Working With Adult Homicide Survivors, Part II: Helping Family Members Cope With Murder

M. Regina Asaro, MS, RN

TOPIC. The process of coping with the murder of a loved one and ways in which therapists may assist homicide survivors in the aftermath.

PURPOSES. To identify coping strategies used by homicide survivors, describe variables that may affect the grieving process, discuss treatment strategies related to posttraumatic stress and complicated mourning within the framework of outcome-oriented nursing process, and explore the concept of posttraumatic growth.

SOURCES. Review of the literature and the author's own clinical work.

CONCLUSIONS. Coping with the aftermath of murder is a difficult and long-lasting process. While no one method or strategy for assisting homicide survivors works for everyone, a combination of therapeutic approaches—including crisis intervention, individual, family, and group therapy, peer support groups, pharmacological—that may assist the survivor in working through the trauma and grief of such a violent loss.

Search terms: Complicated mourning, coping, homicide survivors, outcomes, posttraumatic growth, posttraumatic stress

L. Regina Asaro, MS, RN, is a consultant in trauma & loss and victimology, Newport News, VA.

Loss of a loved one through murder is a traumatic experience that often leaves a great deal of pain and anguish in its wake. The suddenness, preventability, and violent nature of the death may easily place family members at risk for post-traumatic stress disorder and complicated mourning (see Part I of this article). Part II reviews the literature describing coping strategies used by homicide survivors, variables that may affect the grieving process, treatment strategies for assisting homicide survivors within the framework of outcome-oriented nursing process, and the concept of post-traumatic growth. A cautionary word: The information included is not to be regarded as comprehensive, but rather as a guide toward sources that will provide the detail and explanation needed for clinicians to provide appropriate services.

Homicide Survivors' Coping Strategies

In a qualitative study of female homicide survivors (N = 11), Asaro (1992) noted that what was helpful for some individuals was not consistently helpful for others and that a wide range of strategies were used—some positive and others negative.

Faith

Some survivors reported that their faith in God was strengthened after the murder (Asaro, 1992); however, loss of a loved one through murder often calls into question issues of faith and religious beliefs that are seemingly inadequate to account for traumatic loss. When bad things happen to good people, many people experience tremendous rage at God for “allowing” or “causing” the death to occur. In his work with bereaved parents, Czillinger (1986) observed that parents must be encouraged and permitted to express their anger at God for “allowing” the death; he further noted that some...
parents might interpret the death as a punishment from God.

One woman reported that, after her mother’s death, she avoided all contact with ministers and any mention of religion, expressing anger with God for allowing the murder to happen in the first place. She later began some self-help exercises, which led her to understand that her mother had probably been taken to heaven by God before she was able to experience the pain that normally would have surrounded the actual physical death. This realization brought some comfort and peace with God.

The actions of church communities may be construed as helpful; one woman reported that her church provided a counselor for her. Another survivor, however, reported that a minister (in fact, a relative by marriage) told her he was not sure whether her mother had gone to heaven because, although the mother had been “saved” several months before she was murdered, there had not been sufficient time for her to be “forgiven” before she died.

Personal Coping Strategies

Other strategies survivors reported they employed to cope with their reactions after the murder (Asaro, 1992) included staying busy, physical exercise, and reading. One woman reported she read murder mysteries; they were so different from her real experience that she found them entertaining. Another woman went to a psychic, who said a young man was telling her “not to worry about the shoes.” The woman had felt guilty because she was unable to afford a new pair of shoes for her son’s burial. Not all strategies were positive; two participants reported that they drank more after the murder.

Actions of Others

Bard (1982) and Asaro (1992) noted behaviors on the part of others that homicide survivors perceived as supportive: listening, companionship, and help with problem solving. Many survivors reported other people were not seen as helpful when they acted with impatience and irritation around the length of the grieving process. Survivors reported they often experienced feelings of loneliness and isolation, reacted with anger when others had forgotten their loved one was murdered or were not able or willing to permit them to talk about their feelings or their loved one’s case, and felt disenfranchised from their right to grieve (Asaro).

