Female Homicide Offenders Referred for Pre-Trial Psychiatric Examination: A Descriptive Study

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Homicide by women has attracted serious attention from a variety of professionals including psychiatrists, lawyers, and criminologists. Although a survey of the literature suggests that homicide usually results from a single impulsive act by women who are reacting to overwhelming interpersonal conflict within the family,[1] several investigators have postulated that homicidal women suffer from serious psychological and psychiatric disorders.[2,3,4] Most of these latter findings, however, derive only from studies of convicted prisoners. They may thus fail to reflect the actual prevalence of psychiatric disorders in this population, particularly as psychiatrically ill criminals are usually channeled through the mental health system rather than the criminal justice system. Widom (1968)[5] has constructively suggested that female criminals be studied at various stages of the incarceration process, specifically, at the pretrial stage, immediately following incarceration, and after a lengthy interval of incarceration. In this study, the authors have implemented part of Widom's proposal by investigating women accused of homicide at the pretrial stage. An investigation focusing on this stage of the judicial process would yield a more accurate psychiatric profile of homicidal women than do existing studies that selectively focus only on those offenders who end up in prison.

Method

We systematically studied one group of women charged with murder and compared them with a group of female offenders charged with a variety of different crimes with reference to demography, medical and psychiatric disorders, and previous criminal activity. We further studied the women charged with murder in terms of victim characteristics, choice of weapons, mental status at the time of the alleged offense, and history of physical abuse.

The subjects in our study included all women who were charged with murder and referred to a large State Hospital in Missouri for pretrial psychiatric evaluation during a five-year period (1974-1979). All other alleged female offenders admitted for evaluation during the same period were used as the comparison group. These women were accused of committing crimes that included assault, burglary, arson, theft, and fraudulent checkwriting. In all these cases, pretrial psychiatric evaluation was ordered

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by the courts to determine whether the accused suffered from a psychiatric illness, whether she was competent to stand trial, and whether she could be adjudged criminally responsible for the crime she allegedly committed. The forensic service in the study hospital, it should be noted, evalutes 40 percent of the total referrals in the state.

On admission of each of these women, the senior coauthor conducted a structured psychiatric interview. Demographic data were obtained including race, education, marital status, and work history. In most cases, information related to past and present offenses, victim characteristics, and choice of weapons was obtained from police reports sent to the hospital and confirmed by the subjects. Where necessary, data were gathered through a social worker's phone calls to the court, prosecuting attorney and/or other legal officers. Medical problems including diabetes, hypertension, obesity, gynecological illness, and surgical interventions were recorded for the one-year period preceding the referral to the forensic service. For the women accused of homicide, data pertaining to mental status at the time of the alleged murder was gathered during the psychiatric evaluation. Specifically, they were asked about the presence of delusions and hallucinations that might have had any relationship with the alleged criminal behavior. Data on being physically abused in adult life by the husband or other victims was collected by the social worker. This was later confirmed independently with each subject by the examining psychiatrist.

Unless otherwise noted, the statistical comparisons to which these data were subjected used chi-square tests with Yate's correction as appropriate.

Results

Of the 66 subjects in the study, 22 (33.3 percent) women were charged with murder and 44 (66.6 percent) women were charged with other crimes. Women in the homicide group ranged in age from 19 to 54 years with a mean of 31.9 ± 11.43 whereas women in the non-homicide group ranged in age from 17 years to 54 years with a mean of 28.5 ± 9.56. The difference in mean age between the groups was not statistically significant ($t = 1.26$, $p = ns$).

Of the 22 women in homicide group, 12 were white and 10 were black. A chi-square analysis using 2×2 contingency table showed a significantly higher proportion of black women in the homicide group compared to the non-homicide group ($p < .01$). No statistically significant differences between the homicide and non-homicide groups were discovered with reference to marital history, education or work history (see Table 1). It should be noted, however, that among the married women in our population, 8 (80 percent) had become widowed at the time of the evaluation because the alleged homicide victim in each case was the husband.

