Adolescents and Sexually Sadistic Serial Killing Fantasies

by Bradley R. Johnson, MD

Although there are many books in the popular press that address the issue of sexually sadistic serial murderers, there is still relatively little in the scientific literature regarding this subject. Most of the research published has been based on case studies or small collections on serial murderers. However, little has been learned that is applicable clinically, especially when considering how to intervene with children and youth to help prevent them from going on to become sexually sadistic serial killers.

As one looks back into the childhood of notorious serial killers, it becomes evident that there is no one single cause that led to their violent behaviors. It is likely that there are biological predispositions as well as sociocultural influences involved. The development of violent behaviors mixed with sexual deviancy is likely caused by multiple risk factors. Too often these risk factors are only identified after the individual has committed a violent crime such as a sexual murder. Researchers and clinicians need to begin to understand the developmental years of sexually sadistic killers, to understand the multiple influences and identifiable risk factors in children and adolescents so that these individuals can be identified and offered treatment well before they ever act out their fantasies in real life.

What is known

Park Dietz (1992) said that before a man becomes a serial killer, the offense has already been committed in fantasy in his own mind. He identifies the serial killer as an offender who kills others in three or more separate incidences (Dietz, 1987), and is distinguished from a mass murderer who kills multiple victims during a single incident (Dietz, 1986). Many, including Dietz (1986), have proposed typologies of the serial killer. Some people assume that such deviant violent behaviors could only be committed by an individual who is psychotic or involved in organized crime. However, it is likely that the most common type of prolific serial killer is truly a sexually sadistic serial killer. Therefore, although not all sexual sadists are serial killers, most prolific serial killers are sexual sadists.

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It continues to be debated as to the number of actual serial killers that are at large in the United States. The majority of the world's reported serial killers exist in the United States but many question whether this is due to better crime solving techniques and record keeping versus a true surge of actual serial killers in the United States.

The author has interviewed a number of adolescents who have expressed sexually sadistic serial killing fantasies which began in their early adolescence. Many of these youth began to express their fantasies by torturing and killing animals or being cruel to other children or adults. One did go on to kill another person in a sexually sadistic manner.

To understand the development of the serial killer, we need to understand the literature on the sexually sadistic murderer. As early as 1886, Richard von Krafft-Ebing (1965) described the sexual perversions of "lust murder" and "murder through sadism." However, it was not until years later that the issue of sexually sadistic killing reemerged in the literature. Brittain (1970) attempted for the first time to draw a profile of the sexually sadistic killer in hopes of beginning to identify unique characteristics of sexual murderers. He felt that the more precise the description, the greater the likelihood that sexually sadistic murderers could be identified before they had killed. Although his observations were done retrospectively, Brittain noted that many sexually sadistic killers had development histories demonstrating an ambivalent relationship with their mother, an authoritarian father, and social ineptness. They were often introspective, solitary, studious, obsessional, prudish, vain, and hypochondriacal in their personality. Although they rarely showed outward violence, there was evidence of deep hidden aggression. Sexually, many felt inferior, were often impotent and had a rich fantasy life. Cross-dressing and fetishisms were not uncommon and a number engaged in homosexual activities. There were commonalities in some of these killers, such as interest in power, enjoyment of cruelty as depicted in books or films, an overt interest in weapons, and a history of cruelty to animals. Many had an interest in werewolves, vampires, black magic, Naziism, torture, and "escapology." Most had experienced little or no psychiatric intervention and although a few suffered from depression or anxiety, most could not be diagnosed with schizophrenia. These killers were most likely to offend when their self-esteem was low. They often planned their crimes and often committed them via asphyxiation or stabbing. Physical injury to the sexual organs and engaging in violent sexual acts was not uncommon.

McCulloch, Snowden, Wood, & Mills (1983) identified the experience of power and control in the act of sexually sadistic killings to be the most important factor. They proposed that "the wish to control another" by means of "domination, denigration, or inflicting pain" is what produces the sexual arousal for this type of sadist. In thirteen of the 16 cases that

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they reviewed, the perpetrators had fantasized about their sadistic offense prior to its actuality. They often masturbated to thoughts of rape, kidnap, sodomy, bondage, whipping, torture, or fantasies of killing many times prior to committing their first actual offense. The mean age that these fantasies occurred was 16 (range 13-20) and each subject had an increase in their masturbatory activity once the fantasies took on a sadistic content. The acting out of the fantasy (i.e., sexual killing) occurred less than one year after the development of the sadistic fantasy in 11 of the 13 cases. The authors proposed that if a person begins to try out his sadistic fantasy little by little in actuality, there is a higher risk for it to progress toward the act of killing as part of the actual sexual act. Based on their observations, it is essential that clinicians learn to identify youth who have such fantasies early in their development so that intervention can be made before the fantasies become reality.

