The impact and sequelae of murder on surviving family and significant others.

To describe the aftermath of murder: losses, reactions, secondary victimization of surviving family members, contextual issues that may affect the grieving process, and psychological impact.

Review of the literature and the author’s own clinical work.

Loss of a loved one through sudden violence often results in concomitant factors that may compromise the ability of homicide survivors to deal with the trauma, process the loss, and proceed through the tasks of grieving. Further, these factors may put family members at risk for development of posttraumatic stress disorder and complicated mourning.

Homicide survivors. Homicide survivors are those left behind to mourn victims of homicide. From an analysis of more than 300 genograms done with homicide survivor families, Redmond (1989) reported there were 7 to 10 close relatives, in addition to significant others—
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friends, neighbors, and co-workers—who are left behind to mourn each victim. Spungen (1998) described surviving family members as co-victims: They are the ones who “represent the murder victim; it is the co-victim who deals with the medical examiner, the criminal justice system, and the media” (p. 9), sometimes for many years after the murder.

**Losses in the Aftermath of a Murder**

The primary loss resulting from murder is the loss of the victim. Homicide survivors must not only deal with their reactions to that sudden, traumatic and often violent death, but also grieve their particular relationship with the victim. Associated losses might include dreams or expectations for a future life with the victim or a best friend or confidant—the one person with whom one shared problems or adversities. The death also precludes the possibility of resolving past disagreements or angry feelings, which might have been settled over the course of time.

Intrapersonal losses may include a sense of personal control or independence; a questioning of faith or religion; feeling changed; and an inability to work while attending legal proceedings, which may result in additional trauma and loss of income and/or employment.

Interpersonal losses may occur as family structures break apart from the stress of the murder. In cases where the killer and victim were related or in a relationship, family members often take sides for one or the other, resulting in further disintegration of the family structure. Lastly, loss of social standing or other social support often causes increased feelings of isolation.

Extrapersonal losses experienced by homicide survivors can include loss of the victim’s income, or catastrophic medical bills incurred in an effort to save the victim’s life. Such changes in the survivor’s financial status might easily result in loss of home and/or lifestyle.

**Reactions to Loss Following a Murder**

Although reactions following a murder are similar to reactions seen following any loss, Redmond (1989) reported that the former seem to be more intense and longer lasting; in fact, it was noted that it often took at least 3 to 5 years for the most intense grief symptoms to begin to subside. One woman described her reaction on learning of the murder of several family members:

> I remember dropping the phone and it was like my insides just totally erupted and I ran to the bathroom with diarrhea and I could still think straight, but I think my whole insides of my body were just going in . . . you know . . . in fits. (Asaro, 1992, p. 34)

**Distress over how their loved one died.** It is not possible to say that one person’s grief is more painful than that of another or that loss, by its nature, is not in some way usually traumatic. Asaro (1992), however, reported that none of the participants in a study (N = 11) felt her prior experience with loss of a loved one compared to loss through murder. Many homicide survivors worried about the violent way in which their loved ones died and the extent to which the victims suffered (Asaro; Redmond, 1989). As one survivor stated:

> I think the loss of anyone is hard on anybody, whether you’re expecting it or not, it’s still—you’re losing a loved one. But I think the question I have . . . that’s (gone) through my mind so many times is how he must have suffered. (Asaro, 1992, p. 42)

**A desire to know all the facts surrounding the murder.** While some family members do not want to know the specifics of the murder, many others reported an almost obsessive need to know all the circumstances: the who, why, where, and how (Asaro, 1992; Burgess, 1975; Redmond, 1989). One survivor kept the police scanner on whenever she was home in an effort to glean information that might be used to identify her loved one’s killer. The murder had occurred 17 years prior to the time of the study (Asaro).

**Issues of guilt and self-blame.** Surviving family members may blame themselves for the victim’s death or for things they did or did not do that they feel may
have contributed to the death. There also may be a sense of guilt about having survived when their loved one was killed, even if they were not present at the time. Rando (1993) described a number of issues associated with “survivor guilt,” including relief at being alive, a debt owed to the deceased, and, perhaps, a sense of not deserving to live. Feelings of guilt may or may not be realistic. One woman described her reaction to the news of the death of her loved one, several thousand miles away: “I don’t know if I told you about it before, that somehow they would blame me” (Asaro, 1992, p. 50). These will all certainly complicate the grieving process.

**Changes in survivor’s assumptive world.** Loss of a loved one through murder violates our assumptions about the way things are and the order in the world that permits us to feel safe and in control—that is, able to predict, understand, and explain the things that happen in our lives. Janoff-Bulman (1985, p. 18) described three basic assumptions that are shattered following a traumatic event:

1. The belief in personal invulnerability
2. The perception of the world as meaningful and comprehensible
3. The view of ourselves in a positive light.