Analysis of the previous criminal record indicated that 6 (27.3 percent) of the homicide group and 27 (61.4 percent) of the women in non-homicide group had committed various offenses in the past ($X^2 = 8.25$, $df = 1$, $p < .005$). A high proportion of women in the non-homicide group had committed prior offenses against both property and persons. Conversely, only two women in

Table 1. Select Data for 22 Homicidal Women Compared with Those of 44 Non-homicidal Offenders

Characteristic	Homicide Group[a] Number	Percent	Non-Homicide Group[b] Number	Percent	X^{2c}	Significance
Race						
White	12	55.5	37	84.1	8.33	P .01
Black	10	45.5	7	15.9		
Marital status						
Married	10	45.5	4	9.1		
Never married	5	22.7	16	36.4	1.96	NS
Separated or divorced	7	31.8	24	54.5		
Education						
Completed 12 grade	7	31.8	19	43.2		
Completed 8 grade	7	31.8	11	25.0	1.3	NS
Completed less than 8 grade	8	36.4	14	31.8		
Work History						
Consistent work	7	31.8	11	25.0		NS
Inconsistent work	15	68.2	33	75.0		
Prior criminal record	6	27.3	27	61.4	8.25	P .005
Prior psychiatric hospitalization	17	77.3	28	63.6	0.71	NS
Physical illness	7	31.8	18	40.9	0.97	NS

[a] Mean age=31.9
[b] Mean age=28.4
[c] Chi-square analysis with Yate's Correction as appropriate df=1

the homicide group had been involved in previous assaultive crimes and of these two, only one had been previously charged with a murder. No woman in the non-homicide group had ever been charged with murder, although 12 of these women had been charged with physical assault.

A survey of physical problems for the year preceding the present offense showed that 7 members (31.8 percent) of the homicide group and 18 (40.9 percent) of the non-homicide group had serious medical problems. Within the homicide group, there were four cases of hypertension and one each of obesity, multiple sclerosis, and cancer. Among the women in the non-homicide group, there were three cases of venereal disease, and one each of physical deformity, cholelithiasis, neurofibramatosis, and obesity. In addition, 11 of these women were chronically ill as a result of either respiratory infections, gynecological illnesses, or dermatitis. Although 39 percent (25) of the total study group had significant physical problems, the difference between the homicide and non-homicide groups was not significant ($X^2=0.97$, df=1, ns).

History of prior psychiatric hospitalization of the women in the homicide group was compared with that of non-homicide group since a positive psychiatric history seemed to be an important factor leading to the request for a forensic evaluation.[6] Seventeen (77.3 percent) women in the homicide group and 28 (63.6 percent) women in the non-homicide group had had at least one major psychiatric hospitalization ($X^2=0.97$, df=1, ns).

Distribution of psychiatric diagnoses among the two groups is shown in

Table 2. Nineteen (85.4 percent) of the homicide group and 41 (93.2 percent) of the non-homicidal group had at least one primary psychiatric disorder. There were no significant differences between the two groups in the frequency of schizophrenia, personality disorder, alcoholism, and organic brain syndrome with psychosis. However, it is interesting to note that no woman in homicide group was diagnosed as having an affective disorder. Previous reports suggest that affective disorders are infrequently seen among female criminals.[7] Therefore, if found, one would expect an even distribution across offender groups. But the authors found a significant difference ($p<.02$) between the observed and expected frequencies of affective disorders among homicide and non-homicide female offenders. Seven women in the non-homicide group were diagnosed as mentally retarded, only one woman in the homicide group was so diagnosed ($p=ns$).

Table 2. Psychiatric Diagnoses of 22 Homicidal Women Compared with Those of 44 Non-homicide Offenders

	Homicide Group		Non-Homicide Group	
Primary Diagnosis	**Number**	**Percent**	**Number**	**Percent**
Schizophrenia	7	31.8	8	18.2
Affective disorder	0	—	6	13.6
Personality disorder	7	31.8	12	27.3
Alcoholism	2	9.1	3	6.8
Mental retardation	1	4.5	7	15.9
Organic brain syndrome with psychosis	2	9.1	3	6.8
Other diagnosis	0	—	2	4.5
No mental disorder	3	13.6	3	6.8

The relationship between victim type, mode of killing, and psychiatric diagnosis among the 22 women charged with murder is shown in Table 3. There were 24 victims in all including 8 husbands, 10 children, 4 acquaintances, 1 father, and 1 stranger. They ranged in age from 11 days to 67 years; two sets of twins were included among the victims of filicide. Of the 14 adult victims, 11 (78.5 percent) were murdered by a firearm. The child victims, on the other hand, were killed by a variety of methods including knocking, hitting, drowning, physical assault, and suffocation. The distribution pattern between age of victim and type of weapon appeared to be statistically significant ($t=5.96$, $p<.02$) in that adult killings involved the use of a weapon. Additionally, it seems to suggest that the choice of weapon often depends on the age of the victim rather than the age of the offender. It is obvious from Table 3 that all but one victim was previously associated with the offender.

