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Violence Without Thought or Memory

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Abstract

Understanding mental states in criminal defendants who have committed extreme homicidal violence invokes perspectives from neurobiology, psychoanalytic theory, and personality assessment. Individuals who commit extreme violence frequently claim to have no awareness or recollection of their violent actions. This paper examines violence without thought or memory—with a special focus on rage-type murder—through the lens of the neurobiology and neuroscience of affective violence, clinical and forensic personality assessment, and clinical case history. A forensic case study is presented of an extreme violent homicide perpetrated by a 14-year-old youth who killed his foster mother, including a psychological evaluation and a mental state at the time of the offense assessment. The multiperspectival assessment demonstrates conceptual, scientific, and theoretical resources to describe primitive mental states in the assessment of extreme violence. These perspectives are foundational to present compelling scientific evidence in courts of law and to advance understanding of extreme human behavior.

Introduction

Forensic psychologists working in the criminal arena are frequently tasked with conducting *competency to stand trial* and *penal responsibility* evaluations. The latter evaluations require a *retrospective mental state at the time of the offense* evaluation (Rogers & Shuman, 2000; Melton et al., 2007), evaluating the defendant's mental capacity pertaining to a legal insanity standard. Understanding mental states and their relationship to the commission of a criminal offense, especially if it involves interpersonal violence, requires an in-depth understanding of the precipitants and correlates of violent behavior. This paper examines reactive or affective, especially homicidal, violence, focusing on sudden or *rage-type murder* (Cartwright, 2002). Contemporary neurobiology, neuroscience, and psychological theories that illuminate sudden rage-type violence are described, accompanied by a case study of a catathymic matricide (Schlesinger, 1996) perpetrated by a 14-year-old male.

Alexithymia Theory

Psychoanalytic theory makes profound contributions to understanding affective violence. Alexithymia has been identified as a clinical phenomenon with application to violent behavior. Despite the massive literature that has ensued on alexithymia, the primary sources remain most helpful. These sources include the work of Sifneos, Nemiah, Krystal, Taylor, and Bagby. The alexithymia concept originated with Sifneos (1973). Nemiah et al. (1976) articulated a sophisticated theory of emotion. They identified emotional experience as having a neurophysiological and motor-expressive component, and feelings as a subjective, cognitive-experiential component. Emotions must be represented mentally to be experienced consciously as feelings, a process referred to as "psychic elaboration." This includes several elements, including:

> A refinement and delineation of raw emotions into a variety of qualitatively different nuances that have the potential for conscious experience as feelings; a linking of the feelings with words to describe them; the production of images and fantasies expressive of the feelings; and the arousal of memories and associations related to the feelings. It is assumed that an awareness of feelings, together with the thoughts, fantasies, and memories they elicit, facilitates regulation of the emotional arousal induced by affect-evoking stimuli. (Nemiah, 1977)

In their discussion of the neurobiology of alexithymia, Lane and colleagues (2015) proposed an alternate term—affective agnosia—to describe a condition that involves a deficit in the ability to mentally represent the meaning of emotional responses, which requires the integration of information from multiple interoceptive and somatic sensory modalities. They argued that such impairment in the mental representation of emotion, at the most severe end of the continuum, is more accurately conceptualized as an affective agnosia.

Alexithymia, or affective agnosia, is a form of "blindsight"[1] (Lane et al., 1997, 2015), such that the neural basis of alexithymia may consist of a disconnection syndrome in which subcortical emotion-generating mechanisms do not communicate adequately with cortical mechanisms, including the anterior cingulate cortex (ACC), involved in explicit processing. Several studies have found evidence that alexithymia is associated with altered ACC activity. Affective agnosia consists of a failure to engage the medial prefrontal cortex (PFC) areas involved in conscious experience and representation of emotional distress, and the inability to hold this information in mind for complex cognitive processes such as mentalization and goal-directed action selection. Not merely a repressive coping style, the lack of emotional experience due to top-down-inhibitory functions is due to a developmental failure in the capacity for a high-level mental representation and experience of emotion in the rostral ACC and dorsal medial PFC. Lane et al. (1997, 2015) concluded their model with the assertion that alexithymia may include a deficit in the mental representation of emotion, supported by emerging neuroimaging findings that suggest impairments in emotional awareness rather than emotional naming (anomia).

Emotion is the organism's direct evaluative experience of the organism-environment experiential field, furnishing the basis for awareness of that which is adaptively important (Acklin, 1992). In alexithymia, the emotions are not experienced as "distinct, separate, specific responses to a varied and identifiable nature" (Krystal & Krystal, 1988, p. 42). The affects are limited to physiological activation with minimal ideational representation; nor do they provide meaning or significance to interactions through diminished reflective self-awareness. As such, alexithymia represents a defect in the organism–environment relationship, and consequently, a risk factor for problems in adaptation (Acklin, 1992).

