Assessment and Intervention With Youth Exposed to Sexual Homicide of a Family Member

Paul T. Clements, PhD, APRN, BC, DF-IAFN
M. Regina Asaro, MS, RN, CT
Tara Henry, RN, SANE-A
Gregory McDonald, DO

Exposure to interpersonal violence and traumatic death can create some of the most severe postevent reactions. However, little is known about the effects of exposure to the sexual homicide of a family member in youth. Sexual homicide can occur in a variety of situations and as a result of various motives. For youth who witness this event or who find the sexually violated and murdered body of a family member, there can be significant responses related to fears of ongoing threat to their safety or to the safety, stability, and structure of their family and environment. Severe traumas, such as sexual homicide, can have a detrimental effect on youth intrapsychic development and interpersonal relationships. These include posttraumatic stress disorder, with symptoms that can be disturbing and disruptive to daily routines and negatively affect a youth’s otherwise normal growth and development.

[Brief Treatment and Crisis Intervention 5:300–309 (2005)]

KEY WORDS: bereavement, interpersonal violence, sexual homicide, trauma, youth, PTSD.
Although often diminutive in size, youth experience a full affective range with a significant potential for related posttraumatic sequelae including symptoms that can be disturbing and disruptive to daily routines and which can negatively affect their otherwise normal growth and development (Clements, Faulkner, & Manno, 2003). As such, they are in need of not only physical protection but also promotion of adaptive coping, as well as guidance and support toward their intrapsychic growth and development. Certainly, youth who witness the sexual assault and murder or who find the murdered body of a loved one who has additionally been sexually violated can have significant responses related to fears for their own safety or for the safety, stability, and structure of their family environment (Clements, 2001; Vigil & Clements, 2003).

Utilizing information from clinical interviews, research, and related scholarly literature, the potential impact of sexual homicide on youth will be explored. Additionally, assessment considerations and suggestions will be provided toward mitigation of the survivor’s development of a negative worldview and long-term negative health consequences.

Case Study

“Sasha” worked the evening shift at an all-night diner and occasionally went out with her coworkers after work. Sasha worked one Wednesday evening and had not yet returned home on Thursday morning before the children went to school. Sasha’s body was later discovered in the shed in her backyard on Thursday afternoon by her 10-year-old daughter and 8-year-old son when they opened the door to get their bicycles to play after school.

Sasha was lying supine on the floor, and she was naked from the waist down. Sasha’s pants had been removed and were lying at her feet, inside out; the lower portion of a pant leg remained attached to one foot. She was wearing a blood-stained tank-top shirt, which was intact and in place, with another shirt lying under the body. Beneath the tank-top shirt, her bra was pulled up over her chest, with both breasts exposed. There were multiple abrasions, bruising, and large gaping lacerations noted on the head and face. After processing the crime scene, Sasha’s body was transported to the Medical Examiner’s Office (MEO), where a forensic pathologist performed an autopsy. The autopsy revealed that the skull and facial bones were crushed into multiple fragments; superficial cuts were also noted on the neck and one thigh. An examination of the extremities revealed multiple areas of bruising on the arms and legs. Genital and anal examinations with gross visualization revealed no injuries. Forensic evidence was collected from the body, including oral, vaginal, and rectal swabs.

A suspect was quickly charged in the case. The alleged perpetrator was “Walter,” one of Sasha’s coworkers, a man with whom she occasionally had drinks. A friend of the suspect reported that Walter took him to a shed, showed him the body of a female, and described killing her by beating her with a rock and a shovel. The autopsy also revealed that the suspect had also apparently returned to the body multiple times within the first few hours of death to perform postmortem sexual assaults and additional beatings of the body. Toxicology results showed the victim had a high level of alcohol in her bloodstream at the time of her death. DNA was found on the vaginal and rectal swabs obtained. The case continues to be tried in a court of law.

