
Introduction

Each man must find within himself the various methods to contain and control the pain and confusion within. There are no ready-made answers. It is a slow process of rediscovery, where denial or flight from the inward turmoil is the antithesis of self-healing. We go that road alone. We may be helped but we cannot be pushed or misdirected. We are our own self-healers [1].

Losing a loved one is an almost unavoidable human experience and coping with the loss of a loved one is considered one of the most demanding human endeavors [2]. Sudden death complicates grief and violent death complicates it even further. Homicide is viewed as an

adverse stimulus that mobilizes so much painful affect that psychological adaptive mechanisms are overwhelmed, initiating the alternating responses of hyperactivity and hypoactivity [3, p. 217].

Because of the nature of murder and other people's fear of their own mortality, homicide survivors are often disenfranchised or isolated by family and society. They are left to heal on their own. Additionally, the homicide survivor is frequently labeled and victimized by society, which prolongs the healing process.

No one has provided guidelines on how to grieve a death due to murder. The survivor must confront the personal and social reality of the loss, not only the loss of the loved one, but also the loss of dreams, of hopes, and of a future. While there are some characteristics common in this type of traumatic bereavement, the homicide survivor must find his or her own way to deal with

the blackest hell accompanied by a pain so intense that even breathing becomes an unendurable labor [4].

This book offers an interpretation of personal accounts of homicide survivors in order to understand the particular nature of homicide

bereavement. This book is written for homicide survivors and those that want to help them.

Thirteen homicide survivors participated in this study. The survivors consisted of four men and nine women between the ages of twenty-four and sixty-seven who have experienced the murder of a family member. Although homicide bereavement is considered traumatic, it is hoped this research will expand the knowledge of this type of bereavement rather than label it as “pathology.”

Limitations of the Study

The research discussed was a qualitative study using a phenomenologically inspired perspective to better understand the experience of homicide bereavement. As a qualitative research project, there are limitations inherent in the design. This refers to issues of reliability and validity.

The research study was restricted to a very small population. Thirteen people, identified as homicide survivors, were interviewed. All participants were volunteers. All experienced the murder of a loved one. While I attempted to include a diverse group of participants based on ethnicity, age, gender, marital status, sexual orientation, and socioeconomic status, the findings are applicable to the specific people involved in this study. All but one person in the study was a member of the Parents of Murdered Children (POMC) and Other Homicide Survivors support group. Similar findings may or may not be found in homicide survivors who do not attend support groups. The study does not meet the requirements of generalizability. Transferability, rather than generalizability, is a more appropriate measure for qualitative data. Transferability refers to the transfer of findings where the contexts are similar.

Throughout this book the terms bereavement, grief, and mourning are used. *Bereavement* refers to the state of having suffered a loss. “Bereavement simply means that something you once had is no longer yours” [5, p. 4]. The term *grief* refers to experiencing or responding to the loss. “It is the pain a person feels when someone or something that was important in his or her life is no longer present” [5, p. 5]. *Mourning* refers to the cultural and/or public display of grief through one’s behaviors.

Mourning is how our cultural background (nationality, ethnicity, religion) teaches us how we should respond, and how we think others will expect us to respond to our losses [5, p. 6].

Homicide, as defined by the U.S. Department of Justice, is murder and nonnegligent manslaughter, which is the willful killing of one human being by another [6].