The Neurobiology of Violent Behavior

Two major types of human aggressive behavior have been distinguished (Meloy, 1988, 2006): affective and instrumental. Affective violence is characterized by intense emotional arousal, like anger or fear, in response to a perceived threat. Instrumental or predatory violence is

[1] "A corollary of this model is that failure to establish high level representations of one's emotional state (associated with lack of engagement of the medial prefrontal cortex, for example) could well result in the simultaneous inability to know what one is feeling and visceral dysregulation resulting in adverse physical disease outcomes" (Lane et al., 2015, p. 600).

aggressive behavior with reduced emotional reactivity that looks premeditated and deliberate. Analysis of the mechanisms of inducing reactive aggression in mammals in response to a threat provides experimental evidence linking aggression and fear (Blair, 2012).

Affective aggression is exhibited in all mammalian species, and appears to be mediated through the amygdala–hypothalamus–periaqueductal gray (the basic threat system), regulated by the orbital, medial, and ventrolateral frontal cortices (Blair, 2012). Raine and colleagues (1998) used PET scans to distinguish affective and predatory murderers. Affective murderers have lower prefrontal and higher subcortical activity than comparisons; predatory murderers have prefrontal levels similar to nonclinical comparisons, but with excessive subcortical activity. These findings have been validated in a variety of clinical syndromes having increased risk of aggression, e.g., intermittent explosive disorder (IED; Cocarro et al., 2007), PTSD, and borderline personality disorder (Silva et al., 2001).

White et al. (2019) provided a cogent summary of the neuroscience of reactive aggression focused on the basic threat system:

1. Reactive aggression is a response to a threat, mediated by a basic threat system.
2. The basic threat system is activated in response to social provocation, leading to an increased risk for reactive aggression.
3. The basic threat system is activated in response to frustration leading to an increased risk for reactive aggression.
4. Instrumental aggression is the result of a failure to represent harm to others as aversive and to utilize this information during decision-making.
5. Psychiatric populations at increased risk for aggression show dysfunction in one or more of the neurobiological systems underpinning aggression.
6. The neural systems underpinning reactive and instrumental aggression can be activated simultaneously.

The emotional substrates of impulsive or affective aggression implicate the amygdala, hippocampus, hypothalamus, ACC, insular cortex, ventral striatum, and other interconnected corticolimbic structures. The amygdala is activated in situations that connote threat and general negative affect (Davidson et al., 2000). Stimulation and lesion studies using fMRI have confirmed the role of the amygdala and paralimbic prefrontal regions, including the dorsal, ventral, orbital, and medial prefrontal cortices. Mechanisms for suppressing negative emotion operate through an inhibitory connection from areas of the PFC, probably from the orbital frontal cortex (OFC) to the amygdala. Serotonin-rich tracts in the PFC are implicated in emotion regulation. These are regions of the brain inversely associated with activation of the amygdala. The inability to regulate negative emotion may result from impairment in the capacity of the PFC to inhibit emotional activation arising from subcortical structures (Seo et al., 2008).

Cocarro and colleagues (2007, 2011) demonstrated a link between amygdala–OFC dysfunction and impulsive aggression in subjects with IED, finding exaggerated amygdala and diminished OFC reactivity to faces conveying anger in IED subjects relative to controls. In addition to cortical–limbic findings in aggression, neuromodulatory hypotheses have emerged linking the interactions of canonical neurotransmitters dopamine, serotonin, and GABA. Serotonin facilitates prefrontal cortical regions, such as the OFC and ACC, that are involved in modulating and suppressing the emergence of aggressive behaviors primarily by acting on serotonin 5–HT2 receptors (Siever, 2008). Gabaminergic reactivity and GABA receptors also reduce subcortical

reactivity; therefore, reduced gabaminergic activity can increase aggression. Several studies implicated D2 receptor subtype in the mesocortical 5–HT receptor subtypes have emerged to be significant targets for antiaggressive interventions (de Almeida et al., 2005). Methamphetamine's affinity for dopaminergic function has been linked to the level of aggressive social behavior (Seo et al., 2008). The limbic dopamine system is involved in threat perception and the preparation, execution, and consequences of aggressive acts. Serotonin hypofunction may represent a biochemical trait that predisposes individuals to impulsive aggression, with dopamine hypofunction contributing in an additive faction to serotonergic deficit.

Alexithymia and Violence

Alexithymia and the associated impairment in emotional regulation has been linked to violent behavior (Krystal, 1979; Nemiah, 1978). Nemiah (1978) formulated the clinical features of alexithymia based on his observations and the clinical formulations of others. He described people with alexithymia who display sudden outbursts of tears, aggression, violence, or destructive behavior that end as unexpectedly as they began. There was seemingly no premeditation, fantasy, or thought before the outburst. Henry Krystal (1979), researching psychotherapy in Holocaust survivors, reported clinical observations of alexithymic patient's proneness towards abrupt outbursts of rage that ceased almost as suddenly as they began. Upon questioning, individuals reported the outbursts were "for show," or an attempt to convince themselves they there were indeed experiencing something, even though they were seemingly unsure or unaware of the exact underlying emotion. Neither Nemiah nor Krystal's clinical observations of alexithymia and violence were empirically tested at the time.

