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Psychiatric Problems Following Bereavement by Murder or Manslaughter

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Bereavement by murder or manslaughter is often associated with a high incidence of factors which increase the risk of lasting psychological problems after bereavement. In this study it appears that self-perpetuating vicious circles often accounted for the persistence of symptoms, which fitted the diagnostic categories of post-traumatic stress disorders, anxiety states, panic syndromes, obsessive revenge-seeking, and depression. Therapeutic approaches should be aimed at interrupting these vicious circles and fostering the work of grieving.

Situations of extreme stress provide the opportunity to study the onset and psychopathology of the psychiatric disorders to which they give rise. Bereavement following murder or manslaughter must surely be one of the most traumatic types of loss experienced. It has been the topic of several descriptive studies. These include Rynearson's (1984) study of people who attended a support group for those bereaved by murder, a similar study by Amick-McMullan *et al* (1989), Burgess's (1975) account of six people seen by a nurse counsellor after a murder, and several studies of children traumatised by a murder in the family, (Pynoos & Eth, 1984, 1985; Black & Kaplan, 1988). There are also several reports of self-help groups for parents of murdered children (Klass & Peach, 1987; Klass, 1988; Redmond, 1989). These studies describe a range of serious problems, and support the view that the mental health of people bereaved by murder may well be at risk.

Previous research indicates that any or all of the following factors (which are likely to be present after a murder) can increase the prevalence of psychosocial problems in the wake of bereavement:

(a) sudden, unexpected deaths
(b) untimely deaths
(c) witnessing of horrific circumstances
(d) threat to the life of the survivor or other loss of personal security
(e) guilt at having survived
(f) intense anger or ambivalence
(g) deaths by human agency, particularly when compensation is involved.

Parkes (1990) reviews the scientific literature in this field.

Method

It is with the aim of examining the interaction of these and other factors peculiar to bereavement by murder that a detailed study has been carried out of the case records of 17 patients who were referred to the writer's psychiatric out-patient clinic at the Royal London Hospital for the assessment and for the treatment of psychiatric problems arising after a death which was thought by the family to be murder. Manslaughter has been included because in some cases this was the verdict of the court while many of the survivors continued to regard the offender as a murderer and express deep resentment of what they saw as the derisory sentence imposed. If anything, the stress on the families of the victims seems to have been greater in these cases.

Referrals to this clinic come from all parts of London, including several from the self-help organisation for parents of murdered children. Patients are always invited to bring a relative, and those who came were also interviewed.

Results

Only one of the 17 patients referred was a man (he had lost his wife). Of the women, nine were mothers who had lost a child, two had lost a sister, two a friend, and one each had lost a husband, mother, and mother-in-law.

Six of the assailants had been a stranger to the patient (four of whom were never identified) six were relatives (three sons-in-law, two brothers-in-law, and a son), and five other acquaintances. The known assailants were all men.

The most common method of killing was stabbing (8); four victims were strangled, three shot, one beaten to death with an iron bar, and one burned to death with petrol. In two cases the body had been mutilated after death.

The apparent reason for the killing was unknown in four cases, attributed to psychosis in two (one depressive and one schizophrenic illness), marital jealousy in seven, psychopathology in one, a fight in a public house, a family quarrel, and political vengeance.

Half of the patients were seen within a year of the death.

Reactions

Although the numbers are too small to justify statistical comparisons, this group of bereaved people had much in common with others who had suffered sudden, unexpected,

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and untimely deaths such as those that result from road traffic accidents or disasters.

Thus the immediate reaction was most often one of numbness, blunting, or disbelief, and many had difficulty in expressing their grief. "It didn't seem real," "I was knocked for six," and "I couldn't believe it," were typical reactions. Episodes of intense distress were soon suppressed, and some used medication in order to reinforce their need to be in control: "Melleril soon stopped me from crying". Others found themselves unable to cry.

As with other sudden bereavements, the numbness did not prevent a high level of arousal. Restlessness and tension were pronounced, along with pressure of talk, bewilderment, and incomprehension, which made it hard for people to find an effective outlet for their drive to action.

Strong feelings of rage against the perpetrator of the killing were common and one man, whose wife had been murdered, walked the streets with a loaded revolver in his pocket in an attempt to find the killer. (Fortunately the police got to him first.) Anger was also directed against the investigating officers who, at this stage, were often treating everyone with suspicion.