December 24th, 1995 my husband Dan and I were visiting my sister for the Christmas holidays. It was our first Christmas together and we wanted to share it with my family. We were at my sister's house getting ready to drive to Grandma's house for dinner. As Julie, my sister, and I were getting things together, her husband, Jeff received a phone call from the hospital. Jeff was on call at Saint Elizabeth's Hospital where he worked as an Emergency Room Physician. Julie and Jeff were attending to the call while I was packing the food we prepared to take to Grandma's house. Dan went outside to smoke a cigarette and to move the car that I had gotten stuck in the snow earlier that morning. He always said I could not drive properly. We were running late, so things were very chaotic. In the midst of all the fuss, barking dogs, screeching bird, blasting television, etc., I saw red flashing lights in the dining room window. I yelled for my sister and her husband and they went outside to see what was going on. I started to follow them but was stopped by the ringing telephone. I thought it was the hospital calling back so I answered the phone. After I finished the call, I went outside. My sister and her husband were kneeling in the snow in front of my car. My sister immediately told me to go back inside the house. I asked why and she told me just to get back inside the house. Jeff then shouted, "Someone shot Dan!" I saw Dan lying in the snow. I ran over to where he was. There was blood coming from his nose and mouth. I started talking to him, rubbing his face trying to get him to wake up but he just stared straight ahead not moving or talking. He was so cold. Julie and Jeff started CPR; even though there were police, firemen, and an ambulance crew standing around, no one was doing anything. I knew Dan was going to be all right, Jeff was an emergency room physician and Julie was an intensive care nurse. It is their job to save lives. I knew Dan would be fine. It never entered my mind that there was a real problem. After the ambulance crew loaded Dan in the ambulance and the police pushed my car out of the snow bank, Julie and I were permitted to go to the hospital. The receptionist at the hospital told my sister that Dan was not there but of course he was there, it is where the ambulance crew said they were going and Jeff had insisted on that particular hospital because it is a level-two trauma center. After several minutes of checking the computer system, a big male orderly came from the other side of the emergency room and said there was a "John Doe" in the other room but they did not know who he was. They would see if that was my husband. My sister and I were taken out of the hospital waiting room and moved to a private room to wait, probably because of all the blood

on Julie's clothes, hands, and face, not to mention the teeth in her pocket from Dan's mouth. After twenty minutes or so, a young female surgical resident came into the room. She showed me Dan's military identification card and asked me if I knew who it was. I told her it was my husband and she then said, "I'm sorry to tell you he expired." "Expired? What does that mean expired? Milk expires, food expires, people don't expire. They don't have a date stamped on their foreheads. What do you mean he expired?" I could not believe nor did I want to believe what she was saying to me. I was hysterical. My sister finally said, "Jude, he's dead." December 24th, 1995 my husband was murdered and my living hell started. To this day, no one knows why, no one has been arrested, and because I am his wife (and 85 percent of the people murdered are killed by someone known to them) I'm considered a "suspect."

My experience as a homicide survivor has given me a unique perspective and experiential base for examining the phenomenon of homicide bereavement. As a homicide survivor, I am able to have contact with a population that generally keeps to itself, a population that does not trust "outsiders." The intent of this book is to help the reader understand the homicide griever's situation, both as one who grieves and one who grieves within a social context, as one who confronts horrific death at the personal level as well as at the social level. My goal is to normalize that which by society's terms is abnormal and to show how some people survive the unsurvivable.

The following pages provide a review of the literature on what is considered normal and abnormal grief. Abnormal grief is generally approached from a psychological perspective often leading to a diagnosis of post traumatic stress disorder. The nature or abnormality of death by murder often leads to societal isolation or disenfranchisement, which further victimizes the homicide survivor. I suspect it is not until the homicide survivor comes to terms with the traumatic event and its consequences, irrespective of society's definition or expectations, that a healing bereavement process can begin. Looking at grief from the homicide survivor's perspective might help depathologize it and help the survivor get back into mainstream society.

Grief is generally studied from one of four perspectives. The basic theoretical perspectives of bereavement can be classified as psychoanalytic, psychoanalytic-cognitive, behavior oriented, and cognitive stress model [7]. I have also included a list of common elements in the latest grief theories.

Psychoanalytic Perspective

The psychoanalytic perspective is based on a clinical diagnosis where certain mental pathologies prevent the bereaved from recovering from the death of a loved one [8, 9]. Freud's concept of loss, outlined in *Mourning and Melancholia* [8] became the cornerstone of psychoanalytic thought on death, depression, and grief. Basically, he believed that grief was a normal reaction to the death of a loved one. Freud believed that the bereaved experiences catharsis by disengaging from the deceased and placing energy into a new relationship. If a person did not disengage, or work through grief, the pathological condition of melancholia (depression) would result and recovery from the death of a loved one would not be possible.