An empirical study examining the association between alexithymia and violence was conducted by Keltikangas–Järvinen (1982), who hypothesized that the inability to fantasize (alexithymia) is a factor in violent acting-out. Sixty-eight male prisoners (mean age 28.5 years) convicted of violent crimes and 64 nonviolent male controls (mean age 24.1 years) were interviewed and administered the TAT and Rorschach. Interviews with the violent subjects revealed empty, brief, and sterile personalities. They described events with few words and little emotion, and their Rorschach responses were stereotyped as compared to controls. Violent subjects expressed less hostility and aggression in fantasy than did controls. Despite some limitations, Keltikangas–Järvinen's (1982) research was the first empirical study to examine the possible association between alexithymia and violent offending. Louth et al. (1998) examined psychopathy and alexithymia in a sample of 37 incarcerated females. The correlation between PCL–R and Toronto Alexithymia Scale–20 (TAS–20) total scores was not significant, but the socially deviant impulsive factor of the PCL–R significantly correlated with the TAS–20 items that reflect an inability to discriminate feelings and bodily sensations. Alexithymia, but not psychopathy, was negatively related to measures of affective speech content. Both psychopathy and alexithymia were associated with a history of violence. The authors concluded that psychopathy and alexithymia appear to be different clinical constructs despite several manifest similarities.[2, 3]

[2] Despite an underfunctioning amygdala, "specifically reduced, empathy-related amygdala responses to cues of distress in others and a deficit in VMPFC striatal circuits, psychopathic individuals have intact emotional concept representations and mentalization functions which facilitates their manipulation and deception of others…" (Lane et al., 2015, p. 605).

[3] Haviland et al. (2004), using California Q-sets, found that alexithymic and psychopathic individuals lacked empathy, insight, and introspection; alexithymics were anxious, overcontrolled, submissive, boring, ethically consistent, and socially conforming; and psychopaths were anxiety-free, undercontrolled, dominant, charming, deceitful, and non-forming.

Psychological Assessment of Alexithymia

Researchers and clinicians have utilized self-report, observer, and interview-based methods to assess alexithymia. The 20-item TAS, developed by Bagby, Taylor, and associates (Bagby et al., 1994), demonstrates strong psychometric properties, is the most used measure in alexithymia research, is widely translated, and has a voluminous research literature. In the revision of the original TAS scale, the dimension assessing imaginative representations corresponding to fantasy capacity was eliminated. The Bermond–Vorst Alexithymia Questionnaire (BVAQ), a 40-item self-report scale, examines five dimensions of the alexithymia construct: verbalizing, identifying, analyzing, fantasizing, and emotionalizing emotions (Vorst & Bermond, 2001). Several other observer rating scales for alexithymia are available: the Modified Beth Israel Hospital Psychosomatic Questionnaire originally developed by Sifneos (M–BIQ; 1973); California Q-set Alexithymia Prototype (CAQ–AP; Haviland and Reise, 1996); and Observer Alexithymia Scale (OAS; Haviland et al., 2000). There are also two structured interviews for assessing alexithymia: the Diagnostic Criteria for Psychosomatic Research–Alexithymia (DCPR–A; Fava et al., 1995) and the Toronto Structured Interview for Alexithymia (TSIA; Bagby et al., 2006).

In her investigation of alexithymia and violence, Liisa Keltikangas–Järvinen (1982) focused on projective techniques. The Rorschach Test is uniquely suited for the assessment of alexithymia. Based on the work of Vogt et al. (1977), Acklin proposed a Rorschach Comprehensive System Alexithymia Index. The index effectively distinguished psychosomatic patients, including pain patients, from normals (see Table; Acklin & Bernat, 1987; Acklin & Alexander, 1988; Acklin, 1992).

Table

Rorschach Comprehensive System Alexithymia Index

Function	Rorschach Indicator
Fantasy	Low response productivity (low R)
	Low human movement responses (M)
Affect	Restricted affective responses (Low weighted sum C)
	Poorly adapted affect (Low FC)
Cognition–perception	Concrete Cognition (low Blends)
	Perceptual stereotypy (High Lambda)
Adaptive Resources	Deficient ideational and affective assets (low EA)

Using a strict empirical methodology with psychiatric and medical patients, Porcelli and Mihura (2010) extracted three Comprehensive System scores out of 27 variables related to the alexithymia construct: Form Percent (F%), Coping Deficit Index (CDI), and Populars (P). The resulting Rorschach Alexithymia Scale (RAS) demonstrated solid reliability, impressive criterion validity with the TAS–20, and clinically meaningful significance, reflecting concrete, simplistic thinking equivalent to emotional "blindsight" (Lane et al., 1997), hyper-conventionality, poor

coping resources, and social incompetence. Surprisingly, the human movement response (M: "a critically important Rorschach alexithymia variable," Sekely et al., 2018, p. 27) did not survive the statistical analysis. Nevertheless, high F% and low or absent M suggests "the presence of the core cognitive component of alexithymia…using a perceptual–cognitive performance-based test of personality which is uniquely different than self-report and interview-based methods" (Sekely et al., 2018, p. 27). As will be seen below, these findings directly impact emotional self-control, empathy, and theory of mind.