Analysis of the psychiatric diagnosis among the 14 women charged with murder of adults showed 7 had personality disorders, 2 had alcoholism and 2 schizophrenia. Three were found to have no mental disorder. Of the 8 women charged with child murder, 7 (87.5 percent) were diagnosed as having psychosis, and 5 of the 7 had prominent paranoid/hallucinatory

Table 3. Distribution of Psychiatric Diagnoses, Type of Victim and Method Used by 22 Homicidal Women

Diagnosis	Victim	Type of Weapon/ Mode of Killing
Alcoholism	husband	gun
Alcoholism	husband	gun
Personality disorder, antisocial	husband	gun
Paranoid schizophrenia	husband	gun
Personality disorder, antisocial	husband	gun
Personality disorder, antisocial	husband	gun
Personality disorder, antisocial	acquaintance	gun
Personality disorder, passive-aggressive	stranger	gun
Schizophrenia	father	gun
No mental disorder	husband	gun
No mental disorder	long acquaintance	gun
Personality disorder, antisocial	husband	stabbing
Personality disorder, antisocial	long acquaintance	arson
No mental disorder	long acquaintance	strangling
OBS with psychosis	child	head injury/fall
OBS with psychosis	child	suffocation
Mental retardation	child	knocking, kicking, stomping
Schizophrenia, paranoid type	children (2)	stabbing
Schizophrenia, paranoid type	child	drowning
Schizophrenia, paranoid type	child	drowning in salt water
Schizophrenia	children (2)	assault with a deadly weapon
Schizophrenia	child	assault

symptoms involving the victimized child. Apparently, they had acted in response to the "perceived threat from the persecuting child." For example, one woman reported her child as a "monster who was part of a larger conspiracy" out to get her. Interestingly, hours before she immersed her one year old child in salt water, she unsuccessfully sought help from her pastor.

Six of the 14 women (42.8 percent) who were charged with adult murder reported physical abuse by the husbands — who later became their homicidal victims. Interestingly, these victims posed substantial threat to the lives of the perpetrators and most probably the murders resulted from their attempts to defend themselves.

Discussion

The generalizability of the findings reported in this paper is limited by the highly selective nature of the population under study. One out of every three women referred for forensic evaluation was charged with murder; this fact suggests that, for women, the alleged perpetration of a violent crime is in itself an important factor affecting the likelihood of forensic referral, beyond such factors as a positive psychiatric history,[6] the court's "legitimate

doubts about defendant's mental status,"[8] and other legal rationales. In a 1980 survey conducted by the Missouri Department of Mental Health (personal communication) both prosecution and defense attorneys cited the nature of the offense particularly the degree of violence involved as a compelling factor leading to a request for forensic evaluation. Unfortunately, we were unable to ascertain the proportion of alleged female homicide offenders who did not undergo a pretrial evaluation. This points to a need for controlled studies involving women who are referred to a forensic unit for psychiatric evaluation and those who are processed directly through the criminal justice system.

Although the homicide group did not significantly differ from the nonhomicide group with regard to marital history, education, work history, or physical illness, previous criminal records of the allegedly homicidal women were different from the records of their non-homicidal counterparts. While the majority of murderers are apprehended in connection with their first homicidal offense, examination of their prior criminal records may provide a clue as to whether they are in fact persistent criminals. Our finding that women accused of homicide committed significantly fewer prior offenses than women accused of nonhomicidal crimes suggest that the former group was not comprised of persistent offenders, as would seem to be the case with their counterparts who demonstrated such a high rate of recidivism.

Studies suggest that the relationship between mental illness and criminality is nonspecific and complex.[9,10,11] Rappeport and Lassen[9] reported that while women with a history of psychiatric hospitalization are more likely to be arrested for aggravated assault than are women in the general population, their pre- and post-hospitalization arrest records did not differ significantly. On the other hand, Widom's review of studies on female criminals "Toward an understanding of female criminality" suggest that female offenders, as a group, tend to have higher prevalence of psychiatric disorders than do male offenders. More specifically, studies by Ward *et al.*,[2] Suval and Brisson,[1] and D'Orban[4] indicate that among incarcerated female offenders, homicidal women have significant psychiatric disturbances, the fact that many homicidal women with mental disorders are committed to psychiatric facilities notwithstanding. This trend of increased prevalence of psychiatric disorders among homicidal women is also noted in the present sample at the pretrial stage. It is interesting to note that 19 (85.4 percent) of the 22 women charged with murder have at least one recognizable psychiatric disorder with 9 (41 percent) diagnosed as having psychosis.

Most of the relevant studies, perhaps taking their cue from the reported correlation of alcohol use with domestic violence, have emphasized the role of alcohol and drugs in homicide. Gilles (1974)[12] reported that drinking accompanied violence in 50 percent of families where violence had occurred and suggested a significant correlation between alcohol use and family violence. In studies of female homicide, problem drinking and alcoholism were reported in more than 50 percent of the offenders.[4] This finding was not

supported by the present study, where alcoholism was diagnosed in only two women in our homicide group. On the other hand, our finding of low prevalence of drug abuse within the homicide group is not dissimilar from previous reports that drugs play a relatively limited role in homicide by women. Inciardi and Chambers (1972)[13] have reported that shoplifting, prostitution, burglary, and forgery are the crimes most closely associated with addiction in women.

