assembly	13	7,0
3. Arithmetic	7	9,5	3. Block Design	25	7,5
4(a) Digits Forward	7	-	4(a) Digit Symbol 90"	31	8,5
4(b) Digits Backward	4	-	4(b) Digit Symbol 120"	-	-
4(c) Digits Combined	11	10,5	5. Picture Arrangement	16	14
5. Similarities	19	12,5	TOTAL PRACTICAL	-	51,5
TOTAL VERBAL	-	49	PRACTICAL IQ	-	**103**
VERBAL IQ	-	**98**	CATEGORY	-	Normal
CATEGORY	-	Normal	***FULL SCALE IQ***	-	***100,5***
Vocabulary	-	N/A	***CATEGORY***	-	***Normal***

Appendix 3

Thematic Apperception Test Protocols

Individual number 1

Card 1

Picks card up, 6 seconds, puts down

"OK, um, wel ek dink um die seun uh, um lyk of hy dink hoe om die ding te speel of, of miskien het hy, uh, dit gebreek of something, dat hy nou sit en kyk, nou wonder wat nou moet hy nou doen of something en hy kan nie 'n besluit neem of something, of hy dink oor wat hy moet doen.."

OK en wat het voor dit gebeur?

Picks up card again

"Voor dit?...um wel, of miskien weet, het hy nou nie goed gespeel nie, um, en hul vir hom gesê hy moet oefen, of something, en hy's nou nie miskien lus daarvoor nie."

Puts card down

En wat gaan na dit gebeur?

"Na dit gebeur? " [picks card up] "OK, um, miskien gaan hy nie meer lus wees om dit, weet, te oefen, of wat ook al, of te speel of whatever nie, of, ja...en dis al wat ek kan dink as die prentjie lyk"

Card 2

Picks card up

"OK, um...uh, al drie persone lyk my is met hulle eie dinge besig hierso, uh, op die plaas... uh die man is met hard besig om sy lande te ploeg, uh, die meisie sy gaan, lyk my gaan kerk toe of skool toe of something...en dan staan die vrou daar, sy's seker nou moeg gewerk, en uh, want sy's nou verwagtend, ok, en um bly sy maar seker, of staan maar net by die land om by, naby die man te wees en ok, voor dit nie, uh, ek weet nie [laughs] wat voor dit gebeur, hulle het maar, seker maar net van die huis af gekom... of sy het, die meisie het miskien, miskien die ouers gegroet of wat ook al, en vorentoe, ok, hulle, so, ook die vrou lyk nie baie gelukkig nie ek weet nie, en die dogter ook nie...sy's, sy, miskien gaan sy maar net omdat sy half gedwing voel om te gaan..."

Card 3BM

Picks up, frowns, 6 seconds

"Umm, lyk maar half,uh, die vrou, seker maar 'n teleustelling gehad het of 'n... uh... of maar seker maar 'n kar en daar lê die sleutels... Uh, haar boyfriend het haar seker maar haar af gese en ek weet nie sy's, ek weet nie of sy gaan opstaan na die tyd nie, of wat, of sy net daar gaan bly of wat ook al... miskien gaan sy besluit om [frowns and pulls card closer] wat is die? Wat is dit? 'n Vuurwapen of wat is daai?" [points]

Nes U wil

"Uh, uh, sleutels, ok, se maar sleutels, miskien gaan sy ry iewers heen en van haar verlies of something ontslae te raak."

Puts card down

Card 4

Picks card up, 2 seconds

"Uh,....(4 seconds), uh, wel dit lyk soos, ok...man of vrou of 'n... wat miskien 'n woorde stry gehad het of miskien, uh, het uh, hy moet nou miskien 'n, 'n, 'n, werk gaan doen of something, nou probeer hy van haar wegkom of, of sy wil nie hê hy moet weggaan nie of something, uh, hul lyk gelukkig so ek weet nie, lyk maar net of hulle, jy weet uh, net 'n gewone gesprek gehad het en hy moet nou iets gaan doen of something. Voor dit het hy net, seker maar net kom sê 'dag' whatever, koffie kom drink en something. En na die tyd, weet nie, hy sal seker weer terugkom, ek weet nie [laughs, puts card down].

Card 6BM

Picks card up, 3 seconds

"Wel... en... ja lyk of, uh, ok, iets fout is hierso...en... miskien het hy, um, teruggekom huis toe, die seun en dan die ma tee, um, of, um, miskien is die vader dood en uh, hulle het nou, hy het nou gekom huis toe om die begrafnis by te woon. Wat hy vorentoe gaan, seker... bywoon, en want lyk nie baie gelukkig nie, ok, voor dit soos ek gese, is pa dood of something, uh, ja omdat hulle, ok, hulle is elkeen met hulle eie gedagtes besig soos hulle hierso staan jy weet."