Background and Significance

Prevalence

Homicide is a behavioral act that terminates life in the context of power, personal gain, and
brutality. According to the *Uniform Crime Reports* (UCR) of the Federal Bureau of Investigation (FBI, 2003a), in the year 2000 the homicide rate was 5.5 per 100,000 U.S. inhabitants; in 2001, 5.6; and in 2002, 5.6. The persistent nature of this public health problem is reflected in the less than 1% change across statistical data for these 3 years. The Centers for Disease Control and Prevention CDC (1997), the U.S. Surgeon General Satcher (2001), and Healthy People 2010 USDHHS (2000) have all declared homicide to be a significant public health problem in the United States. Homicide remains a significant cause of death with relatively little research examining the individual impact on the surviving family members, particularly the youth.

The selected offenses reported to the UCR are (a) murder and nonnegligent manslaughter, (b) forcible rape, (c) robbery, (d) aggravated assault, (e) burglary, (f) larceny-theft, (g) motor vehicle theft, and (h) arson. For practical purposes, the reporting of known offenses is limited to the selected crime classifications because they are the crimes most likely to be reported and to occur with sufficient frequency to provide an adequate basis for comparison (FBI, 2003b).

Although the UCR provides information regarding age, race, gender of victims, type of weapon used, and some general situations within which the homicide occurred, there is no difference between homicides that included sexual assault and those that did not have sexual aspects obscured, some experts argue that many sexual homicides may be reported in the ‘unknown motive’ category” (Ressler et al., 1995, p. 2).

**Types of Assaults**

With the belief that sexual homicides have been thought uncommon and more often a stranger-to-stranger crime, many may have been and will probably continue to go unrecognized. Gerberth (1996) classified sexual homicides into four categories based on frequency of occurrence: (a) interpersonal violence, (b) rape and/or sodomy, (c) deviant assaults (commonly referred to as a lust murder or psychotic killing), and (d) serial murder.

**Interpersonal Violence**

Sexual assault is a common form of abuse found in violent relationships, so it is not surprising that the most common type of sexual homicide is one that occurs in relation to a history of interpersonal violence. In 2000, the UCR reported that 44.3% of all murder victims knew their offender and that 33% of female murder victims were killed by their husbands or boyfriends (FBI, 2003a). Loss of control over the female, jealousy, and revenge may be some of the motives behind the sexual homicides that occur in this category.

**Rape and/or Sodomy**

In this type of sexual homicide, usually the offender is not a killer who has raped, but a rapist who has killed. The intent of the offender is to rape and/or sodomize the victim, and the homicide occurs due to the excessive force that is used to accomplish the sexual assault. If the offender is known to the victim, then the murder may occur intentionally to
prevent the victim from identifying the offender and reporting the sexual assault.

**Deviant Assaults**

In this category of sexual homicides, killing is frequently part of the sexual fantasy. Mutilation of the body is commonly seen in these homicides and occurs to the parts of the body that are significant only to the offender and his fantasies. The body and crime scene are likely to be gruesome sites and would be horrifying for a family member to encounter, especially a child or adolescent.

**Serial Murder**

A serial murder occurs when two or more separate homicides are committed by the same offender with a period of time or “cooling-off” between them. The offenders who like to kill will continue to do so as long as they are able. Many, but not all, serial killers are sexually motivated. According to Gerberth (1996), a study of 387 documented known serial offenders showed that 248 of them were sexually motivated.

**Psychological Assessment of Youth Exposed to Sexual Homicide**

There is a paucity of literature on youth witnessing the homicide of parents (Clements, 2001; Clements & Burgess, 2002; Malmquist, 1986; Pynoos & Eth, 1986) and even less on those who witness or are exposed to a sexual homicide. It is known, however, that the effects of witnessing family violence, where the threat of death is real or assumed, are broad ranging, and the assessment of children exposed to such events must also be broad based.

Mental health professionals, including Advanced Practice Psychiatric Nurses, especially those with forensic, trauma, and/or grief training related to youth, will best undertake formal assessment of youth exposed to sexual homicide. Youth who have severe symptoms or who have been exposed to extreme and repeated violence should be referred, when possible, for more extensive assessment and therapy.