Bard (1982) noted that relationships with others often changed after a murder. It was observed that when someone was not helpful in the aftermath of a murder, despite a close familial relationship or friendship, bitter feelings ensued. Conversely, survivors reported positive experiences with “casual friends” or co-workers who were unexpectedly helpful or kind after the murder. Bard reflected that, while unpleasant, it is possible to view these perceived unhelpful behaviors by others in a different way, rather as a “positive adaptive force . . . [that] motivates survivors to rejoin society” (pp. 21-22).

Working With Homicide Survivors

The sudden and violent nature of the death and the reactions of survivors are central to the core trauma of the murder and, therefore, must be central to therapeutic strategies.

Assessment

While the situation bringing the client into therapy may be apparent, Rando (1993) emphasized the importance of doing a complete assessment (Table 1) at the onset of treatment. She discussed the following issues: assessment as an ongoing process; the impact of the client’s state of mind on the assessment process; and the caregiver’s ability to identify and understand all past, associated, and secondary losses experienced by the client.

Variables that may affect the grieving process. Rando (1984) described 28 psychological, social, and physiological factors that may affect the grieving process after a loss. Among these are the meaning of the loss to the individual, the role of the deceased in the family, the mourner’s prior coping skills and mental health, the sup-
Table 1. Assessment Factors

**Emotional Factors**
- Reactions and range of reactions exhibited
- Expected reactions not exhibited
- Stronger than expected feelings of guilt and/or rage
- Flat or restricted affect
- Reactions to other family members’ feelings/needs

**Cognitive Factors**
- What is the perception of the loss? What brought client into treatment at this time?
- Coping methods used in prior crisis situations? Were they tried in this instance?
- Knowledge of available systems/services to assist in aftermath?
- Alteration in concentration/ability to focus and complete tasks?
- Thinking that she/he is “going crazy”
- Presence of “irrational” thoughts or interpretations
- Reexperiencing of traumatic event through “flashbacks”
- Knowledge of the specific facts of the murder and its aftermath

**Behavioral Factors**
- Presence of avoidance behaviors
- Social isolation
- Behaviors geared toward preservation of self and/or other family members, which may seem excessive or unwarranted
- Seeking behaviors geared at finding lost loved one
- Potential for harm to self or others

**Physical Factors**
- Increased or decreased appetite
- Increase or decrease in quantity or quality of sleep, including nightmares or panic symptoms
- Prescription and/or over-the-counter medications taken
- Amount and frequency of alcohol and/or substance use

**Spiritual Factors**
- Questioning of previously held religious beliefs, that formerly were a source of comfort and/or support
- Evidence of shattered assumptions

In his study, homicide survivors from minority backgrounds were “neither surprised nor particularly upset by perceived poor service or communication lapses” (p. 21). On the other hand, white survivors from middle and upper classes who had had less prior experience with these services often were disappointed and frustrated. Bard also found that the socioeconomic status of the survivor family might affect the manner in which grief is expressed; for example, he observed that “with the poor, necessity seems to limit the scope and duration of debilitating functional disturbances” (p. 22). He further noted that those with greater economic security might find they are able to “buy” the tolerance for dysfunction often regarded as part of ‘normal’ grieving” (p. 22).

Ogawa (1990) noted that all victims of violent crime share a “commonality of suffering,” but observed there are “cultural, socioeconomic, and situational factors to consider in attempting to understand the impact of crime on minority victims” (p. 78).

Fish (1986) noted that anticipated deaths were found to be more difficult for mothers; sudden deaths, however, were more difficult for fathers. Murphy et al. (1999) noted that over the course of 2 years, the proportion of mothers meeting criteria for post-traumatic stress disorder decreased; however, the rate for fathers increased from 5% to 14%.

**Instruments.** Psychometric instruments may be used to aid in diagnosis, identifying the presence of comorbid symptoms, and evaluating perceived and measurable improvement after treatment. Some commonly used instruments include the Grief Experience Inventory (Redmond, 1989), the Grief and Mourning Status Interview and Inventory (Rando, 1993), the Clinician Administered PTSD Scale (CAPS) (Shalev, 2000), Traumatic Experiences Scale (Murphy et al., 1999), and the Posttraumatic Growth Inventory (Tedeschi & Calhoun, 1996).