Puts card down

Card 7BM

Picks card up and frowns

"Uh... um..ok lyk my daar is 'n pa en seun wat nou bymekaar is en, uh, ok... lyk of die seun 'n bietjie nors is en die pa, hy het nog, hy, of die seun borsel met 'n ding by hom, en die, en die pa probeer seker maar deur die seun, deurdring maar lyk nie of hy baie suksesvol is nie. En voortgelyk, uh, en die, die seun het seker gekuier of something, of uh, of uh, 'n probleem iewers

gehad of whatever, na, en verder wat vorentoe sal ek se miskien sal hulle, uh, die pa se liefde is seker maar die probleem wat hy het, en miskien maar oplos, of miskien nie, ek weet nie, kan nie eintlik se hierso nie."

Card 8BM

Picks up, 8 seconds, frowns

"Wel hier lyk, uh, uh so 'n operasie, ok, want die ou het hom seker self geskiet. Voor dit, die ou het nou seker geskiet, nou is hulle besig in die hospitaal met 'n operasie maar dit lyk of hy nou, uh vorentoe, lyk dit of hy nou, of nou sy gees hierso opgaan of opvaar na die hemel toe of something of ookal [laughs] uh hulle is nou hard besig maar ek weet nie of daar iets gekoppel, so ek kan sien of hy nou wel lewe of nie sien, en dit is dit [smiles]."

Card 10

Picks card up, 10 seconds

"Uh, ok, um, ok die man en vrou, seker maar 'n woordewisseling gehad en hulle het na besluit om vrede te maak... want hulle hierso mekaar vashou... uh, en vorentoe sal hulle seker maar nog steeds gelukkig wees want hulle lyk of hulle nou al diep in die jare is en lank getroud is en se maar 50 jaar getroud of something."

Card 12M

Picks up, 2 seconds

"Uh, ok [frowns], uh... hierso... uh... is die, die seun het seker maar, uh, siek geword, uh of van die huis, hy was in die skool en toe nou van die skool afgekom want hy lyk of hy nog sy skoolklere aan het of something. En dan die, miskien is dit die pa of die dominee wat vir die seun kom bid, of miskien is hy dood want dan lyk of hy gaan um, hm, se, ok sy oë is toe, wat seker

maar, seker maar seker die seën op hom of something."

Card 13MF

Picks up card, frowns, 10 seconds

"Uh, wel lyk of, uh... die vrou ook maar dood is of some... whatever... die ou hel of die man of something, nee ek weet nie, jy kan nie eintlik se van wat sy dood is nie, wat ookal... en dan die man het seker nou net by haar gekom en gevind dat sy nou dood is, of wat ookal, en hy is nou baie teleurgesteld daaroor... ja ek weet nie wat vorentoe, hy sal maar seker maar weer aangaan met sy lewe ek weet nie of miskien sal nie dit kan hanteer nie... [wipes brow]."

Individual Number 2

Card 1

5 Seconds

"Uh...jong seun...hy dink moet hy speel...wat gaan hy speel? Hy kan nou dink... miskien aan 'n pa, of dit miskien sy pa s'n was, dis miskien herinnering aan sy pa, of iemand in sy verlede... dis basies dit."

En wat het voor dit gebeur?

"Voordat hierdie geneem is? [ja]... uh... wel basies daar kan miskien soos ek gese, dit kan miskien iemand wees wat... 'n herinnering wil vasgelê het. Dis maar basies dit."

En wat ga na dit gebeur?

"Ek dink dat as dit 'n herinnering was, sal die kind daai nou vat en dit wegbêre, miskien êrens in 'n vertoon kas sit. En as dit die foto wat geneem is, sal dit miskien êrens bewaar."

Card 2

18 seconds

"Twee vroumense, een man. Een vrou wat hierso staan, vertoon wragtig swanger. Dis swaar jare wat hulle beleef, want die vrou hier, aan die voorkant, pas nie in by die kleredrag. Hulle kleredrag en die styl van die woonarea, dis asof die vrou, vir my, sy staan buite, met haar rug gedraai. Met ander woorde dis iets vir my, wat hier agter gebeur is 'n herinnering vir die vrou, dis iets waar aan sy terugdink. Dit kan moontlik haar ma en haar pa wees waaraan sy terug dink en... sy kyk vorentoe, jy weet, in die toekoms maar sy wil terugkyk na die verlede en dis basies wat ek sien met hierdie prentjie."

Card 3BM

4 seconds

"Eerste ding wat ek hierso sien is... hartseer, bedrukte, die persoon kan moontlik 'n verslaafde wees aan iets. Uh, die manier wat dit, wat dit sit, die bene, en die manier wat die, wat die arm een kant le, ek kan nou nie presies opmerk wat hier is nie maar dit lyk vir my asof daai miskien 'n vuurwapen kan wees. Dit kan miskien inspuiting wees, ek is nie so seker nie wat dit is daai nie, maar dit wys vir my net basies wat ek sien is 'n, is 'n verslaafde, iemand wat heeltemal moed opgegee het, maar ek sien niks verder nie."