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The issue of serial killing is mentioned in the literature much more recently than is sexually sadistic murder. Levin and Fox (1985) concluded that most serial killers are male, Caucasian, and in their 30s. Hickey (1986) found that of identified serial killers during this century, only 14% were female. Of the 36 sexually sadistic serial killers studied by Ressler, Burgess, & Douglas (1988), all were male, 33 were Caucasian, 20 were the eldest son, and 27 had an average or greater than average intelligence. Many had family histories of psychiatric, criminal, sexual, alcohol or drug abuse problems. Many had a personal history of physical, sexual, and psychological abuse. And most importantly, most demonstrated a history of multiple sexual deviant fantasies and behaviors. Of the 36 cases, 75% reported adolescent histories of daydreaming, compulsive masturbation, isolation, chronic lying, rebelliousness, stealing, and assaults on adults. Over 50% had a history of enuresis, nightmares, destruction of property, fire setting, cruelty to children, and poor body image. Nearly half demonstrated a history of cruelty to animals. Most serial killers murder by strangulation, beating or stabbing (Dietz, 1987). These forms of killing may demonstrate a greater "intimacy" in the violent act, reflecting the sexual component of the killer's motivation. Most sexually sadistic criminals carefully plan their offenses in detail, even to the point of preparing a "torture kit" to use on their victim (Dietz, Hazelwood, & Warren, 1990).

Prentky, Burgess, Rokous, Lee, Hartman, Ressler, & Douglas (1989) compared 25 serial sexual murderers with 17 single sexual murderers. Those in the serial group were more likely to be Caucasian, possess a higher than average IQ, and experience fantasies of rape and/or murder. A higher percentage of the serial group had a history of compulsive masturbation, voyeurism, fetishism, and cross-dressing. They proposed that once a sexually sadistic fantasy is acted out for the first time, the offender is likely to engage in a series of sexually sadistic acts. Each sexual act comes closer to actually enacting the particular deviant sexual and violent fantasy. However, since it is difficult to ever exactly match the sadistic fantasy, there is an impetus to begin restaging the fantasy over and over, each time reinforcing the deviant fantasy with orgasm. The fantasy could eventually develop to combine sexual deviancy with violence that could possibly even end in killing the sexual partner. Warren, Hazelwood, & Dietz (in publication) proposed that actual murders likely become the fantasy material for subsequent masturbation, reinforcing the sadistic arousal pattern.

Langevin (1991) compared sexual killers with sexually aggressive non-killers as well as to non-sexual killers. In his study, the victims of sexual killers were more often a stranger and killed via strangulation. The use of strangulation could be a means of prolonging the sadistic suffering of the victim and in turn cause a prolonged feeling of pleasure and control by the offender. The element of total control a sexually sadistic killer has over his victim may be a critical piece to the puzzle (Weinberg & Levi-Kanel, 1983). The issue of control may lead to the sexual excitement and the actual death itself could be anticlimactic.

Although data is still sparse, biological predispositions may also be a contributing factor to sexually sadistic murder. Langevin (1991) showed it to be more common in both sexual killers and in sexually aggressive non-killers to have abnormalities in the right temporal horn area of the brain as seen on scans. He also noted elevated testosterone in both of these groups. Others (Gosselin & Wilson, 1984) have argued that left hemispheric dysfunction was more commonly seen in individuals who suffered from deviant or bizarre sexually deviant fantasies. However, Langevin (1983) noted temporal horn lobe damage in many individuals who suffer from fetishism and cross-dressing, the two types of sexual deviancy that are more commonly seen in serial killers. Although many individuals have proposed other neurological abnormalities in serial killers, many known serial killers have suffered from head injury or trauma when younger (Norris, 1988). New research is linking recurrent or obsessional-like sexually deviant fantasies with low serotonin levels (McClung & Wasyliw, 1993). Other biological causes or relations to serial

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killing are being studied and the use of multiple medications are being attempted to see if they help decrease this type of sexually deviant/violent fantasy or act

Abel, Becker, Cunningham-Rather, Mittleman, & Rouleau (1980) have shown that it is common for an individual to generally suffer from multiple types of sexual deviant fantasies and behaviors rather than just one type. Additionally, they demonstrated that these behaviors often begin prior to the age of 18 (Abel, Becker, & Mittleman, 1985). Therefore, multiple sexual deviant fantasies and behaviors can and often do develop during adolescence. This author has seen numerous cases that have demonstrated sexually sadistic homicidal fantasies that have developed in teenage adolescents. This is consistent with the assumption made by others who have interviewed serial killers who claimed their killing behaviors began in adolescence. Therefore, once again, it is evident that these individuals need to be identified early on and intervention attempted

Further studies will need to occur to help identify if standard treatment for sexual offenders, or a modified version thereof, could be helpful in treating this specific population.