**Treatment Outcomes**

Following assessment, specific diagnoses can be formulated using the DSM-IV (American Psychiatric Association, 1994). Shalev et al. (2000) discussed the difficulties...
inherent in measuring treatment outcomes in post-traumatic stress disorder as a natural outcome of the complexity of the diagnostic process. Outcomes related to the grieving process and coping with posttraumatic stress symptoms are described.

**Grieving process.** The six “R” processes (Rando, 1993) of normal grieving are outlined in Table 2. Outcome measures include the completion of any or all of these six “R” processes.

1. Acknowledge the loss and the meaning of the loss.
2. Express feelings about the loss; react to the loss; identify and grieve any additional losses, some of which may not become obvious until later in the grief process; and describe the circumstances of the death.
3. Verbalize a transformation in the emotional attachment with the deceased from “one of presence to one of memory” (Irion, 1966, p. 48) and review the positive and negative aspects of the relationship with the deceased.
4. Verbalize the loss of or modification of the old assumptive world and verbalize specific reactions to changes in the assumptive world (e.g., “shock and numbness, stress, anger, anxiety, guilt, sadness, despair, hostility, idealization, depression and psychological reorganization” [Rando, 1993, p. 51]).
5. Verbalize new assumptive views about the world in general or to particular aspects of the world; verbalize the concept that, although she or he may maintain an abstract love for the deceased, the person is no longer living; move forward “adaptively into the new life” (Rando, 1993, p. 55); verbalize plans for the future that do not include the deceased; adopt new roles, skills, and/or behaviors that the deceased may have held; meet own needs previously fulfilled by the deceased; and form a new identity and self-image, taking into account all the changes associated with the loss of a loved one.
6. Redirect emotional energy into other areas, which may include present or new relationships or, for example, promote causes or ideas, which provide a measure of gratification or satisfaction.

**Post-traumatic stress symptoms.** Rando (1993) noted that the goals of dealing with the trauma are to reduce symptoms and to minimize secondary losses. She described two difficulties that hinder this process: (a) dissociation and post-traumatic amnesia may interfere with memory; and (b) the anxiety generated by these traumatic memories is sometimes so strong that the individual will avoid dealing with them and, therefore, may not have access to the memories. Client outcomes are geared toward minimizing the post-traumatic symptoms so that the underlying grief issues may be addressed; in practice, however, the clinician may need to address both the stress and grief symptoms either separately or simultaneously (Rando, 1997).

**Optimal client outcomes:** The client will verbalize
1. Decreased episodes of intrusive recollections.
2. Decreased feelings of anxiety, guilt and/or shame associated with the murder, verbalizing the circumstances surrounding the murder, as appropriate; and manage life events without needing to avoid reminders of the murder.
3. Decreased fears for self and other family members, observing a decrease in or absence of anxiety symptoms associated with the murder.

**Planning**

Detailed information on a broad range of approaches to dealing with grief and post-traumatic stress symptoms following a murder is well beyond the scope of this article. The clinician can make use of crisis intervention; individual, family, and group therapy; and/or peer support...
groups to assist the client in the aftermath of murder. A combination of approaches (e.g., trauma-focused counseling, pharmacological approaches) is more effective than use of any single approach. Table 3 is a conceptual representation of how potential blocks to completion of the tasks of grieving may result in one or more of the syndromes of complicated mourning. This table is not intended to be all inclusive but contains some of the most common symptoms and issues arising after a murder.

**Crisis intervention.** Aguilera (1990) noted that the goals of crisis intervention are to resolve the immediate crisis and, Aguilera hoped, teach the individual effective coping strategies for dealing with future difficulties. She described three balancing factors that affect the way individuals deal with crisis: prior coping abilities, presence of social support, and the individual's perception of the event. Usually, the period of immediate crisis is self-limiting because either the crisis is resolved or the person no longer can tolerate the associated anxiety, resulting in possible long-term sequelae such as depression. The increased sense of vulnerability often motivates individuals in crisis to seek assistance in solving the problem; for this reason, it may be possible in the very early stages following a murder to correct distorted perceptions and improve the client's ability to cope with the crisis.

