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Bereavement after Homicide
A Comparison of Treatment Seekers and Refusers

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Background. This brief report presents initial findings from a prospective descriptive study of adults after the homicide of a family member. Within the first year of bereavement, the responses and risk factors associated with unrecovered grief and post-traumatic stress disorder in subjects who requested or refused supportive psychotherapy were compared.
Method. Fifty-two adult members of 237 families contacted within three months of a homicide attended a specialised out-patient clinic (32 requested, and 20 refused, supportive therapy) after a structured interview and completion of measures of grief (TRIG), trauma (RIES and DES), and death imagery.
Results. Only two risk factors (childhood history of sexual abuse and lack of religious faith) were associated with treatment seeking. Treatment-seeking subjects also scored significantly higher ($P<0.001$) on all measures of grief, trauma, and intrusive re-enactment imagery of the dying.
Conclusion. Adults who seek therapy after the homicide of a family member are highly reactive to all measures of trauma, grief, and death imagery.

Homicide can herald a particularly discordant and prolonged bereavement in the remaining family members. Descriptive studies of treated family members (Rynearson, 1984) have documented clinical findings of trauma associated with the homicidal death, i.e. intrusive re-enactment imagery, rage, and self-blaming, which interfere with the resolution of bereavement associated with the death itself. Preliminary studies have focused on adult subjects presenting for individual psychotherapy (Parkes, 1993) or supportive group therapy (Amick-McMullan, 1988). Authors have applied standardised measures of trauma and grief to adults (Amick-McMullan *et al*, 1991; Rynearson & McCreery, 1993), lending more reliable verification to this complex response.

The vast majority of family members do not seek treatment after a homicidal death. Since the bereavement responses of this larger group remain unstudied, it might be misleading to presume that the more extreme responses of trauma and grief measured in treatment-seeking subjects would apply. Since risk factors for dysfunctional responses of trauma (childhood abuse, degree of exposure, previous diagnosis of post-traumatic stress disorder (PTSD)) and grief (loss of a child, poverty, multiple prior losses, ambivalent relationship) have been well established in other trauma and bereavement treatment studies (Parkes, 1990; Green *et al*, 1992; Bremner *et al*, 1993; North *et al*, 1994), a strong presumption might follow that these risk factors are positively correlated with treatment seeking by family members after homicide.

A long-term naturalistic study of family members after homicide would (a) clarify whether these presumptions of risk are warranted, and (b) delineate the incidence and pattern of bereavement reactions.

Method

Setting of the study

In 1990, the Support Project for Unnatural Dying was initiated in Seattle to offer support and early intervention to adult family members after homicide. There are 100–125 homicidal deaths each year in the Seattle (WA, USA) area. We have attempted to contact each family within the first three months of a homicide to offer support.

Another purpose of the project has been a systematic study of those adult family members enlisted and the serial monitoring of changes in responses to homicide. This preliminary report presents comparative data collected during the first year of bereavement from those who seek treatment and those who refuse treatment.

Description of the study

Our hopes for a prospective, naturalistic study of grief and trauma after homicide have been stymied by several factors. Twenty-five per cent of the homicidal victims had no recorded family members, or their family members were out of state and unavailable for interview. The remaining members who were

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contacted were grateful for our concern and our offer of assessment and support, but a distinct minority (52 of the 237 families we contacted) accepted assessment, and, of that small group, only 32 have requested supportive intervention.

The small group of family members we have assessed and the smaller group we have assessed and treated represent biased samples – those who report they are adjusting well and are willing to cooperate for assessment and testing and those who actively seek treatment because of their incapacity to recover.

Our initial study (Rynearson & McCreery, 1993) presented the salient findings in a group of subjects ($n=18$) who actively sought treatment. These findings included a high frequency of antecedent psychiatric disorder, an idealised attachment to the deceased (often a child), disorganising flashbacks and dreams of the death (though unwitnessed), and high levels of trauma and grief on self-report measures.