Besides the social taboo regarding death, psychological theories discouraged interest in emotions such as grief [10]. Interest in bereavement grew as the effects of World War II, the results of bereavement research and clinical studies [9, 11], and the theorizing in psychiatry and psychology [12-18] led to the conclusion that the grief process was long and painful with a wide range of somatic and psychological problems.

According to Miles and Demi [19], the focus on grief in the 1970s paralleled the increased interest in death and dying fostered by the writings of Becker [20], Fiefel [21], Glaser and Strauss [22, 23], Kastenbaum and Aisenberg [24], Kübler-Ross [25], Quint [26], Schneidman [27], Weisman [28], and others. The hospice movement, which centered on issues of terminal illness, also served to focus attention on the grief process as it related to terminal illness [29].

Stages of Grief

Stages or phases of grief were popularized by Kübler-Ross [25] (during her work with terminally ill patients) in her book *Death and Dying*. Initially Kübler-Ross identified the stages as consecutive steps but later emphasized that people do not always experience the stages in an orderly or sequential fashion. She saw the stages as overlapping or consecutive. Stages or phases are used to explain the bereavement process in most psychoanalytical theories.

Bowlby [30], Doyle [31], Glick, Weiss, and Parkes [32], Kübler-Ross [25], Pollock [33], and Westberg [34] have identified various stages or phases of grief. Basically the stages are described as follows. Stage 1: attempts to limit the survivor's awareness of the death. This stage includes the initial shock, denial, and isolation felt by the bereaved. Stage 2: consists of the awareness that the loved one is gone. This allows

for emotional release such as crying seen at the funeral rites and other family gatherings. Stage 3: begins the sadness or depression typically associated with death. Stage 4: involves acceptance and resolution on the part of the bereaved that the loved one is dead and that life must go on without them.

The stage or phase model of bereavement has been useful in explaining the process of grief as a normal part of the life cycle. Sooner or later everyone experiences the death of someone they love and the stage or phase model provides a framework for understanding the grief process. The stage model has been criticized for being developed from small, non-representative samples, not addressing the individuality of the bereaved, and for not using comparison groups in the studies [31, 35-37]. Overall, there has been a general agreement among the various researchers of the symptomology of grief, but not in the conceptualization of the process of grief. Worden [38, 39], for example, thought the stage or phase theory was acceptable since mourning is considered a process but that the stage model, although a basic explanation of grief, did not describe the process of grief. He developed the tasks of mourning as an explanation of that process.

Tasks of Grief

Worden [38, 39] criticized the stage models of grief as taken too literally. His concern is that those who deviate from the stages are labeled as dysfunctional or sick, when in fact the bereaved are very adaptive to the death. Worden developed the “tasks of mourning” which he insists empowers the bereaved to take an active role in their recovery rather than go through the passive stages of grief. Worden felt the tasks were

more consonant with Freud’s concept of grief work and imply that the mourner needs to take action and can do something. . . . In other words, the mourner sees the concept of phases as something to be passed through, while the tasks approach gives the mourner some sense of leverage and hope that there is something that he or she can actively do [39, p. 35].

Worden believed that the tasks of mourning were necessary activities to get the griever through the bereavement process. Not completing the tasks would cause the bereaved to become “stuck” in grief, which would lead to pathology. The tasks consist of accepting the reality of the loss, working through the pain of grief, adjusting to an environment in which the deceased is missing, and emotionally

relocating the deceased and moving on with life. Worden describes emotionally relocating the deceased as finding

an appropriate place for the dead in their [survivor's] emotional lives—a place that will enable them to go on living effectively in the world [39, p. 17].

Worden refers to Schuchter and Zisook:

A survivor's readiness to enter new relationships depends not on "giving up" the dead spouse but on finding a suitable place for the spouse in the psychological life of the bereaved—a place that is important but that leaves room for others [40, p. 117].