Card 4

6 seconds

"Hierdie laat my so, hierdie laat my eintlik baie dink aan my kinderjare nou weer, jy weet. Wanneer my ma altyd met my pa probeer praat het, die gesigs uitdrukking is tipies my pa, koud jy weet, daai "Ek wil niks met jou te doen hê nie". Dit is wat hy basies hier sê. Sy smeek, sy praat mooi, en hy wil niks, hy draai sy kop weg... En as dit , as dit 'n verhouding is dan is die toekoms

vir hulle ...daar's nie, daar's nie kontak nie, die kontak is gebreek, die feit dat hy weg kyk. Hy wil niks weet nie... en jy sien nie hartseer in sy oe nie, met ander woorde dis bitterheid, daardie gesig spreek van bitterheid, afsydigheid. Dis basies wat ek sien."

Card 6BM

5 seconds

"'n Moeder en haar seun, dis wat ek hier sien. 'n Moeder wat staan, die seun het verkeerd gedoen... of... dit kon iemand wees wat slegte tyding vir haar gebring het. Maar wat ek basies hier opmerk is dit kan 'n seun wees wat vra, hy het iets verkeerd gedoen maar hy, kyk na die manier wat hy die hoed in sy hande hou, jy weet, lyk dit asof hy vra om verskoning, vir iets wat hy gedoen het, maar sy's, sy's, sy's koud, sy's afsydig, want daars nie hartseer nie. Jy sien net bitterheid op haar gesig, daars nie trane, daars nie, daars niks nie, by hom sien jy, jy sien die erns, daai 'asseblief', daai oe wat neerkyk. Dit is basies wat ek hier sien."

Card 7BM

4 seconds

"'n Pa en 'n seun... al twee... is ernstig, jy weet. Maar die feit dat die pa na die seun kyk, wys dat as jy eintlik na hulle liggame kyk dan sien jy hulle is eintlik langs mekaar, met ander woorde dit wys vir my dat hulle, hulle is saam. Kan moontlik dat die pa in 'n gesprek is met die seun en die seun luister aandagtig na die pa, hulle is miskien erens op pad want al twee die liggame wys soontoe, met ander woorde hulle kan miskien besig wees om te loop. Dis basies dit."

Card 8BM

7 seconds

"Hierdie laat my dink aan 'n boek wat ek gelees het [chuckles], jy gaan nou dink dis snaaks, maar,

uh dit het gegaan oor, uh, ek weet nie hoe, hoe stel 'n mens dit nie, um, waar die persoon, want ek kan nou nie die gesig nou mooi daar duidelik sien nie maar dit kan moontlik wees... dat die kind is moontlik dieselfde persoon wat daar lê. Dat hy miskien nou uit sy liggaam uit is, jy weet, die gees is uit, en hoe hy toe kyk op hoe, dis miskien 'n operasie wat op hom, op hom uitgevoer word want daar is 'n strook van lig, met ander woorde, dit kan moontlik wees dat die kind nou, jy weet, die gees uit die liggaam uitgaan, jy weet, en dat hy wil nie terugkyk op dit wat was nie, hy wil net vorentoe kyk. Dit is basies wat ek sien."

Card10

5 seconds

"Twee dinge sien ek hier, een- 'n man en 'n vrou wat... mekaar omhels, jy weet, blydskap, maar dit kan ook wees dat dit, dat die man die vrou probeer vertroos. So dis een van twee dinge wat ek sien... dis basies dit."

Card 13MF

6 seconds

"Hier... wat ek sien is ek sien uh... die man het berou, het iets verkeerd gedoen. Hetsy dit nou net gewone gemeenskap was met die vrou, hetsy moontlik die vrou verkrag het? Hetsy die vrou doodgemaak het? Maar jy kan sien dat hy berou het. Hy weet hy het iets verkeerd gedoen, jy weet, dit kan ook moontlik wees dat sy net dood is en dat hy net op haar liggaam afgekom het. Maar jy kan duidelik sien, jy weet, dat die feit sy hand voor sy oë sit wys dat hy het seer binne in hom, daar is hartseer, of hy het, of hy dit nou verkeerd gedoen het of hy op haar liggaam afgekom het. Maar ek sien niks versteurend uit die kamer nie so dit lyk nie na 'n, na 'n verkragting of enige iets wat verkeerd gegaan het, so dis moontlik dat die vrou of miskien selfmoord gepleeg het of oorlede is, die moontlikheid bestaan. Dis dit."