Amnesia, Dissociation, and Violence

Bourget and Whitehurst (2007) provided a detailed and nuanced description of amnesia and crime. They provided theoretical and clinical perspectives on crime-related amnesia. They noted that dissociative amnesia has legal repercussions, due to its relevance to competency to stand trial, and criminal responsibility. There is further concern about the potential fabrication of memory loss. Moskowitz (2004) reviewed the literature on dissociation and violence, noting that amnesia for violent crimes is frequent and reported in almost a third of homicides (in some samples up to 60%), and is typically associated with a lack of premeditation, significant emotional arousal, and alcohol use. He noted that most claims cannot be easily dismissed as dissimulation. He described a clinical picture of dissociative flashback-driven violence associated with PTSD. Individuals may be traumatized by their violence, and reports of transient depersonalization or peri-traumatic dissociation may be indicators of this. Amnesia for violent crime may be a state-dependent factor, such that experiences encoded during a state of high emotional arousal, as is commonly reported to accompany homicides, cannot be generally accessed from a clinically calmer emotional state. Dissociative adolescents, particularly those who demonstrate other risk factors related to violent behavior (Meloy et al., 2001), deserve special attention.

Psychoanalytic Contributions to Understanding Violence

Fonagy (2003) linked violence with impaired mentalization. Mentalization is the capacity to reflect and think about one's mental states, including thoughts, beliefs, desires, and affect, and the ability to distinguish one's mental state from others. According to the theory of mind, in the absence of good-enough mothering during earliest infancy, the child is unable to develop a representation of their own experience, and instead internalizes the image of the caregiver. This representation is experienced as foreign or bad and will never be fully integrated into the overall schema of self-representations. The person is then forced to develop an identity around an alien persecutory internal object, or introject, that is unable to think or feel, and must be defended against by violent means.

A primary developmental role of early attachment is neurocognitive, establishing the capacity for self-mastery, achieved by creating a representational structure for mental states. Threats to self-esteem trigger violence in individuals whose self-appraisal is on shaky ground, because they exaggerate self-worth, and cannot see beyond the threats to what is in the mind of the person threatening them. Because of representational deficits, as Keltikangas–Järvinen (1982) in her study of alexithymia in murderers discovered, in many cases of reactive aggression, the person has no conscious violent fantasies. "For individuals who have a poor capacity for whole object representation or mentalization as described above, fantasy cannot be symbolized within the mind and can only be acted out in concrete form and actual violence" (Yakeley & Meloy, 2012, p. 237). In the absence of symbolic or representational experience, violence is meaningless, and

begins and ends with the visceral excitement or somatic gratification of violent penetration of another. It is violence without thought.

The expression of aggression is potentiated by the reduced capacity to mentalize; if a child is unable to see others as having mental states different from their own, this will reduce the inhibition of aggression and violence towards others, as they are unable to empathize and appreciate another's suffering. "The absence of mentalizing removes key restraints on action against both the self and other" (Fonagy et al., 2002, p. 476). When facing challenges to self-worth, and when partners refuse to be the recipient of malign projections, the return of the alien self threatens the person's fragile stability of mind, leading to unbearable feelings of shame and humiliation that cannot be managed by representational means within the mind. They experience unbearable feelings that need to be expelled in violent action in an attempt to regain control.

Rage-Type Murder

These recent developments in psychoanalytic theory, in combination with the neuroscience findings reviewed above, permit a heretofore impossible integration of psychodynamics and neurobiology in understanding violent mental states (Perelberg, 1999). Psychoanalysts have been particularly interested in distinguishing between "affective (reactive, impulsive, emotional, hot-blooded, self-preservative) and predatory (instrumental, cold-blooded, premeditated), with relatively distinctive behavioral manifestations and neurobiological underpinnings" (Yakeley & Meloy, 2012, p. 237). Affective aggression is linked to threat and anxiety, activated by frustration or threat from an internal/external object (Blair, 2012; Kohut, 1972).