Characteristics of Offenders

Our study findings highlight certain distinct characteristics of female homicide offenders. First, female homicide victims are in general either immediate family members or long-term acquaintances; only rarely are they strangers. To this extent, a more than casual ongoing association between the offender and her victim routinely precedes the crime. In our sample, only one victim had been a stranger to her alleged murderer.

Second, our data suggest that victims usually take some active role in precipitating violent behavior from their assailants. Specifically, the finding that a significant proportion of female murderers are subjected to physical abuse by their husbands supports the view that wife beating constitutes a major contributing factor in interspousal murder. Wolfgang's (1957)[14] concept of victim stimulation, which is relevant in this connection, postulates that victims behave in such a way as practically to elicit their own eventual murder. According to Dobash and Dobash (1978)[15] 10 percent of all male homicide victims are killed by wives, even if the most common response of an abused wife is to remain entrapped in the marital relationship and continue to suffer at the hands of the abusive husband. Only a small percentage of women appears to respond to violence with violence. For such women, self-defense appears to be the common underlying factor in homicides that are typically unpremeditated and hastily carried out. According to The National Commission of Causes and Prevention of Violence (1969)[16] women are seven times more likely than men to commit homicide in self-defense.

Third, the impulse to kill may originate in either the homicide offender or the victim. In the case of psychotic murderers, the aggressive feelings are projected onto the victim who is then perceived as persecutory. It is interesting to note that seven of the eight women in our homicide group who were charged with child murder were psychotic. Several investigators have identified certain special characteristics of children who are subjected to physical abuse; these risk factors include, among others, physical handicap, illegitimacy, rejection, and chronic behavior problems. Clearly, there is a need for more systematic research to delimit factors of this sort; such research should further attempt to distinguish murder-prone children from children who are merely prone to abuse.

Finally, the study findings suggest that female homicides are restricted to the home. Previous homicide studies have reported a large majority of murders occur in the bedroom and kitchen and further have shown that most

female homicide offenders assault their victims with household instruments (such as knives) and poison. In Wolfgang's study (1968),[17] 62.4 percent of the women used knives or other household instruments, whereas only 20.4 percent used guns. But the choice of weapons used by homicide offenders has undergone a dramatic change over the past two decades. Ward *et al.*, (1968),[2] for example, found that more than 50 percent of the murders of his 1968 group of women were committed by guns compared with 25 percent of the murders of his 1963 group. Our study seems to bear out the trend reported by Ward for those cases in which an adult was the victim.

Preventive Aspects

Our study findings point to several relevant strategies for preventing homicide by women. The findings that female homicide is mostly intrafamilial underscores the important role of clinicians and law enforcement officials in preventive intervention. A high index of suspicion by clinicians would facilitate recognition of violent families. Direct inquiries concerning child abuse, marital violence, criminal history, alcoholism, and psychiatric history would certainly prove productive and useful. Once a clinician suspects spouse abuse, he or she should be alert to the potential for homicide within the family. Similarly, law enforcement officials should be prepared to intervene in family disputes, as 90 percent of all familial homicides are preceded by domestic disturbance.

Indirectly, the results also underscore the importance of remedying the flaws in the protection offered to battered women by our criminal justice system. Although American courts have begun to recognize the criminality of wife beating, domestic disturbance calls still frequently go unanswered. Police often sympathize with the attacker and when his assaults incite a response that culminates in homicide, it is the survivor who is prosecuted.[18] Dvoskin (1978)[19] has helpfully described the various legal alternatives available to battered women who kill their abusers. Most importantly, such women may invoke "self-defense" in cases of homicide that follow continuous physical abuse. Such a defense presupposes three basic conditions: (1) the defendant has not provoked the difficulty; (2) she was in impending peril; and (3) she had no convenient or reconcilable mode of escape. The key element in such a defense, obviously, is the unavailability of any alternative to the accused woman.

Another important step in preventive intervention is the identification and treatment of psychiatric disorders among criminal offenders. We suggest that all women accused of homicide be given a thorough psychiatric evaluation. Special efforts should be made to identify mothers who are prone to abuse children and are at the same time psychiatrically ill. These recommendations follow from our own study, but also from the verdict of Ward and his associates (1968)[2] that "prevention of further violence may be feasible in those cases in which presence of psychological disabilities gives warning of future trouble."

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