Foa (1997) did a study (N = 20) with evenly matched groups of female rape victims with the diagnosis of post-traumatic stress disorder (PTSD) 2 months after their attack. Each group received either a Brief Prevention Program (weekly 2-hour sessions for 4 weeks, including psychoeducation, breathing exercises, and muscle relaxation) or were in an assessment control group. After 2 months, only 1 of the 10 participants in the treatment group still met criteria for PTSD, compared with 7 in the control group. While this is a different client population, it does suggest that early intervention might be beneficial in relieving post-traumatic stress symptoms and warrants further study.

**Individual counseling.** Participants who found counseling helpful had the opportunity to deal with issues specifically related to trauma and loss. Strategies described as unhelpful included being "lectured" about the grief process or having to explore early childhood experiences unrelated to the murder (Asaro, 1992). Psychodynamic approaches such as cognitive-behavioral treatment, including prolonged exposure and systematic desensitization, have been used with success (Foa & Meadows, 1997). Additional interventions are included in Table 4.

**Post-traumatic stress disorder.** Rando (1993) noted that several strategies—including behavioral, psychoanalytic, and eclectic approaches—have been used in dealing with PTSD symptoms and observed that these approaches paralleled that of working through the six “R” processes (see Table 2). Further, these strategies may provide the mourner with a sense of empowerment and may “liberate him from the traumatic effects of victimization” (p. 588). Therapy must address not only the primary post-traumatic symptoms but also the defenses and behaviors used to keep them at bay, and these approaches must be used within the framework of a trusting relationship.

Clinicians also must assist clients in the reconstruction of a worldview that incorporates the experience of victimization (Janoff-Bulman, 1985). She described two general types of coping strategies: cognitive (redefining the victimization and finding meaning in the event) and direct action (changing behaviors and obtaining social support). Janoff-Bulman further noted that the concept of “behavioral” self-blame (compared to a “characterological” self-blame) was seen as adaptive because it enabled individuals to reconstruct a worldview in all three assumptive domains (personal invulnerability, world as comprehensible place, and view of self in a positive light). “People can be powerless in preventing their own victimization and powerful in coping with it” (p. 31).

**Complicated mourning.** Rando (1993) described three syndromes of complicated mourning: “problems in expression (absent, delayed, or inhibited mourning); skewed aspects (distorted or conflicted mourning); and problems with closure (chronic mourning)” (p. 156). For a complete discussion of the syndromes of complicated mourning and therapeutic implications associated with traumatic loss, see Chapters 4 and 12, respectively (Rando).
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Table 3. The Impact of Potential Blocks on Completion of Six “R” Tasks