Particular interest has been focused on rage-type murder, defined as murderous acts triggered by a sudden, primitive explosive affective state (Cartwright, 2002). Rage-type murders suddenly erupt when there is a collapse in a fragile defensive system (the "narcissistic exoskeleton"). Violence is the outward expression of unbearable states of mind. Rather than a simply diffuse, objectless, affective discharge, full-fledged rage "always reveals an underlying conscious or unconscious fantasy that includes a specific relation between an aspect of the self and an aspect of a significant other" (Kernberg, 1992, p. 22). Rage, at the most primitive level of object relations, removes an imminent source of extreme psychic pain, erupting as "a defensive response to the threat of self-annihilation with the aim of destroying the perceived annihilator" (Cartwright, 2002, p. 25). Glasser (1998) considered "self-preservative" violence as a primary response triggered by any threat to the physical or psychological self:

> Such threats may be external, and could include attacks on a person's self-esteem, frustration, humiliation, or an insult to an ideal to which the person is attached…The violence response is fundamental, immediate, and aimed at eliminating the source of danger. (Yakeley & Meloy, 2012, p. 235)

Sudden murders have been studied since 1950s and demonstrate a well-recognized set of developmental and personality factors. These are described as homicides in individuals with no prior evidence of violence; such acts appear senseless and motiveless, with the offender displaying a degree of dissociation during the event (Cartwright, 2002, p. 4). Rage-type murder is defined as murderous acts triggered by a sudden explosive affective state.

> "The sudden murderer is defined as a person who, without having been involved in any previous serious aggressive antisocial acts, suddenly, unlawfully, and

> intentionally kills (or makes a serious attempt to kill) another human being. The murder is "sudden" in the sense that it appears to be a single, violent, impulsive acting-out behavior—behavior that is never well thought out, behavior that has no obvious purpose or hope for personal advantage or profit foreseeable as a result." (Weiss et al., 1960, p. 669)

In the legal context, these homicides are commonly referred to as crimes of passion and fall under manslaughter statutes for extreme mental and emotional disturbance. These are affective homicides where the killing is driven by intense emotions and classified as a rage-type murder (reactive, impulsive, emotional, hot-blooded, self-preservative).

This type of homicide has also been classified as a chronic catathymic homicide (Schlesinger, 1996). Catathymic murders were first described 100 years ago to explain:

> otherwise inexplicable acts of violence committed by an individual who has a long-term relationship with the decedent. These attacks consist of seemingly unprovoked explosions of rage with accompanying agitation and destructiveness; and partial amnesia for the event commonly occurred. (Werthan, 1937; Schlesinger, 1996)

"The chronic form of catathymic homicide is recognized by a lengthy incubation period, a sudden act of killing, and a period of relief. The victim is usually an intimate (mother, spouse…)" (Yakeley & Meloy, 2012, p. 235). Crime scenes may be characterized as instrumental or expressive (Salfati, 2003; Salfati & Canter, 1999). Crime scenes in rage-type murder are typically disorganized and gory. The body of the decedent typically demonstrates evidence of overkill (Solarino et al., 2019). Wounds are directed especially to the face and head. A study of 123 single-victim, single-offender homicides (Trojan & Krull, 2012) defined injury severity by the number of wounds inflicted. Variations in frequency and location of wounds occurring during a homicide depend upon the intimacy of the victim-offender relationship. Injuries to the face and head were found to occur significantly more frequently in the intimate and family/friend categories. Characteristics of offenders loading on the expressive theme indicated a history of relationship and emotional issues. Since the killing occurred in the context of an oppressive and pathologically dependent relationship, perpetrators commonly exhibit a period of normalcy and calm after an act of violence. The perpetrator cannot give a logical explanation for the act, and in many but not all cases, they only partially recall it.

Finally, rage-type killing is commonly classified as *self-preservative violence* (Glasser, 1998). Self-preservative violence is a primitive response triggered by any threat to the physical or psychological self. The response is fundamental, immediate, and aimed at eliminating the source of danger, which may be an external object, or an attack on the person's own body. These sudden murders are often committed by inadequate, passive, dependent, and passive–aggressive individuals, who have histories of trauma and disruptions to their attachment system in childhood. Due to problems with attachment and internalization, they "are subject to unbearable feelings of shame and humiliation that cannot be managed by representational means within the mind. … Phantasies of being engulfed or attacked by the maternal object underlie the type of self-preservative violence" (Yakeley & Meloy, 2012, p. 236).[4]

[4] Yakeley and Meloy (2012) noted that "affective violence and Glasser's self-preservative violence are virtually synonymous" (p. 235).

Case Study

The Crime

The defendant, Ikaika, [5] a 14-year-old youth, violently stabbed and killed his adoptive mother with a kitchen knife and meat cleaver, and then called the police. He was referred for an evaluation (for transfer to adult court) and an assessment of his mental state at the time of the offense. He was evaluated at the juvenile detention facility over several days. He was placid, cooperative, and, according to staff, seemed to enjoy the setting and the attention he received from the correctional officers.

Honolulu Police Department arrest reports indicate that Officer Cory Gibson arrested Ikaika on July 5, 2014, at 8:10 a.m., on a Saturday morning. The offense was alleged to have occurred at 7:48 a.m. A breathalyzer test was administered on 07/05/2014 at 10:30 a.m., and the result was BAC = 0.000. Ikaika was advised of his rights at 10:44 a.m. on 07/05/2014 and again at 8:19 a.m. on 07/06/2014. He declined the offer of an attorney and made a statement, and signed waiver forms indicating the same (the Warning of Juveniles Being Interrogated of their Constitutional Rights).