Of primary concern are the following: Who was the victim in relation to the child and, if it was the mother or primary caretaker, then who is taking care of the child following the murder? Are there surviving biological relatives or foster parents? Have the child’s living circumstances changed dramatically since the murder?

Of importance to practitioners is that children who are confronted with their mother being abused and, worse, murdered during a sexual assault are highly likely to experience emotional and behavioral problems similar to children who are themselves physically abused. It is known that children who witness abuse frequently experience posttraumatic stress disorder, with accompanying symptoms such as extreme anxiety, fear, irritability, intrusive thoughts and flashbacks about the violence, unpredictable anger outbursts, and avoidance of situations that remind the child of the abuse witnessed. These children will frequently experience difficulty concentrating as well as behavior and learning problems (Clements, 2001; Clements & Burgess, 2002; Vigil & Clements, 2003).

Keep in mind that there are a number of main, as well as subtle, effects of witnessing family violence. Among the best-documented and the most notable effects are increased acting out and aggressive behaviors, as well as depression and anxiety. Low self-esteem, withdrawal, and lethargy are also observed, and it is not uncommon for these children to become aggressive with siblings, peers, and teachers (Burgess, Hartman, & Clements, 1995, 1996; Clements & Burgess, 2002; van der Kolk, 1988). They tend to be noncompliant, and may be
irritable and easily angered. Children who destroy property and have a tendency to get into fights may develop juvenile delinquent behavior in teenage years. The acting out behaviors are more often pronounced in males but are found in a significant number of females as well.

Many children living in abusive homes may never have known a calm and peaceful environment, even from their earliest childhood or infancy, and thus their development and reactions are differently and more chronically affected than those children who experience a single traumatic event in a peaceful and supportive environment. Frequently, there are also more subtle symptoms related to children exposed to violence, such as inappropriate attitudes about the use of violence in resolving conflicts, inappropriate attitudes about violence against women, condoning violence in intimate and dating relationships, hypersensitivity about problems at home, and a sense that they are to blame for the violence (Clements & Benasutti, 2003).

Other children experience somatic complaints (bodily aches, pains, and illness with no known medical cause). These symptoms may result because the children have a lot of internal tension, with no effective way of altering the problem, expressing the issues, or seeking help. Many observers have felt that internalizing problems, along with a need to be perfectly behaved and an exaggerated sense of needing to help their mother, are particularly common in girls who witness family violence.

Children who have witnessed family violence are often misdiagnosed as suffering from attention deficit disorder because questions about witnessing family violence are not necessarily asked. As a result, these children are at elevated risk for depression, truancy, delinquency, and running away from home (Burgess, Clements, & Hartman, 1996; Burgess et al., 1995; Clements & Burgess, 2002).

Prior to assessment, it is necessary to form a relationship with the child such that the child feels safe and comfortable talking about what she or he witnessed (Burgess & Clements, 1996; Clements & Benasutti, 2003; Clements, Benasutti, & Henry, 2001). This is particularly true if the perpetrator is still at large or unknown. In cases of family violence, children exposed to such events have often been influenced by a “code of secrecy” around the violence and have been taught not to reveal any family secrets to outsiders (Clements & Benasutti, 2003). Also, children are often embarrassed and, more importantly, fearful about revealing details of the abuse; talking about the scenes they have witnessed may bring back negative emotions and memories. Therefore, it is important to reassure the child that it is alright to tell and that he or she will help the situation by telling; sometimes, however, it will take a number of sessions before the child will feel comfortable disclosing information. It is helpful to have some other activities and topics to explore while the rapport building occurs; if this step is skipped, then formal assessment procedures may elicit a lot of denial and “I don’t know” or “I don’t remember” responses (Clements & Benasutti, 2003; Clements et al., 2001).

Before interviewing the child, it is important to have as much information as possible about the nature and details of the murder. This gives the child a sense that the person has taken the time and care to find out this information. This also assists in understanding what the child is referring to, especially in the case of younger children, and it helps the interviewer gauge the level of denial, minimization, or frankness on the part of the child (Clements, Benasutti, & Henry, 2002; Clements & Burgess, 2002; Vigil & Clements, 2003).