<table>
<thead>
<tr>
<th>“R” Processesa</th>
<th>Potential Blocks to Completion of “R” Processes</th>
<th>Possible Impact on Completion of “R” Processes</th>
<th>Related Syndromes of Complicated Mourningb</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognize loss</td>
<td>Denial/Psychic numbingb</td>
<td>Denial of loss</td>
<td>Absent mourning (rare)</td>
</tr>
<tr>
<td></td>
<td>Death is unexplained and unbelievable</td>
<td>Assumptions are shattered; security is lost</td>
<td>Unanticipated mourning</td>
</tr>
<tr>
<td></td>
<td>Death is presumed/body of deceased never found</td>
<td>Denial of loss</td>
<td>Delayed mourning</td>
</tr>
<tr>
<td>React to separation</td>
<td>Participation in criminal justice system</td>
<td>May elect to postpone grieving</td>
<td>Delayed mourning</td>
</tr>
<tr>
<td></td>
<td>Reexperiencing symptomsb</td>
<td>Inability to tolerate overwhelming physical/emotional response</td>
<td>Inhibited mourning/Distorted mourning</td>
</tr>
<tr>
<td></td>
<td>Avoidance symptomsb</td>
<td>Same</td>
<td>Same</td>
</tr>
<tr>
<td></td>
<td>Arousal symptomsb</td>
<td>Same</td>
<td>Inhibited mourning</td>
</tr>
<tr>
<td></td>
<td>Extreme guilt/Self-blame</td>
<td>Difficulty with loss of negative, overly ambivalent relationship</td>
<td>Conflicted mourning</td>
</tr>
<tr>
<td></td>
<td>Numbing/Dissociationb</td>
<td>Death may seem to be fulfillment of mourner’s wishes</td>
<td>Distorted mourning</td>
</tr>
<tr>
<td></td>
<td>Amnesia to aspects(s) of traumaab</td>
<td>Limited access to memories</td>
<td>Delayed mourning</td>
</tr>
<tr>
<td></td>
<td>Extreme anger</td>
<td>Inability to express/overexpression of negative/overwhelming emotions</td>
<td>Inhibited mourning/Distorted mourning/Conflicted mourning</td>
</tr>
<tr>
<td>Recollect and reexperience deceased and relationships</td>
<td>Reexperiencing symptoms; arousal symptoms; avoidance symptomsb</td>
<td>Inability to tolerate anxiety of recollection/review of relationship</td>
<td>Distorted mourning/Conflicted mourning</td>
</tr>
<tr>
<td></td>
<td>Somatization</td>
<td>Physical symptoms may replace unmourned aspects</td>
<td>Inhibited mourning/Distorted mourning</td>
</tr>
<tr>
<td>Relinquish old attachments</td>
<td>Reexperiencing symptoms; arousal symptoms; avoidance symptomsb</td>
<td>Inadequate prior grief work accomplished; unable to relinquish old attachments</td>
<td>Chronic mourning</td>
</tr>
<tr>
<td>Readjust to move adaptively into the new world without forgetting the old</td>
<td>Reexperiencing symptoms; arousal symptoms; avoidance symptomsb</td>
<td>Same</td>
<td>Chronic mourning</td>
</tr>
<tr>
<td>Reinvest</td>
<td>Same</td>
<td>Same</td>
<td></td>
</tr>
</tbody>
</table>

Rando, 1993
American Psychiatric Association, 1994
Table 4. Interventions for Homicide Survivors

1. Promote feelings of safety and security within the physical environment of therapy.
2. Discuss the specifics of the murder, even if not brought up by the client.
3. Determine which "R" processes have been substantially completed and identify issues/symptoms that may interfere with progress.
4. Address comorbid symptoms (e.g., panic attacks, alcohol abuse/dependence).
5. Determine which aspects of the trauma are most troublesome.
6. Provide information to help differentiate between grief and post-traumatic stress symptoms; provide psychoeducation as necessary.
7. Allow client to repeat and review trauma as needed.
8. Encourage exploration of "why" questions and rebuilding of shattered assumptions.
9. Assist in exploring feelings of anger and/or rage, helplessness and/or powerlessness.
10. Reframe distorted/irrational perceptions, especially related to guilt, anger, and control.
11. Make appropriate referrals for additional services, e.g., peer support group.

Family therapy. Horwitz (1997) gave an excellent description of transitional family therapy with clients experiencing traumatic loss. The goals of therapy were identified: to assist family members to complete the unfinished business between them and the deceased, and reorganize the remaining family roles and relationships. These goals are accomplished using the resources of the family.

Group therapy. van der Kolk (1987) described the positive aspects of group therapy for trauma survivors, including the opportunity to share feelings with others who have similar experiences, promotion of self-esteem as group members alternately receive help from and provide assistance to others, and finding personal meaning in the traumatic event. Redmond (1989) described a 12-session model of group therapy for homicide survivors.

Peer support groups. Peer support groups often have been founded by survivors who already have worked through many of the issues in the aftermath of murder and who wish to help others going through the same process. People experiencing other types of losses may find their reactions invalidated if they attend support groups with homicide survivors, feeling perhaps that their loved one may have died but "at least she wasn't murdered."

Support groups provide a safe place for survivors to share experiences, feelings, frustrations, and successes. Some survivors may find they feel worse after attending group, because they are actively dealing with the feelings and issues that surround the trauma and the loss. Survivors who have lost a loved one recently learn that others have experienced the same feelings and reactions they did, and survived, providing a measure of hope that they, too, will be able to cope with the experience. "[T]o see that there were other people that had survived and that they had done something about it and that you do get better and ... boy, that was the biggest shot in the arm to me" (Asaro, 1992, p. 43).