Police officers were called to investigate a possible stabbing case (the following information was extracted from 911 transcripts and police reports as presented in the discovery documents, to illustrate Ikaika's state of mind). The distraught caller told the police dispatcher "that something dark came over him and his mother was on the bed with blood all over her and a knife in her stomach." Dispatch further related that "the caller said that he didn't remember if he did it or not and that he had blood all over him, had no weapons on him and that he would meet with officers." Per written reports, police officers encountered "the juvenile male who was heavily covered in blood in the living room." Officers observed a body in the room at the end of the hallway that was wedged between the bed and wall/closet. Concerning spontaneous utterances:

> I asked the juvenile male, now verbally identified as Ikaika, if he had any injuries and he said no. As I did the patdown, Ikaika kept saying: "I'm not a murderer! I don't know what happened! I went black, everything went black. How's my mom?"

The Follow-up Report stated that Ikaika kept repeating, "This wasn't me! This wasn't me! The police officer asked Ikaika, "What's wrong? Are you okay?" to which he replied, "I was going to bathe her then everything went black." When told to get on the ground, "He kept saying, 'This wasn't me! You need to handcuff me before something else bad happens!'" Police officers observed numerous severe wounds to the decedent's torso and face that appeared to be consistent with stabbing, slashing, and blunt force. Two weapons were located near the foot of the bed, a kitchen knife with a bent blade and a meat cleaver.

At 9:52 a.m., Officer Bryant transported Ikaika to the local police station after medical examination at a local emergency room. The Investigation of Death report completed by the Honolulu Medical Examiner indicated that the murder occurred at 7:45 a.m. on 07/05/2014, in the bedroom of the decedent's residence.

> The decedent, a 52-year-old Hawaiian-Japanese-Caucasian female was found unresponsive with multiple sharp force trauma wounds to her body and face from an apparent homicide and was pronounced dead at the scene. The attack took place

[5] All names have been changed to protect identities.

> in the decedent's bed. The decedent had medical history of thyroid issues, allergies, hypertension, diabetes mellitus, morbid obesity, anemia, chronic diarrhea, Clostridium difficile colitis, and sleep apnea. The decedent occasionally ambulated with a walker or used a wheelchair.

The report documents sharp force injuries of head and neck, including nine chop wounds of face and head, three incised wounds of neck, 10 sharp force injuries, stab wound of medial anterior left thigh, six incised wounds of torso, 13 incised wounds of upper extremities, blunt injury of head, and four sharp force injury of torso. Cause of death: Sharp force injuries of head, torso, extremities. Manner of death: homicide. The medical examiner described the scene in the following terms:

> There was blood splatter on the walls, inside the closet on the floor and blood had seeped into the curtains and carpet. Several blood smears were found on the wall behind the decedent's body. There was blood splatter on the pillows and sheets on the bed. There was a large blood pool found on the mattress and box spring. After the decedent was removed there was a large, congealed blood pool found on the floor where her body was found. The autopsy report describes the decedent as having hypertensive cardiovascular disease with cardiac hypertrophy, multiple renal cortical scars, right kidney, obesity (BMI = 39.2), and hepatomegaly with smart hepatic steatosis and moderate hepatic fibrosis.

Clinical Assessment

The interview was conducted in the juvenile detention home. Ikaika revealed that he had been kept out of school during the previous spring to take care of his ailing (foster) mother, who had significant health problems associated with obesity and diabetes. He was left alone with her during the day while his father and older brother went to work. The house was surrounded by a 10-foot fence, and the gate was locked when the father left in the morning. He was primarily responsible for bathing, feeding, and toileting her. Collateral interviews indicated that Ikaika was the last and youngest of 14 foster children that had been in the home over the previous decade. The foster children were used to perform household chores. The interviewee stated that the atmosphere in the household was abusive, controlling, and neglectful.

Psychological Evaluation

Review of records provided some family background. When he was a small child, Ikaika was exposed to extreme trauma and neglect in his birth family, characterized by drug problems, domestic violence, and criminality which eventuated in multiple foster placements until he was placed in the decedent's household at age 6, which specialized in foster adoptive care, having had 14 children over the previous decade. He was placed in a special education classroom in the 9th grade.

Ikaika was administered a battery of standard psychological tests (WASI, Rorschach, MMPI–A) to provide information concerning his cognitive and personality status. Review of the test and interview data ruled out the presence of malingering or feigning of symptoms. Ikaika was administered the Wechsler Abbreviated Scale of Intelligence (WASI), an abbreviated measure that provides estimated Wechsler IQ scores. Ikaika achieved a Full-Scale IQ (FSIQ) of 79, which places him at the 8th percentile when compared to peers his age. He received a Verbal IQ (VIQ) of

78, which places him in the 7th percentile when compared to peers in his age group. This corresponds to the Borderline range of intellectual abilities. Ikaika's Performance IQ (PIQ) of 86 ranked him in the 18th percentile when compared to age-related peers. This corresponds to the Low Average range. Overall, Ikaika's intelligence fell within the borderline range. This corresponds with the DSM–5 diagnostic category of Borderline Intellectual Functioning (V62.09).