This is why, to a large extent, homicide survivors no longer feel they or their loved ones are safe (Asaro, 1992; Burgess, 1975; Janoff-Bulman, 1985). One woman reported, “I found that I was taking a sleeping bag and sleeping by the door because I was so nervous” (Asaro, p. 40). Another survivor spoke of her reaction:

So if someone leaves and they don’t come back at a certain time or I don’t hear from them, then I worry myself sick. . . . I love them so much and I don’t want to lose them and I’m always scared of that. (Asaro, p. 40)

The questions “why?” and “why him/her?” make it very difficult for people to come to terms with what happened and begin to feel secure in their lives after the murder.

**Case Study**

Marian is a 50-year-old woman, married for 30 years with three grown children: Tina, age 20; Bob, 24; and Sandra, 27. Once her youngest child was in high school, Marian went back to work as a bookkeeper at a local manufacturing plant. Her husband, Tom, 53, owns a computer repair business.

One night, Tom opened the door to find two police officers, who informed them that Tina had been murdered. Receiving few answers to any of her questions, Marian found herself hitting one of the officers and being restrained. She remembers very little of the next hours and days as she went with her husband to choose a casket and, with her other two children, to plan the funeral.

As her feelings of shock began to subside, Marian began to be aware of other feelings and sensations. She had no appetite, could not sleep for more than an hour, kept hearing Tina call to her for help, could not focus on anything or concentrate, and stayed in her nightgown for days until someone pushed her toward the bathroom to shower and brush her teeth. Marian kept the curtains closed and sat in a recliner in the living room. She took an indefinite leave of absence from work.

All Marian could think about was how afraid Tina must have felt just before she died. The violent images came unbidden. She thought she should have been with Tina and felt guilty she was unable to help her. Concerned for her health, Tom brought Marian to their doctor, who prescribed medication for anxiety and sleep. Marian began to feel a little stronger.

Several months later, an arrest was made. After traveling for a meeting with the district attorney, Marian was told the case against the alleged perpetrator was strong and that a trial date would be set. Marian was extremely anxious about seeing her daughter’s killer in the courtroom—she was not sure she would be able to control herself. The judge set a date for the trial to begin in 6 months. Needing to take off time from work and make travel arrangements, Tom called the district attorney’s office 2 weeks before the trial to confirm the day and time. After gearing up physically and emotionally, Marian and Tom
arrived in court, only to find the proceedings had been postponed. After profuse apologies, the victim/witness assistance coordinator agreed to let the family know in the future when scheduling changes occurred.

During the trial, Marian and Tom met Nancy, a homicide survivor and member of the support group based in the city where the trial was taking place. Although not a lawyer, Nancy was able to answer many of Marian’s questions about the criminal justice process, as well as validate many of the emotional reactions she was experiencing. Seeing evidence of the crime scene was very difficult for Marian, and she had to temporarily leave the courtroom once the trial began.

Following a guilty verdict, the sentencing phase was scheduled. Marian and Tom both prepared “Victim Impact Statements,” which expressed the pain and injuries experienced as a result of Tina’s murder. They felt, at last, that someone would speak for Tina. The killer was sentenced to jail for 15 years.

On returning home, Marian thought her life would now go back to “normal”; however, what she found was that she had just put her feelings and reactions on hold for the trial. The flashbacks she experienced, although not as frequent, were worse; she frequently awoke with panic symptoms and nightmares, so she avoided going to sleep. Marian once again became reclusive, stayed at home, and expressed fear about going out, even to church or the local store. She kept the door closed to Tina’s room and took down all family pictures from the walls of her home, saying they were all such painful reminders. Their family doctor now referred Marian to a trauma counselor.

Marian was diagnosed with post-traumatic stress disorder (PTSD). During assessment, it became evident that Marian blamed herself for Tina’s death because she had encouraged her to attend the out-of-state college. The therapist was able to reframe this distortion for Marian. With encouragement, Marian discussed this with her family and learned they, too, had supported Tina’s decision.

The therapist prescribed medication to help relieve some of the re-experiencing, hypervigilence, and avoidance symptoms that Marian was experiencing and began a course of EMDR (eye movement desensitization and reprocessing) to help Marian cope with her fears and the traumatic images. These subsided over time. Through a period of treatment, Marian was able to leave her home gradually for longer and longer periods.

After more than a year, Marian felt as if she had come a long way in her own recovery and wanted to help others. She worked with another homicide survivor to establish a support group in her own town and has testified in support of victim’s rights legislation in her state.