With time, we have collected data on a sufficient number of subjects ($n=32$ refusing treatment) to allow a meaningful comparison study of the two groups.

Protocol of the study

As part of our initial visit, we completed a 60-min semi-structured interview (to gather demographic data and inquire about specific risk factors), at the end of which we asked each family member to complete standardised self-report measures of trauma (Revised Impact of Events Scale (RIES) and Dissociative Experience Scale (DES)), and bereavement (Texas Revised Inventory of Grief (TRIG)). These are self-report measures of trauma, dissociation, and grief that have been extensively used in multiple clinical populations and have been shown to have acceptable reliability and validity. We included a brief survey of reported imagery of unnatural death to monitor its frequency and content. Since there is no standardised testing for the classification and quantification of death imagery, we devised a simple inventory. The study protocol thus included:

(a) semi-structured 60-min interview;
(b) Texas Revised Inventory of Grief (TRIG);
(c) Revised Impact of Events Scale (RIES);
(d) Dissociative Experience Scale (DES);
(e) death imagery survey.

Results

The data from the structured interviews and self-report measures (TRIG, RIES, DES, death imagery) were compared between the treatment-seeking and refusal groups, *t*-tests being used for continuous and χ^2 tests for categorical variables. Nonparametric methods were used for confirmation.

The data collected with the semi-structured interview compared demographic variables, antecedent risk factors, and details of the homicidal death. The demographic data from the two groups suggest that the two samples are similar (sex, race, income, education). There were non-significant trends towards treatment seekers being younger ($P=0.07$), less religious ($P=0.05$), and less apt to be married ($P=0.06$). Antecedent risk factors of serious accident, previous bereavement, depressive/anxiety/chemical dependency disorder, or hospital admission were not significant. There were non-significant trends towards therapy seekers' previous involvement in individual therapy ($P=0.06$), previous treatment with psychotropic medicines ($P=0.09$), and claiming a childhood history of physical abuse ($P=0.08$) or sexual abuse ($P=0.04$; the only risk factor that reached significance). The multiple variables related to death and dying did not show any significant differences or trends between the two groups (time since death, relationship to the deceased, relationship to the perpetrator, whether the subject had witnessed the death, whether death had been caused by firearm, beating, or strangulation, preceded by kidnap, torture, sexual abuse, or mutilation).

The data show that our assessment (and intervention if requested) occurred within the first year of bereavement (6–7 months), so the subjects would be at a particularly reactive phase in their adjustment. It should also be noted that the frequency of intrafamily homicide showed no significant difference between the two groups, and the frequency for the entire sample (14/52, or 27% intrafamily homicide) approximates the national form for intrafamily homicide. Both groups contained a majority of subjects who were a parent to the deceased. Only one subject actually witnessed the homicide.

The comparative scores of the two groups obtained on standardised self-report measures of grief (TRIG), and trauma (RIES and DES) showed a robust difference ($P<0.001$) between the two groups on all measures. Those subjects seeking treatment reported a significant increase of measures of pining and longing with grief (85.7 ± 8.0 treatment/65.5 ± 7.8 non-treatment), as well as intrusion (29.4 ± 6.3 treatment /15.3 ± 8.4 non-treatment) and avoidance (24.2 ± 7.6 treatment/9.8 ± 8.0 non-treatment) of trauma. The DES reflects the increased use of dissociation in those subjects seeking treatment (19.7 ± 12.6 treatment/8.5 ± 8.6 non-treatment), which is presumably associated with a predilection or trait for dissociation that predated the homicide.

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Table 1
Presence and frequency of four types of imagery

	Re-enactment		Rescue		Revenge		Reunion	
	Rx+	Rx−	Rx+	Rx−	Rx+	Rx−	Rx+	Rx−
None	2	11	18	16	16	14	20	12
Monthly	1	2	2	1	3	3	1	3
Weekly	13	4	9	1	7	2	7	2
Daily	16	3	2	2	5	1	4	3
P value	0.0004		0.1954		0.3392		0.4683	

Rx+ treatment seekers
Rx− treatment refusers

Table 1 compares the presence and frequency of re-enactment imagery (where the events are unreflectively witnessed) and imagery of rescue, reunion, and revenge (in which the events are actively reversed, revenged, or both by a fantasied autonomous self). Of the four types of imagery, re-enactment showed the only significant difference ($P<0.001$) and was directly associated with those subjects seeking treatment.