Communication of information at this early stage was often absent or chaotic, with conflicting messages being received about who had died and how. The police were sometimes suspicious of family members, reluctant to make allegations of murder, and sensitive about the details of the crime. Distraught relatives who demanded information were met with silence, and some had been unable to discover what had happened until they read about it in a newspaper. News reporters were usually to hand, and while some had found them sympathetic and supportive, others had felt hounded and resented the intrusion. Despite these difficulties there were some families who had been greatly helped by the sensitive understanding and support which they had received from individual policemen.

People who had witnessed the killing or discovered the body were preoccupied (or 'haunted') by the clear visual memory of the experience. Thus one woman whose daughter had died two and a half days after her former husband poured petrol over her and ignited it, was haunted by the image of her daughter's burnt and swollen body, "Like a Michelin Man".

Others had horrific images of what they imagined they would have seen. A 50-year-old woman whose daughter had been hit over the head, raped, and then strangled had a vivid image of the daughter's body lying on a slab. Vivid nightmares often had a 'haunting' quality, as in the woman whose landlady had been stabbed to death and mutilated by a psychotic man whose attention she had rejected. The patient had warned the victim of the risk she was taking and had been ignored. She had been so afraid of the man that she slept with a knife under her own pillow. After the murder the patient's main presenting symptom was a recurrent nightmare in which the murderer was pursuing her with a bloody knife, and in which she ran screaming to the police, who refused to believe her.

Two young children, brought by the patient to attend an interview, who had witnessed the murder of a parent had apparently midsunderstood the event and distorted their memory of it to fit their interpretation of what they had witnessed. Thus a four-year-old girl who had been told to 'go away' by the baby-sitter who had killed her mother with an axe subsequently said, "Mummy cut herself shaving and was taken to hospital", and a girl of three whose mother had been stabbed to death by her jealous husband said, "Daddy punched her", and later denied any recollection of the event.

Those who had not witnessed the killings were usually concerned to find out exactly what had happened; at the same time they were apprehensive and were easily dissuaded from visiting the mortuary or attending the inquest. Typically husbands persuaded their wives not to attend while attending themselves. Later they would be expected to give a detailed report of the medical evidence. This was usually regarded as helpful. Thus one woman was relieved to hear that her daughter had died from the first of five stab wounds in her back, and another was relieved to learn that there was no evidence that her daughter had been sexually assaulted before being strangled by the man who had lured her into his car on her way home from school.

Feelings of guilt and self-reproach were commonly expressed, particularly when the killing had been carried out by a relative. In these cases there had usually been threats or intimations of danger, and surviving relatives blamed themselves for ignoring or underestimating these. One woman had been lured out of the house by an anonymous telephone call informing her that her husband was in hospital. After she left, her son-in-law (whose wife had left him to return to her mother on the previous day) broke into the house and killed his wife. The mother bitterly reproached herself for failing to protect her daughter.

An Asian woman had regularly left her school-age daughter in the care of a brother-in-law who resided with them but whom she disliked. She had felt obliged to offer the hospitality of her home to this man who, subsequent to a quarrel in which her husband had threatened to evict him, had stabbed the daughter to death. The bereaved mother expressed intense reproach towards the killer, towards her husband for inviting him to stay, towards his family for not warning them of his previous delinquency, and towards herself for leaving him in charge of her daughter. When members of her husband's family came to England, visited the killer in prison, and gave evidence in his defence, she refused to have anything to do with them, and when the court committed him to a special hospital for psychiatric treatment she saw this as an outrageous failure to punish him for his crime.

An identical twin whose sister had been shot by her boyfriend felt that it should have been she who died.

Feelings of guilt could become an obsessional preoccupation, and sometimes led to self-punishment. One woman whose sister had been stabbed in the presence of the patient felt extremely guilty that she had run away when threatened by the assailant. Her sister's face had been spotted with blood and she later inflicted injuries to her own face in an attempt to punish herself for her cowardice. She also engaged in compulsive hand washing.