Use of multiple modalities of assessment and sources of information is important when
working with these children. Mothers, extended family members, teachers, child advocates in shelters, and child-care workers in other settings are all important sources of information, when available. Interviewing the child as well as using paper and pencil self-report questionnaires, drawings, and behavioral checklists and talking are all appropriate (Clements, 2001; Clements et al., 2001, 2003; Clements & Weisser, 2003). Assessment of the child’s symptoms should be supplemented by an assessment of the child’s environment. An “anchor for safety,” an individual with whom they can talk and rely on once they return to the “real world” and are confronted with the reality of the loss, can be of great help (Burgess et al., 1995; Clements & Benasutti, 2003; Clements & Weisser, 2003).

The assessment process can be employed as a treatment readiness intervention to help the child feel more comfortable when talking about the violence and to help highlight the availability of group or individual therapy to assist the young person in overcoming the trauma he or she has experienced. Children will have to continue to deal with the trauma and loss as they progress through their developmental stages; this is especially true concerning the sexualized aspects of the murder. In the case study, family members of any age would have particular difficulty understanding how someone could sexually assault their loved one postmortem.

Although the work of this agency is of utmost importance, it is intrinsically connected with an association to death. The MEO is the final voice of the victim. Because the victim can no longer tell the facts surrounding the final moments before death, it is the role of the Medical Examiner to make a final determination of the cause and manner of death. Frequently, it is the information gleaned from the forensic autopsy that provides the surviving family members with the details surrounding the final moments of their loved one’s life (DiMaio & DiMaio, 1993).

Many children express fear and confusion by the need for an autopsy on the body of their loved one (Clements, 2001; Clements & Burgess, 2002). Children described struggles with what they saw as additional violation and destruction of their loved one. There may be anxiety surrounding the perceived additional mangling and disfiguring of their family member’s already violated and murdered body (Clements & Burgess, 2002). Amplifying these feelings can be horrific fantasies about the autopsy, in which the child may fear that the autopsy will cause more pain for their loved one when the body is cut. Although this process is of utmost medicolegal and forensic importance, it may create disturbing fantasies and fears surrounding the decedent’s death and afterlife.

When children ask questions about the forensic autopsy, answers should be given in the presence of a supportive adult family member or caretaker, the information should be provided in a developmentally appropriate approach with matching content level, and horrific information should be provided in a mitigated and nonaffectively charged manner. This is done in order to decrease the risk of polarizing the child to any additional highly charged environmental cues that may ultimately result in trauma-related symptoms (Burgess et al., 1995).
Supporting the Child Through the Criminal Justice System

Along with the potential psychological distress associated with the postmortem examination, there is also the reality that if the child was a witness to the event, then the child might be called to testify in court proceedings. This may compound an already emotionally charged situation, creating feelings of mixed loyalties relative to the perpetrator and victim; raising levels of fear for the child’s own safety because he or she now has to “tell,” potentially bringing back painful memories regarding the murder; and, possibly, contributing to survivor’s guilt when questions are asked in court, which the child may interpret as blaming or suggesting that he or she could have done something to prevent the death (Blandford-Bynoe, 1996; Clements & Burgess, 2002; Henry-Jenkins, 1993; Pynoos & Eth, 1984, 1986). To alleviate the primary trauma of testifying in court, some jurisdictions do continue to utilize anatomically correct dolls and videotaping of children’s testimony in court. This can be very helpful, especially if the perpetrator is the child’s father, primary caretaker, or another adult who was considered a member of the family system.

Education for Surviving Family Members and/or Caretakers

Working with the family and/or guardians to assist children in the aftermath of a sexual homicide can be difficult at best, especially if the victim was the child’s mother. Parents and caretakers must understand the need for honesty with children—they can be assisted to answer children’s questions with age-appropriate information. They can also learn that they do not have to hide their grief completely and can also acknowledge how scary it is to talk about what happened and how they feel.