After he was determined to have the requisite reading level, Ikaika was administered the MMPI–A. The MMPI–A profile indicates that Ikaika experiences profound feelings of anger and alienation and experiences feelings of guilt and shame concerning the consequences of his behavior. He tends to alternate between behaviors that show alienation from social norms and standards and excessive concern about the effects of his behavior on others. He does not appear to be overtly defiant but rather sullen, withdrawn, and alienated. Ordinarily, these teens act out and feel bad afterward. In Ikaika's case, he does not have a history of acting out or delinquent behaviors at school or home. He has substantial conflicts between dependence and independence. He is insecure and has a strong need for attention and reassurance of his self-worth. His self-regard is very poor, and thus, he anticipates that others will find him faulty, stupid, or incompetent. Teens with his profile usually present a mixed picture of internalizing and externalizing behaviors in which tension and episodic acting out behaviors are likely associated. However, there is no overt history of acting out in his case. Individuals with this MMPI–A profile have difficulty delaying immediate gratification because they distrust that pursuit of long-term goals will be effective. They have little or no internalized trust. The profile suggests a history of unpredictable emotional letdowns and abandonments in which the individual distrusts caregiver availability and consistency. He is insecure, tends to have conflicts regarding emotional dependency and assertion, and has extremely low self-esteem.

Ikaika produced a valid 22-response Rorschach protocol utilizing the Rorschach Performance Assessment System (R–PAS). He obtained an average number of prompts, pulls, and card turning. He demonstrated very low complexity, which suggested a cognitive deficit likely associated with a history of limited autonomous functioning outside of a structured environment. Consistent with Acklin's Rorschach Alexithymia Index and the Porcelli & Mihura Rorschach Alexithymia scale, Ikaika's record indicates simplistic, concrete processing, impaired ability to mentalize affect, inadequate psychological resources, and limited ability to engage in the world around him. He finds it difficult to describe his feelings, thoughts, and reactions. He approaches the world in a manner that is disengaged, distant and uninvolved, which results in neglect of opportunities to attend to novelty, richness, and complexity. Furthermore, he lacks the ability to use his imagination to comprehend and elaborate human experience or activities.

Ikaika has difficulty thinking clearly and seeing things accurately, which results in distortions or misinterpretations in conventional situations. His responses are associated with unconventional and idiosyncratic ways of interpreting the world. He does not appear to be under notable levels of stress and does not demonstrate strong dependency needs. The profile indicates a poorly adapted understanding of self and others. He is not interested in relationships or does not view relationships as cooperative or supportive. The record is absent of trauma indicators or signs of depression or mood disturbance.

Combining the interview with psychological testing results indicated evidence of brooding resentment, anger, and hostility toward family members, with the perception of his family environment as unsupportive, hostile, unloving, and punitive. He feels misunderstood and unjustly punished by family members, and reports a history of physical and emotionally abusive relationships. He may wish to run away or escape from his home and family. He feels that his

family is critical, quarrelsome, and refuses to permit adequate freedom and independence. He has never had love relationships with anyone and harbors hostility toward family members. His cognitive processes can be described as concrete and simplistic, and he may have difficulty concentrating. This results in difficulty with academic and behavioral problems at school and demonstrates a low achievement motivation.

In psychological terms, Ikaika has significant impairments in his mentalization, that is, the ability to represent his feelings and experience. This is the likely result of biological–constitutional factors with a history of attachment trauma, abuse, and neglect (Fonagy et al., 2002). Psychologically and developmentally, Ikaika presents the picture of long-term neglect. This is superimposed on an adverse, early developmental history documented in the various Family Court records. He demonstrates clinical features of complex PTSD based on developmental trauma and borderline intellectual functioning. The net consequence for his personality development is a psychologically and emotionally "stunted" individual. It seems clear that he experienced an early history of neglect and attachment trauma, and subsequent foster placement and adoption, in a neglectful and traumatizing home. This prevented him from forming emotional attachments to his caregivers or to individuals outside his family. This has had profound consequences for the development of his inner resources, including his cognitive development, emotional life, and social relations. In relation to the waiver to adult court, consideration of his history did not demonstrate a history of conduct disorder, hardening of his personality into antisocial attitudes, association with criminal peers, or alcohol or drug use.

Mental State at the Time of the Offense Analysis

Forensic psychology and psychiatry have established practice guidelines for the assessment of mental states as they apply to legal standards. At the request of the court, a mental state at the time of the offense evaluation was conducted to assess factors related to Ikaika's state of mind at the time of the offense (Shuman, 2002). Rogers (1984) developed the Rogers Criminal Responsibility Assessment Scales (R–CRAS) as a method of standardizing data for use in mental state at the time of the offense evaluations.[6] The R–CRAS is composed of 30 variables scored on a five- or six-point scale. The R–CRAS is intended to quantify essential psychological and situational variables at the time of the crime to implement criterion-based decision models for criminal responsibility (Rogers & Shuman, 2000).