Psychoanalytic-Cognitive Perspective

The psychoanalytic-cognitive perspective is based on the notions of bonding and attachment where grief is conceived as separation anxiety [11, 41, 42]. Bowlby [41] contended that attachment is an expression of affective needs within humans, as well as animals. Attachments come from a need for security and for safety. Much of Bowlby's earlier work was describing and explaining normal and so-called pathological reactions when attachments are severed. According to Bowlby, grief is a subjective experience from the loss of a love object and is considered a normal reaction. He explains the experiences, symptoms, behaviors, pain, and purpose of grief and mourning in human beings and then makes an analogy to other primates. "The mourning responses of animals show what primitive biological processes are at work in human beings" [38, p. 9]. It is the similarity of separation responses that convinces Bowlby that grief responses are instinctual, adaptational, and valuable for survival. Death is viewed as an unwanted separation from an attachment figure and childhood experiences in bonding affect the outcome of bereavement. According to Bowlby [43] mourning in mentally healthy adults lasted longer than previously suggested and that responses that were considered pathological were in fact common and normal. These responses include anger directed at third parties, the self, and the lost person; disbelief that the loss occurred; and a tendency to search, often unconsciously, for the lost person in hope of reunion. The psychoanalytic-cognitive perspective is different from the psychoanalytic view in that a relationship with the deceased is continued and that the continued relationship with the deceased provides comfort to the bereaved. Grief is resolved when new relationships are developed and new structures of meaning have been established.

Behavior Oriented Perspective

The behavior perspective [44, 45] conceptualizes grief as causing psychological and physiological changes in the mourner. These changes are considered greatly influenced by environmental factors. Parkes describes grief as

a complex time-consuming process in which a person gradually changes his (her) view of the world and the places and habits by means of which he (she) orients and relates to it [11, p. 465].

Grief involves making psychologically real an external event that is not desirable and for which coping patterns do not exist [46]. Averill [12] hypothesized that bereavement has significance beyond the well being of the individual. He suggested bereavement fulfills an evolutionary societal need—the maintenance of the long-term social bonds needed for survival of the species. This perspective’s emphasis is on external factors such as social supports.

Attig [47] suggests that grieving is a process of relearning the world in which we live. Instead of mastering the idea that one’s life is different because a loved one has died, Attig says we relearn our world. Relearning involves investment of ourselves “as whole persons, in all facets of our life all at once” [47, p. 13]. Through the relearning the survivor reestablishes self-confidence, self-esteem, and an identity.

We strive to adapt our behaviors and daily life patterns to new circumstances not of our own choosing and to recover our own sense of daily purpose [47, p. 14].

Cognitive Stress Perspective

The cognitive stress model insists that the stress of death exceeds the limits of the bereaved’s coping ability and that grief is a process of coping, learning, and adapting to the stress [48, 49].

Demi [50, 51] proposed a model of bereavement that synthesizes grief, life transitions, stress, and coping theories. Demi suggests that the bereaved experience at least three crisis periods during bereavement and the outcome of each crisis is a potential turning point in the survivor’s life. The outcome may lead to improved health and greater maturity or to poorer health and psychosocial deterioration.

Horowitz [52] considers the response to death to be a general stress response syndrome. According to Horowitz, a stressful event contains news that is severely out of line with the way an individual believes himself or herself to be in the world. This causes a sudden and powerful breach in the individual’s security and violates his or her assumptive

world. Following a serious life event and immediate efforts at coping, the individual typically undergoes the following responses: outcry, denial and numbing, intrusion, working through, and completion. Outcry involves fear, sadness, and rage. Denial and numbing involves the refusal to face the memory of the trauma. Intrusion includes the unbidden thoughts and images, feelings, behaviors, and physiological responses associated with the event. Working through the stress involves facing the reality of what happened, addressing meanings, mourning, and developing new plans. Completion is the integration of thoughts, feelings, and memories that end the intrusions. Stress models of grief consider bereavement a stressful life event and offer an explanation for the physical health consequences of bereavement. Pathological responses include being overwhelmed, dazed, confused, and swept away by immediate emotional reactions; panic or exhaustion, dissociative reactions, and reactive psychosis; maladaptive avoidances such as resorting to extreme measures to deny pain; flooded and impulsive states; psychological disruptions, anxiety and depressive reactions; and character distortions such as long term inability to work, create, or feel emotions.