As long as the killer remained at large, the survivors were likely to be extremely anxious. The 10-year-old sister of the girl referred to above who was abducted on her way home from school was unable to sleep at night for fear of being

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murdered in her bed. She kept glancing over her shoulder for fear of being attacked from behind and, in succeeding weeks, this habit developed into a tic. Her mother aggravated the situation by becoming very anxious and overprotective; she too felt that she was waiting for the next attack.

People who have suffered major bereavements commonly lose the sense of invulnerability that enables most of us to move about the world without undue anxiety. It is hardly surprising that some of those bereaved by murder experienced chronic fear, shut themselves up at home, avoided people and places associated with the loss, and were unable to go to work. The mother described above was afraid to drive her car or to return to work, she became very tense and anxious, and became generally irritable.

As time passed most patients expected their symptoms to improve, but in fact feelings often seemed to remain unchanged or to get worse during the first year or so. Sometimes this occurred as the initial numbness and denial passed off, sometimes grief was 'kept alive' or renewed by the protracted legal procedures of the inquest, trial, appeal, compensation hearings, etc., and at other times anniversaries or other events prevented patients from putting their grief aside.

The horrific circumstances of the death made it difficult for friends and relatives to know what to say, and the social support systems on which many bereaved people can rely were often absent. Husbands and wives found it difficult to support each other. Typically the husband would feel a strong need to 'hold himself together', but could only succeed in doing this by distancing himself from his wife; as one put it, "I can't stand her grief". Those who were less upset than their wives were seen as uncaring, and those who were more upset as weak; either way, the husband and wife were unable to support each other at a time when both of them were in desperate need of help.

Other factors which undermined both partners were expression of irritability and the sheer duration of the distress. Partners who tolerated outbursts of rage and bitterness early in their bereavement found they lacked patience after some months, and there were many marital conflicts. Only one couple are known to have divorced, and this did not take place until several years after the bereavement. The truth often seemed to be that no matter how bad things had become at home, the prospect of a life apart was even more grim. Most couples seem to have stayed together in the hope of improvement.

The overall feeling was of sadness, bitterness, and disillusionment, as if the powers that be had failed to provide the protection from danger which we all expect, and the very basis of a just society was in question. The legal processes resulting from the death were matters of great concern, but it was unusual for the sentence of the law to be regarded as appropriate to the magnitude of the crime.

Psychiatric diagnoses

Many of the symptoms reported by bereaved people in the wake of murder or manslaughter can be seen as those of a post-traumatic stress disorder (PTSD), as defined in DSM-III-R (American Psychiatric Association, 1987). Thus, haunting memories, sometimes associated with nightmares of the murder and leading to fear and hyperalertness were common. Reminders of the murder (e.g. by the press) would evoke severe distress, and often led to avoidant behaviour. Many of the bereaved patients could also have been diagnosed as suffering from anxiety states or panic disorders, with agitated depression as an additional alternative.

In view of the magnitude of the trauma inflicted on these bereaved families, it might be thought that prior vulnerability would have played little part in the causation of their psychiatric problems, but this was not the case. A systematic psychiatric history revealed that 10 of the 17 patients had evidence of previous insecurity. Most often this took the form of general shyness and lack of self-esteem which could be traced to problematic relationships with parents in childhood. These problems had continued in adult life, when insecure attachments had led either to intense, close and dependent relationships, or to ambivalence and rejection. In a few cases these family problems had probably helped to set the scene in which the murder took place, for example by sowing the seeds of mental illness or relationship problems which ended in murder. Whether or not this was the case, such problems undoubtedly influenced the bereaved person's ability to cope with the bereavement and with the many difficulties which followed in its train.

The most severely disturbed patient in this group was the elderly lady who had been lured out of the house by her daughter's husband. She had never been a secure person, and suffered from diabetes, multiple sclerosis, and osteoarthritis, which seriously limited her mobility and vision, and threatened her life. Her retired husband was supportive, but she gave him a bad time. Members of his family had criticised her daughter in court, the charge of murder had been reduced to manslaughter, and the assailant was already out of prison by the time the patient was referred to me. She would not allow her husband to contact his family or play the violin at home (because it made her cry); angry outbursts were frequent and, at times, had been violent. She was depressed, embittered, and would probably have killed herself if she had had the means to do so.

Depression was a presenting symptom in most cases, with associated difficulty in sleeping, loss of appetite and weight, and tearfulness in a minority. Two patients were abusing alcohol.