Contextual Factors That May Affect the Grieving Process

In addition to the reactions noted earlier, Redmond (1989) described factors associated with the violent nature of the death: cognitive dissonance, murderous impulses and rage, fear and vulnerability, conflict of value and belief systems, guilt and blame, stigma, intrusion by other systems such as the media and the criminal justice system, loss of control, and social withdrawal. Some of these factors are discussed below.

Cognitive dissonance. The disbelief and horror that arise on hearing of a loved one’s murder is extreme. As Redmond (1989) noted, “There is no preparation for this sudden onslaught. . . . The death does not make sense; the mind cannot comprehend the meaning. The mind demands more information than can be processed or stored . . .” (p. 31). Indeed, Figley (1985) noted five questions that survivors often ask themselves: “What happened? Why did this happen? Why did I act as I did then? Why did I act as I have since then? What if it (the catastrophe) happens again?” (p. 404).

Rage and desire for revenge. Rando (1993) noted that anger may have been present in the relationship before the death in addition to the anger felt as a result of the murder. Asaro (1992) and Redmond (1989) described rage and desire for revenge, including revenge fantasies. Family members often feel even more out of control and frightened about these feelings and impulses, which may conflict strongly with their religious or moral beliefs. One family member stated:
“Bubba” is the big brute who’s going to rape this guy (in prison). Yeah . . . that seems to me it would be one of the worst things that could happen . . . for him to lose control . . . but you can’t say that stuff out in polite society. (Asaro, 1992, p. 40)

Media intrusion. Surviving family members often are subjected to insensitive media coverage, where a microphone is thrust into their faces to get their reaction to the news of the death or the latest development in their loved one’s case. Family members, often in a vulnerable state, do not realize they have the right to refuse media requests. With or without their permission, however, family members often find their loved one’s picture in the paper, especially when it is part of a story important to the community or the nation. Very often, in sensationalized cases, family members are subjected to frequent and in-depth discussions of the case and of their loved one’s life and lifestyle. Sometimes, the first details they may learn about their loved one’s lifestyle are in the newspaper.

Dealing with the criminal justice system. At a point when most survivors feel they are not cognitively or emotionally able to handle one more thing, they must begin to deal with the ongoing pleas, motions, hearings, trials, sentencing procedures, and appeals that make up the criminal justice system. Homicide survivors often find each step of this process is fraught with potential to cause additional anger, frustration, and emotional distress.

Although there is increased awareness of the importance of how this is accomplished, death notification often is described as one of the most traumatic aspects of the death. One woman was driving into town with her husband after receiving a phone call from a friend informing her that her son had been “injured.” When they tried to cross a road blocked by the police, they were told:

“You people get out of here . . . get the hell out of here. We’re dealing with a homicide.” That’s how we found out. (Asaro, 1992, p. 39)

Where sufficient evidence permits charges to be filed against the alleged killer, family members find that the “state” is the victim, not their loved one; in fact, their loved one’s name is rarely used during the proceedings. Family members often are excluded from the courtroom, either on the pretext they may be called as witnesses or because of the fear their emotional reactions might somehow influence the jury. In cases where there is insufficient evidence for the jury to find the defendant guilty, the family may feel even more anguish, helplessness, and rage that their loved one’s killer was not brought to justice. Plea bargaining may bring additional frustration to family members. Even if the perpetrator is found guilty, surviving family members may find the sentence was not long enough or that the sentence given was not the sentence actually served.

Social stigma and the reactions of others to the murder. Michalowski (1976) noted that it is the way the person died that determines the aftermath of the murder. He observed that “[I]t is the perceptual dimensions of inevitability, controllability, intent, deviance, and social utility which underlie and determine the ultimate meaning ascribed to any particular category of violent death” (p. 91). One woman described her frustration with friends and co-workers after her loved one was murdered:

Sometimes you just get irritated at people, you know, the way they act. You just want to shake them and say, “You know, it could be you. . . .” (Asaro, 1992, p. 48)

In cases where the victim had engaged in high-risk behavior before the murder, family members described feeling isolated from others and disenfranchised from their right to grieving their loss.