It is possible that the child may be too young to understand the nature of the sexual violence of the death and only react initially to the fact of the loss. As the child grows and becomes more aware of the details of the murder, they will need help in assimilating those aspects, as well. In cases where children were either too young or did not understand all the ramifications of what they witnessed, it would be important to try to shield the child from hearing explicit details about the murder until they could be explained to them in age-appropriate ways and with adequate adult support. Too often, children and teenagers may learn aspects of their loved one’s case from other children or through the media (Clements & Burgess, 2002). As such, children and adolescents will need an ongoing opportunity to discuss their feelings and reactions to help them to try to come to terms with what happened.

If the sexual homicide follows in the wake of past family violence, there may be other dynamics at work. Older children might have taken on the responsibility of protecting and seeing to the needs of their younger siblings. Caretakers must ensure that children are allowed to be children from this point forward.

Parents and caretakers must understand that children grieve on and off—they may seem fine for periods of time but then may become sad, act out, or ask questions regarding the murder. Pynoos and Eth (1984) observed that young (preschool) children may feel particularly helpless after murder in that they “do not appear to be able to imagine alternative actions they might have taken to prevent or alter the episode” (p. 94). These young children may often imagine someone with superpowers coming in to rescue their loved one or the victim. Pynoos and Eth further noted that older children do have this capacity and may act, if just in fantasy, as though they had a greater role.
in what actually happened or in what they could have done to prevent the murder. Parents and caretakers must be made aware that these “inner plans” represent efforts on the part of the child to cognitively come to terms with the murder (Attig, 2001; Pynoos & Eth, 1984). Teenagers, on the other hand, have a more realistic understanding of what happened and may implicate their own and others’ responses differently than those younger than themselves; they have a greater capacity for self-guilt and blame for others, whose actions either might have contributed to or did not prevent the killing (Pynoos & Eth, 1984).

Parents and caretakers can be guided to look for “developmentally inappropriate” problems such as enuresis or behavior problems, as well as somatic symptoms, especially those for which there are no physical findings.

As with adults, children and teenagers will need help addressing the traumatic aspects of their experience. Parents and guardians should be made aware of the impact of trauma and keep the therapist informed of the frequency and nature of these reactions.

Children, as well as adults, often have safety-related concerns in the aftermath of a traumatic experience. They may fear danger (real or imagined) to themselves, their siblings, and other surviving family and friends.

Often in the aftermath of murder, family members keep to themselves; adults are usually unable to talk about it, and it is even more difficult to know what to say to children. In addition, family members often protect each other by trying not to bring up the subject and upset each other. Especially in cases where the father was the perpetrator, family members often take sides for or against the victim (Asaro, 2001). This usually leaves children and adolescents at a loss for getting information and finding relief from their fears and anxieties. It is therefore important for parents and guardians to understand that children need to be able to explore their own grief and trauma reactions in the “reassuring presence of an unaffected adult” (Pynoos & Eth, 1986).

If the child or teenager has been a witness to the violence, parents and/or guardians should work with the child’s therapist to prepare the child psychologically for what is to come in court; there is also the recommendation that child witnesses be made aware of the outcome of all judicial proceedings (Pynoos & Eth, 1984).

Summary

With the paucity of literature surrounding child and adolescent exposure to sexual homicide of a family member, clearly additional research needs to be conducted on this issue; this should include qualitative research to explore repetitive themes and self-identified issues of importance to this specific population of children. Especially salient is the issue of compounded grief and bereavement after exposure to sexual homicide in comparison to other forms of violent death. There is also a dearth of information regarding the long-term impact that might be inherent in the violent loss of relationships created by sexual homicide and the potential benefits of early intervention relative to mitigation of posttraumatic sequelae and therapeutic standards for guidance and support.

What is known is a basic understanding of how children and teenagers cope with loss and crisis. Unfortunately, this information may be inadequate in the shadow of the chaotic wake created by sexual homicide. Clearly this issue is on the forefront of clinical issues faced by those in the mental health care arena.

References