Participation in a support group also may be helpful for those attempting to reconstruct their worldview after the murder. The validation of feelings and reactions among group members is highly normative and may help reinstall a sense of order in their lives. By helping other members solve problems, survivors may find meaning in their own experience.

Some survivors may feel uncomfortable sharing their feelings in the group setting or fearful about the intense emotions they or others might exhibit in the group. If so, support group members often speak with other survivors on the phone or individually, away from the group setting. Chapters of national organizations (such as Parents of Murdered Children and Other Loved Ones, and Compassionate Friends) and local, nonaffiliated support groups have been helpful to many homicide survivors. Often, the local district attorney's Victim/Witness Assistance Program is aware of homicide support groups operating in a given area.

Pharmacological approaches. Homicide survivors may or may not present to treatment with full-blown PTSD but may describe only one or two of the three
symptom clusters. Survivors also may have comorbidity (Brady, Killeen, Brewerton, & Lucerini, 2000), including but not limited to major depression, anxiety, and/or substance abuse or dependence. Use of drugs and/or alcohol provides an instant defense against the anxiety and emptiness generated by the loss. That symptoms seem to arise from different sources in the body further complicates treatment, making pharmacological approaches difficult to standardize.

van der Kolk (1997) described biological abnormalities associated with PTSD, including psychophysiological, neurotransmitter (norepinephrine and serotonin, hypothalmic-pituitary-adrenal (HPA) axis, memory, and neuroanatomical changes, as well as impaired immune function. He noted that future neuroimaging studies may have an impact on the conceptualization and treatment of PTSD.

Friedman (1998, 2000) provided an excellent review of the literature on the psychobiological basis for pharmacological approaches to treating PTSD. Currently, SSRIs seem very promising in treating all three symptom clusters of PTSD. Alarcon, Glover, Boyer, and Balon (2000) developed algorithms for treatment of PTSD and described some of the challenges—the heterogeneity of the population, existence of comorbid symptoms, patient compliance, and cost. They noted, however, that approaching treatment (of which pharmacological approaches are just one aspect) in a systematic manner allows for all variables to be addressed.

Other approaches. Spungen (1998) discussed a number of other strategies for dealing with posttraumatic stress symptoms following the murder of a loved one; for example, eye movement desensitization and reprocessing (EMDR), thought field therapy, traumatic incident reduction, guided imagery, and neurolinguistic programming. She noted that, while no one technique is promoted over another, these “methods are at once highly focused, directive and controlled, yet noninterpretive and nonjudgmental. In competent hands, they are powerful tools for use in the rapid and successful resolution of virtually any trauma-related condition” (p. 166).

Evaluation

Recovering from the loss through homicide of a loved one is a process, not an event. Evaluation of outcome criteria is ongoing; completion of certain processes or treatment goals provides the groundwork on which other goals are set and implemented. Rando (1993) noted that both anniversary reactions or subsequent temporary upsurges of grief (STUGs), experienced by many mourners, should be seen as normal within the process of coping with trauma and loss, not as a pathological response.

Post-Traumatic Growth

Calhoun, Cann, Tedeschi, and McMillan (2000) described the concept of posttraumatic growth in trauma survivors, defined as the “individual’s experience of significant positive change arising from the struggle with a major life crisis” (p. 521). Three broad categories of benefits were described: perceived changes in self-perception, changed sense of relationship with others, and changed philosophy of life.

Perceived Changes in Self-Perception

Tedeschi and Calhoun (1996) observed that some people experiencing a trauma expressed increased feelings of self-confidence and self-reliance following the event. People seemed to feel they had faced the most difficult experience they are likely to face; thus, there was a sense of emotional strength gained from the event, which seemed to be generalizable to other life situations.