Redmond (1989) noted that often the victim and family are blamed by others (family, friends, the general public) for the murder, often irrationally. This may again refer to the “just world” theory (Janoff-Bulman, 1985), in which people assume that others get what they deserve in order to reinforce the assumption of their own personal invulnerability.
Psychological Impact

The circumstances and sequelae of the murder may easily interfere with the mourner’s ability to work through the tasks of grieving. Indeed, as Rando (1993) observed, homicide survivors have more to deal with and fewer internal resources with which to cope. So much more complex is traumatic loss than a loss perceived as “normal,” that Prigerson et al. (1999) have proposed criteria for a new diagnosis of “traumatic grief,” to be included in the next revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM). They believe this diagnosis would capture the “two core components of the syndrome—symptoms of both ‘separation distress’ and ‘traumatic distress’” (p. 67). The authors attempted to identify and differentiate the wide range of symptoms that may occur following loss into what would be perceived of as normal or pathological.

Complicated Mourning

Rando (1993) lists the six “R” processes of normal grieving:

1. Recognizing the loss
2. Reacting to the separation
3. Recollecting and reexperiencing the deceased and the relationship
4. Relinquishing old attachments
5. Readjusting to move adaptively into the new world (without forgetting the old)
6. Reinvesting

Rando described complicated mourning in this way: “Given the amount of time since the death, there is some compromise, distortion or failure in one or more of the six ‘R’ processes of mourning” (p. 149). Rando further noted that a number of factors, such as suddenness, deliberateness, and preventability—all aspects of murder—may easily place homicide survivors at risk for complicated mourning.

Posttraumatic Stress Symptoms

Homicide survivors must deal not only with issues of loss and risk of complicated mourning, but also with the presence of post-traumatic stress symptoms. Losing a loved one through murder certainly would meet criteria for exposure to a traumatic event, according to the DSM-IV diagnosis of PTSD (American Psychiatric Association, 1994). The hallmark symptoms of this disorder—persistent reexperiencing of the event, hyperarousal, and avoidance behaviors—have been reported in many studies with homicide survivors (Amick-McMullan, Kilpatrick, & Resnick, 1991; Burgess, 1975; Parkes, 1993; Rynearson & McCreery, 1993). Redmond (1989) noted: “Homicide survivors may present symptomatic behaviors characteristic of PTSD up to five years following the murder of a loved one. This becomes a normal range of functioning for this distinct population” (p. 52). Murphy et al. (1999) reported that the additional post-traumatic symptoms of “denial and numbing represent efforts to avoid what has happened. The persistent need to talk about the event with others allows survivors to revise it in ways that make it more tolerable and impose order on experience . . .” (p. 274).

Other symptoms of PTSD include triggers and anniversary reactions. Triggers are stimuli, representing some aspect of the trauma itself or of the aftermath of the trauma, that bring reminders of the event or a sense of reexperiencing the event. One woman described how, even years after her son was murdered, the scent of flowers could bring back all the feelings she experienced at his funeral (Asaro, 1992). Anniversary reactions may occur around the time of the murder, or with significant personal events such as holidays or the victim’s birthday. These significant times are often a source of dread for homicide survivors as they anticipate the memories and feelings that might arise.

Comorbidity. Homicide survivors are at risk of developing comorbid conditions along with PTSD; these frequently include depression, anxiety disorders (including panic and phobic reactions), and drug and alcohol abuse or dependence.
Nursing Implications

The circumstances surrounding murder may be quite diverse, resulting in different reactions of varying intensity; intrapersonal variables also may have an impact on how survivors react in the aftermath. These factors may put surviving family members at risk for developing PTSD, with associated comorbidity, and/or complicated mourning. Family members often experience significant secondary victimization following the murder of a loved one. By becoming acquainted with processes and events that occur in the aftermath, clinicians may be better prepared to minimize these secondary victimizations so that the experience is not made worse than it needs to be.

Many clinicians find it difficult to address death-related issues. It is sometimes overwhelming and exhausting to work with clients who are grieving. Redmond (1989) noted that some survivors felt the need to take care of their therapists after describing the violent nature of their loved one’s death. For these reasons, clinicians must develop the ability to listen to repeated and often strong descriptions of violent imagery and fantasies of revenge.

Much has been written in the last few years about the impact on clinicians of working with traumatized clients. McCann and Pearlman (1990) noted that the traumatic imagery encountered during therapy either may trigger countertransference issues or cause development of secondary posttraumatic stress symptoms in the clinician, a concept they termed “vicarious traumatization.” Clinicians must be careful not to assume feelings of helplessness and hopelessness and to attend to supervision and self-care issues when working with this traumatized population.

Conclusion

Reactions seen in homicide survivors are similar to those seen after any loss; however, they are usually more intense and longer lasting. In addition, many factors surrounding the violent nature of the death may affect the homicide survivor’s ability to cope in the aftermath and place him or her at risk for developing post-traumatic stress disorder and/or complicated mourning.

Author contact: rasaro68@pinn.net, with a copy to the Editor: mary77@concentric.net

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