Ikaika's R–CRAS variables are presented in a narrative form. Ikaika's self-report was considered highly reliable. The examiner was impressed by Ikaika's openness and honesty which included volunteering self-damaging information. There is no evidence of involuntary interference with Ikaika's self-report. There is no evidence that Ikaika was intoxicated at the time of the alleged crime through alcohol or drug use. There is no evidence of brain damage or disease. There does not appear to be a relationship between brain damage and the commission of the offense. There is no evidence of intellectual disability based on recent administration of a recognized intelligence test. There is evidence of a relationship between borderline mental deficiency and commission of the alleged crime. Based on the crime scene analysis and death report, there is evidence that Ikaika engaged in continuous bizarre behavior predominating during the commission of the offense (including stabbing and chopping with a knife and meat cleaver). Ikaika did not report severe or extreme levels of anxiety during the commission of the crime. He claimed that he was completely amnesic for the criminal conduct. There was no evidence that he was experiencing definite

[6] The R-CRAS is a forensic assessment instrument that applies a structured clinical judgment methodology that integrates multi-source and multi-method information into a psychological-legal formulation.

controlling delusions at the time of the offense. There is no evidence that he was experiencing definite controlling hallucinations at the time of the offense. There is some evidence to support the idea that he was experiencing moderate to severe levels of depressed mood prior to the offense. In the previous months, he had been kept home from school to provide care to his seriously ill adoptive mother. There is no evidence that he was experiencing elevated or expansive mood at the time of the offense. There is no evidence to suggest that Ikaika's level of verbal coherence at the time of the alleged offense was impaired. It seems clear from the crime scene and death reports that the crime involved extreme expression of emotion incongruous to the situation. Based on the information available about Ikaika's functioning, there is no evidence of formal thought disorder at the time of the alleged offense. The offense did not involve planning or preparation; there was no (conscious) forethought. It seems clear that he retrieved a knife and meat cleaver from the kitchen before attacking his mother. Ikaika claimed to have no awareness of the criminality or wrongfulness of this behavior during the sudden outburst of violence. Focus of the crime was markedly specific, directed to his adoptive mother, who was bedridden. Level of activity during commission of the offense was extreme, involving explosive behavior, as in a rage. There is some evidence to suggest that defendant was experiencing moderately impaired social behavior during the weeks prior to the commission of the offense. Ikaika demonstrated extreme impairment in self–control over the alleged criminal behavior; Defendant reported himself completely out of control of his behavior throughout the criminal act. This is consistent with the examiner's assessment of extreme impairment in self-control. There is no evidence that the loss of control was the result of a psychosis.

Summary, Conclusions, and Opinions

In summary, the case analysis indicates the following: the crime was not driven by delusions or hallucinations. There is no evidence that the defendant was intoxicated or psychotic at the time of the offense or had ever been previously diagnosed with a schizophrenia-spectrum disorder. There is evidence that he had a history of severe early trauma and neglect that forced his removal from his family and placed him into a series of foster homes, where he was subsequently raised. He has a history of special education and borderline intellectual disability. Although the history suggests the possibility of PTSD because of early life neglect and trauma, his foster/adoptive parents never sought treatment. There is evidence of an oppressive, pathologically dependent, and abusive relationship with his adoptive mother.

The offense behavior was the result of sudden and murderous loss of self-control consistent with a chronic catathymic crisis (Revitch & Schlesinger, 1981; Schlesinger, 1996). He claimed to be amnesic for the event. He denies awareness of his actions while stabbing and chopping and any memory afterward. There is no evidence that he was malingering amnesia. When he was evaluated after the event, his manner was bland, placid, and he did not demonstrate remorse or anxiety about his conduct. In fact, he felt safe in the youth facility where staff were sympathetic, and he had regular meals and a place to sleep. The offense characteristics, including mode of killing, are consistent with extreme affective or reactive violence homicide. The case demonstrates features of a violent crime associated with a primitive mental state: a sudden, rage-type, catathymic matricide (Yakeley and Meloy, 2012).

After a Family Court proceeding, Ikaika was determined to not meet criteria for waiver to adult court, and he was taken into custody of the Family Court.

Conclusion

In performing mental state at the time of the offense evaluations in cases of extreme affective or reactive violence, forensic psychologists have a rich variety of concepts and tools from empirical behavioral science, forensic criminology, and psychological theory. A developing body of cognitive neuroscience models provides models for understanding violence-related thinking, deciding, and behavior. These resources form the basis for expert opinions concerning state of mind and applications to legal standards of extreme mental and emotional disturbance and insanity, including the assessment of legal and moral culpability and capacity for self-control.

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