Changed Sense of Relationship With Others

Following a traumatic event, some people found they were better able to disclose feelings and reactions to others, particularly feelings of vulnerability. Others found they had greater compassion and sensitivity to the feelings and needs of others or that they were able to reach out and help others who had experienced similar types of losses or traumas (Tedeschi & Calhoun, 1995).
Changed Philosophy of Life

Some individuals who have gone through traumatic experiences reported changes in priorities, a new appreciation for life, and not taking others for granted (Tedeschi & Calhoun, 1995). Asaro (1992) noted several survivors reported they felt good about their participation in the study because they were helping others. On the other hand, Calhoun et al. (2000) observed that individuals who process the trauma and contemplate its meaning or significance are more likely to report post-traumatic growth. Janoff-Bulman (1985) noted that finding meaning in a traumatic event may be evidence of reconstruction of the assumptive world destroyed by the traumatic event. Calhoun et al. further noted, however, that not everyone who anticipated or expected post-traumatic growth did so; conversely, others who had not gone through this period of introspection did experience post-traumatic growth.

Polatinsky and Esprey (2000) studied gender differences in perceived positive benefits following traumatic loss of a child through accident, suicide, and homicide. No significant gender difference was observed among participants; one reason that may have accounted for this was that both bereaved parents were participating in a social support network. This finding suggested to the researchers that perhaps social support was an important underlying factor in helping bereaved parents find meaning in the death of their child. Polatinsky and Esprey also suggested that the experience of losing a child through murder may be more stressful and difficult to deal with than other types of loss, although the small sample size of homicide survivors (N = 7) made it difficult to generalize findings. Parents who lost a child through illness scored higher on the total Posttraumatic Growth Inventory (PTGI) than parents of a child lost through suicide or homicide, suggesting that having the ability to anticipate the death may somehow be associated with a higher level of perceived benefit after the death.

Calhoun and Tedeschi (1999) cautioned clinicians to remember that not all who experience trauma will report post-traumatic growth. Although it is hoped that individuals will report growth in the aftermath, it must be noted that some clients may never reach that point in their therapy. However, clinicians should be aware of the client’s movement in that direction and provide support in exploring positive benefit from traumatic experiences.

Nursing Implications

The difficulty of assisting survivors in coping with the aftermath of murder should not deter clinicians from taking on this challenge. With appropriate knowledge, therapists can better assist their clients in coping with the traumatic aspects of the death, processing the loss, proceeding through the tasks of grieving, minimizing the secondary victimizations and/or losses that may occur in the aftermath, and facilitating post-traumatic growth. Clinicians must examine their own experiences, values, beliefs, and attitudes so they are not roadblocks to helping traumatized individuals to grieve their losses.

As nurse therapists providing care to homicide survivors, we must remain truly “present” and “in the moment.” It is difficult to work with people who are in such extreme pain; we must remember that survivors do not have a choice—they cannot change what has happened to their loved one. We also must be able to tolerate the persistence and relentlessness of the pain of this experience and be willing to sit with clients as they work through it.

Although therapists may not be directly involved, increasing one’s knowledge about the criminal justice system may help clients deal with their anger and frustration in a more effective manner; clinicians also will be able to make more appropriate referrals to local crime victim assistance programs that provide advocacy, intervention, and/or peer support group services. Many states cover therapy for homicide survivors under crime victim compensation funds; information about this resource is available through the local district or state attorney’s Victim/Witness Assistance Office.
Although identified for many years, the synergy of trauma and grieving has been addressed to any great extent only in the last 10 years or so; in addition, most of the studies on the impact and treatment of trauma have been done with clients other than homicide survivors. It is clear, therefore, that while there is a growing body of research attempting to identify the most effective approaches and/or combination of approaches to treatment of PTSD, there remains a vast amount of work to be done.

Findings of Calhoun and Tedeschi (1999) related to post-traumatic growth in clinicians observed that “The empathic understanding by the clinician can lead him or her to realize that, as human beings, we are more vulnerable to loss than we had hoped, but we are also stronger than we had imagined possible” (p. 129).

Conclusion

The difficulty of assisting survivors to cope in the aftermath of murder should not deter clinicians from taking on this challenge. The use of a variety of strategies—including crisis intervention, individual, family and group therapy, peer support and pharmacological and other approaches—may promote the client’s ability to cope with the trauma and loss, and facilitate personal growth in the aftermath.

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

References


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