Course and treatment

Most of the patients were referred to psychiatric care within two years of bereavement and were seen by the writer for short-term psychotherapy. Only five of the 17 had more than six interviews. An antidepressant drug (mianserin) was prescribed in one case (the elderly lady described above) but without much benefit.

In four cases the patient's spouse was included in the therapy, and in two cases children were seen in family interviews while also receiving individual therapy from a child therapist.

In the psychotherapy sessions, patients were encouraged to review the events leading up to and following the death,

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and to express any feelings that emerged. Most were asked to bring photographs of the deceased and any other artefacts, forms of funeral service, etc., which would help to 'bring the dead person into the room'. The therapist adopted a friendly but matter-of-fact manner without in any way belittling the powerful feelings involved.

Most patients were clearly improved by the time therapy ended, and none was worse. Anger and self-reproach remained, but they came to be expressed in creative rather than destructive ways. One man whose irritability had threatened his marriage after the death of a relative in a pub fight took part in a campaign which succeeded in bringing about changes in legislation on the carrying of offensive weapons. The man who had walked the streets with a loaded revolver in his pocket realised that, "If I had succeeded in finding my wife's murderer and killing him I would have been doing to this man's daughter what he had done to mine". He subsequently spoke out in public against the reintroduction of capital punishment. Other survivors remained strongly in favour of capital punishment and critical of a legal system which they saw as sympathetic towards the culprit. Even so, the amount of unrestrained anger which they expressed at home diminished.

Post-traumatic symptoms seemed to respond to reassurance, although it is hard to know how many of them would have subsided spontaneously. Important factors seemed to be the recovery of a sense of control over one's life. Taking a history helped the bereaved to put things in perspective. Thus one woman who had herself been arrested on suspicion after two friends had been found stabbed was released when further investigations cleared her name and the assailant was sent for trial. Hounded by the press and distanced by the victim's family, she shut herself up at home in a state of continued anxiety and fear with typical symptoms of PTSD. She was much helped by the opportunity to talk through the events in detail, and to attend the preliminary law hearing. After only four interviews she was free of symptoms.

The elderly lady referred to above remained depressed but allowed her husband to start playing the violin again, and was much helped by attending a 'marathon' weekend-long group-therapy session with a distinguished American psychiatrist at which her husband moved the entire group to tears with his playing.

People who had initially avoided too close a confrontation with places and people associated with the loss often seemed to benefit from deliberately finding out what happened. A woman whose son had been robbed and murdered while abroad visited the scene of the crime and talked to the investigating officers. This seemed both to reflect and to enhance her sense of control over the painful memories and imaginings which plagued her.

Given a little support from outside the family, relatives became more supportive. A patient who was seen only once subsequently wrote to say that when her family learned that she had been to see a psychiatrist, they became so understanding that she did not need to return again. The 10-year-old girl who had developed a tic improved rapidly and was soon sleeping through the night. In this case it is hard to know how much the improvement resulted from regular therapy from a child therapist and how much from the change in behaviour of her parents who, once they began to feel more secure, adopted more supportive and less coercive attitudes (e.g. by sitting with her when she went to bed and permitting her to sleep with the light on).

For a few people, the creation of fitting memorials to the dead was an important way of negating the loss. Thus the parents of the young man who had been robbed and murdered funded a project at his school to commemorate his name, and purchased the villa in Spain where he had enjoyed his last holiday.

Discussion

It is hard to know how typical the bereaved people seen in this psychiatric clinic are of all those bereaved by murder. The fact that they had sought help from a psychiatrist suggests that their problems may have been worse than those of families who did not seek this help. Yet their symptoms did not differ markedly from those described by Rynearson in his study of 15 attenders at a support group who had not been referred for psychiatric treatment. The main difference between his sample and mine was that whereas Rynearson describes a marked improvement in most symptoms within 6–18 months of the bereavement, the opposite was reported by my patients, most of whose symptoms had worsened in the course of the first year. This initial worsening of symptoms may well reflect a gradual reduction in the avoidance which is often pronounced in cases of PTSD, and it was reassuring to witness eventual improvement.