Ideas of Interviewing and Interventions

It is important to ask adolescents who have been referred for violent crimes or sexual offenses about the nature of their sexual fantasies and to take a very thorough and detailed sex history. The adolescent should be reassured that the sexual history questions are a confidential routine part of the medical or psychological interview and they should be given the opportunity to voice any general concerns or questions regarding their sexual life before being asked specific questions of interest to the examiner. One should obtain information about sex and growing up, parental attitudes toward sex, age of onset of puberty or menarche, the age of first intense romantic or sexually oriented relationship, history of abuse, sexually transmitted diseases, and masturbatory fantasies and frequency. One should continue by questioning about the age of first intercourse and the number of sexual partners as well as the frequency and type of sexual activity. Finally, a complete history should include questioning the adolescent about sexually deviant fantasies or behaviors (paraphilias). A list of common paraphilias can be found in *The Diagnostic and Statistic Manual of Mental Disorders,* Fourth Edition

The sexual history should include asking whether the adolescent becomes sexually excited when experiencing or fantasizing about violence. They should also be questioned about fantasies or actions involving sexual sadism and killing. It helps if the interviewer is comfortable listening to material presented and is able to allow for ample time when interviewing. If the adolescent realizes that the interviewer is comfortable with the topic, they are often willing to talk openly and divulge information that has been bothering them for a prolonged period of time.

This author would propose that the evolving nature of the sexually sadistic fantasy often begins in adolescence and is a possible key factor that must be looked for in order to identify youths who are at risk for becoming sexually sadistic serial killers. Adolescents who demonstrate sexually sadistic fantasies, especially those of a violent nature that end in killing, should be red flagged, followed closely, and offered treatment to help extinguish or control the deviant fantasy before it becomes a reality. If cognitive/behavioral and psychopharmacologic treatment is offered early enough in the development of the sexually sadistic and homicidal fantasy, one would hope to decrease or even prevent the eventual possible outcome of serial homicide.

Conclusion

The study of the development of sexually sadistic paraphilias that lead to the most common type of prolific serial killing is still in its infancy. Children and adolescents who are developing sexually sadistic fantasies and talk about single or serial killings need to be followed over time in a prospective manner to help researchers and clinicians better understand the developing nature of the sexual serial killing fantasy. In doing so, one would hopefully begin to better understand if there are specific subtleties that would help one identify those who would go on to kill and those who would not. Further studies will need to occur to help identify if standard treatment for sexual offenders, or a modified version thereof, could be helpful in treating this specific population.

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Defining the Interview Process

By Wendy Deaton, M.A. and Lt. Mike Hertica

INVESTIGATION

Over a decade has passed since a rash of child sexual abuse allegations occurred in day care centers across the nation. One result of these events was a new focus on the child interview process. A decade later, however, the plethora of articles and books that continues to emerge from therapeutic, social service and child abuse fields reveals a continued lack of consensus on a protocol that can be used with young children to produce effective, credible fact- finding interviews.

Questions still under debate include which professional discipline should be responsible for child interviews in cases where child abuse is suspected? Should direct questions be asked or must the child produce a totally spontaneous recounting of events? How susceptible are children to leading questions, direct suggestion, or subtle innuendo? Can the memories of children be trusted? Can anyone's memory be trusted?

This article proposes to add another to this profusion of questions, "What is the purpose of the interview?" It is the authors' contention that the question of purpose is the most critical question to be addressed in the debate about an effective, credible interview process. The purpose of an interview determines what questions can appropriately be asked of the child, clarifies the guidelines for interviewer interaction, and defines how the interviewer can respond to the child's disclosures. It defines which type of professionals, from which disciplines, should most appropriately conduct the interview.

It is the authors' contention that the question of purpose is the most critical question to be addressed in the debate about an effective, credible interview process.

This article draws on the authors' combined experience in law enforcement, social work and mental health to provide an outline of three types of interviews that may be conducted during a child abuse investigation: the investigative interview, the therapeutic assessment (also known as a forensic evaluation), and the treatment interview. Although there are tremendous overlaps, establishing credible and reliable protocols for interviewing children depends upon clearly differentiating the specific types of interviews that may be conducted. While all interviews with both children and adults use the three phases of rapport, information gathering, and closure, these three types of interviews have different purposes, requirements, goals, tasks and limitations. These differences are described below.

The Treatment Interview

Purpose

The purpose of the treatment interview is to determine what should be done about what has happened. While the outcome of treatment may enable a child to provide a more credible accounting of traumatic events of interest to the criminal justice system, the purpose of treatment is not healthy disclosure, but a healthy child. In fact, the outcome of treatment may result in a recommendation that the child stop participation in the criminal process, as such participation may be seen as too detrimental to the child's prognosis for recovery and health.

Interview Content

The treatment interview identifies goals and objectives that will help the child recover from the current traumatic events. In addition to exploring the allegations of abuse, the interview includes a review of other significant life experiences which may be affecting the child's development and adjustment. The treatment interview explores the child's current level of functioning; his or her internal perceptions, beliefs and attitudes; the defense mechanisms commonly utilized; the weaknesses and strengths demonstrated.

Interviewer

The treatment interview is conducted as a prelude to the treatment process. As such, it is conducted by the treatment therapist, with the goal of establishing a plan of action. The specific areas the therapist explores and the historical information sought are determined, in large part, by the therapist's treatment approach and style. For some therapists, the debriefing of traumatic details may be primary, while others may look to the restructuring of cognitive beliefs, the cathartic release of emotional reaction, or the redoing

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