Discussion

Since only 52 of 237 of those families we contacted sought psychiatric support or agreed to assessment, our subjects cannot be considered to be representative of a normative population. Instead, they represent adult subjects who had experienced the same stressor (homicide of a family member) but whose inclusion into the study is biased by their self-selection for treatment or for assessment only (no treatment). The validation of these differences must await a more inclusive sample.

The demographic data tend to confirm the risk factors of younger age and marital instability for those who seek treatment. The significant affirmation of spirituality, religion, or both in those refusing treatment may suggest the presence of a more coherent schema for coping with homicidal death – i.e. that one's spirit transcends death of the body and that death is a release from suffering. History of previous psychiatric treatment and childhood abuse approached or reached significance in those who sought treatment. The historical data came from a retrospective reporting of subjects and remain unconfirmed by clinical records or interviews with primary family members. The combination of these factors is not surprising and may be associated with a significant use of dissociation as well. Treatment seekers are apparently so distressed that they are intensely responsive to all self-report measures (DES, RIES, and TRIG). The RIES and TRIG each contain subscales whose combinations are associated with specific syndromes of acute, chronic, or delayed trauma or grief responses. Treatment seekers score highly on all subscales, indicating an acute and overwhelming disinhibition of trauma and grief responses. We plan to repeat measures in both groups during the second year of bereavement to monitor change in responses to trauma and grief.

There were no differences in recent history of trauma (deaths or accidents) that might have increased vulnerability to the trauma of the homicide.

Since homicide is one of the leading causes of death before age 30 in USA, it is not surprising that a disproportionate number of middle-aged parents comprise the major kinship group. The death of a child (regardless of the child's age) often presents the surviving parents with particularly strong feelings of guilt because of their perceived failure to provide. This guilt-laden response may be especially intense in treatment seekers who present in a highly reactive state.

Death by shooting was the most common mode of homicide. The horrific antecedents to homicide (kidnap, torture, sexual abuse, mutilation) were evenly distributed between the two groups. Although this small study cannot confirm these horrific antecedents as risk factors for seeking treatment, it should be noted that they present as intense re-enactment imagery whose persistence can complicate recovery.

The significant increase in frequency of re-enactment imagery in unrecovered subjects might be an important clinical sign. In our initial study, we noted that an early issue in treatment was management of the terrifying identificatory re-enactment of the homicide distilled from police and media reports, and further embellished by elaborate projective fantasies. The imagery contained not only portrayal of the homicidal events but also a painful re-enactment of the fantasied thoughts and feelings of the victim during the terminal moments. In an effort to document the primacy of re-enactment imagery as a sign of nonrecovery, we monitored the presence of additional imagery (rescue, reunion, and revenge) in both treated and untreated subjects. Re-enactment was the only theme that reached a significant level of

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comparative frequency (29/32 treatment seekers experienced re-enactment imagery each day or week, while 11/20 non-treatment subjects denied its occurrence).

A narrative re-enactment of the homicidal death is an inevitable part of early assessment as the clinician is reviewing the details of history. This would be an obvious time to ask more specifically whether this re-enactment image occurs with enough frequency and intensity to interfere with concentration during the day or sleep during the night. Occurrence on a daily or weekly basis would suggest that this is a probable sign of non-recovery. The co-occurrence of intense reactivity to distress and intrusive traumatic imagery in treatment seekers creates a synergistic combination. While acknowledgement of and adjustment to the loss is a fundamental focus of treatment, the initial goal of therapy will be the moderation of these traumatic sequelae. In a separate publication, I have outlined a treatment strategy to manage this synergism of trauma (Rynearson, 1994).

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