We have no means of knowing how the symptoms of either of these samples compare with those of people who do not seek help from support groups or psychiatrists. Are they resilient people who get all the help they need from family and friends, or could it be that they are more disturbed than the rest and try to limit their distress by avoiding situations in which they will be expected to confront the painful reality of their loss?

None of the phenomena described here are unique to bereavement by murder but, taken together, they show clearly why this type of bereavement is particularly conducive to psychopathology. The combination of sudden, unexpected, horrific, and untimely death, with all the rage and guilt which followed and, often, the overwhelming of the family as a support system to the bereaved, is bound to interfere with normal grieving.

It does this in several ways: (a) by inducing post-traumatic stress – a kind of emotional shock which generates anxiety, depressive avoidance, and vivid mental imagery; (b) by evoking intense rage towards the offender and all associated with him at a time when there may be little opportunity to vent that rage

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effectively; (c) by undermining trust in others, including the family, the police, the legal system, and God; (d) by evoking guilt at having survived and at failing to protect the deceased. These consequences easily set in train vicious circles. Avoidance of confrontation or reminders ensures that grief will be delayed (Amick-McMullen *et al*, 1989), feelings of helplessness easily become transmuted into withdrawal and depression, lack of trust causes people to turn away from sources of help and become socially isolated, and feelings of guilt may cause them to engage in self-punitive grieving. The bereaved people in this clinic saw themselves as in a rut from which they could not escape.

The fact that with short-term therapy most did improve should not blind us to the fact that nothing can undo the memories or fill the gap left in the family by a murder. Some may well have benefited from longer-term therapy if it had been available, and it is not possible to know the extent to which psychological trauma of this kind extended to relatives who were not seen, particularly children whose problems may well have been disregarded by their parents on the principle of 'least said, soonest mended'. Research into children traumatised by murder (Black & Kaplan, 1988) suggests that some will be at special risk, and may even pass on their problems to future generations.

From the point of view of the therapist, families who have been traumatised by murder can be a daunting prospect. We easily feel overwhelmed by their grief and helpless in the face of their helplessness. The sheer enormity of the outrage that has been committed against them may be hard for us to bear, and it is tempting for us to distance ourselves from their suffering. For our own sake as well as the family's, we need to have a frame of reference, a way of thinking about their plight, which may not yet justify the term 'plan', but which is sufficient to enable us to 'hang in' with the pain of their chaotic experience.

The minimum desiderata for such a frame of reference may be: (a) the knowledge that, however horrific the circumstances, most people do eventually come to terms with them (order will emerge from chaos); (b) that neither the therapist nor the relatives can be expected to think about or cope with more than one problem at a time; and (c) that it is worth a little time working out what is most salient or important to consider at any time, bearing in mind that the bereaved person's agenda should take priority over the therapist's.

As the family begin to share their thoughts and feelings, patterns will begin to emerge. The aim of psychotherapy is to address each of these patterns of reaction in a way which will help the individual to break out of the vicious circles. Taking the history initiates a process of confrontation in an atmosphere of support, and reduces avoidant behaviour. By consistent reassurance of worth and respect for the bereaved family, the therapist helps to restore its integrity as a mutual support system to its members, and by staying calm and committed (and not over-reacting to the horror of the situation) a model of control is presented which can then be used by the bereaved.

A perpetuating factor in the obsessional rumination and recurrent dreams which haunt families bereaved by murder is the belief that such thoughts cannot be prevented. When people go to bed dreading nightmares, their dread creates the nightmares. The patient described above who was regularly pursued by a man with a knife in her dreams was told that since we create our own dreams, she could choose how the dream would end. Several 'happy endings' were discussed, and she admitted that it had never occurred to her that she might control her own dreams. When seen three weeks later she was sleeping normally and the nightmares had not recurred.

To control thoughts is not to avoid them. In essence we are inferring that nothing is unthinkable, nothing is too painful or distressing to be excluded from our consideration. Given this encouragement, the extraordinary becomes ordinary, and the sufferer begins to accept reality, however painful this may be. Redundant basic assumptions about the world are called into question and replaced with new and more appropriate assumptions, and a new image of the self and of others is achieved. These may be less optimistic than the ones that preceded them, but they are in keeping with a fact of life that mostly we prefer to forget, that with all our civilised pretensions, man is still dangerous to man.

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