Basically, bereavement begins with shock, followed by adjustment, and resolved with the development of new life patterns. Specific somatic symptoms are identified for each stage or phase of bereavement. A time frame for grief is determined as normal for each stage and a deviation from that is diagnosed as complicated, abnormal, delayed or distorted.

Newer Models of Mourning

Neimeyer [53] identifies the following elements as common to a “new wave” of grief theories:

- (a) skepticism about the universality of a predictable “emotional trajectory” that leads from psychological disequilibrium to readjustment, coupled with an appreciation of more complex patterns of adaptation,
- (b) a shift away from the presumption that successful grieving requires “letting go” of the one who has died, and toward a recognition of the potential healthy role of maintaining continued symbolic bonds with the deceased,
- (c) attention to broadly cognitive processes entailed in mourning, supplementing the traditional focus on the emotional consequences of loss,

- (d) greater awareness of the implications of major loss for the bereaved individual's sense of identity, often necessitating deep-going revisions in his or her self-definition,
- (e) increased appreciation of the possibility of life-enhancing "post traumatic growth" as one integrates the lessons of loss, and
- (f) broadening the focus of attention to include not only the experience of individual grievers, but also the reciprocal impact of loss on families and broader (sub) cultural groups [53, pp. 109-110].

Researchers have tried to describe the process of grief and have also tried to establish parameters of normalcy of grief. It is helpful to review this to show how a person becomes pathologized. Most early researchers of grief, particularly grief involving traumatic circumstances, have looked at bereavement as a clinical disorder. The next section defines abnormal grief and traumatic loss leading to post traumatic stress disorder.

"Abnormal" or Complicated Grief

"Abnormal" grief reactions have been labeled atypical [46], morbid [9], chronic [41, 46], complicated [16, 54], and pathological [55, 56]. These reactions involve absent, delayed, intensified, inhibited, or prolonged aspects of "uncomplicated" or normal bereavement.

Complicated Mourning

Rando [54] identified seven complicated mourning syndromes. They include three syndromes with problems in expression (i.e., absent, delayed, and inhibited grief), three syndromes with skewed aspects (i.e., distorted, conflicted, and unanticipated grief), and one syndrome with a problem with closure (i.e., chronic grief).

Absent grief, also called repressed or masked grief, is distinguished by a void of emotions [57-59]. Absent grief shows up as physical symptoms often similar to those experienced by the deceased prior to death or as a maladaptive behavior such as acting out [60].

Delayed grief is also called inhibited, suppressed, or postponed grief. A survivor may have had an emotional reaction at the time of the loss but the reaction is not considered sufficient for the loss. The reaction is released later and is considered excessive at that time and could lead to somatic complaints [9, 33, 39, 41, 56, 57, 61, 62]. Zisook and his colleagues use a similar term of unresolved grief [63].

Distorted or exaggerated grief is an intense grief reaction in which the survivor feels overwhelmed. Distorted grief is excessive and

disabling because the survivor experiences excessive depression and excessive anxiety [9, 39, 59, 64].

Chronic grief is characterized as: excessive in duration without a satisfactory conclusion [39, 65, 66]; yearning for an idealized relationship that never existed [57]; an overly dependent relationship with the deceased [41, 62]; and grief that is continually unremitting [46, 64]. Years later, however, many pathological explanations of bereavement were explained as “normal” reactions [67]. For example, Bonanno et al. [68, 69] found that individuals who fail to “work through” the emotional significance of a loss do not suffer delayed grief or enduring or delayed health difficulties as traditionally assumed.

Recently, “complicated mourning” has replaced the phrase “pathological grief” as a description in which “there is some compromise, distortion, or failure” [54, p. 149].

Even among the mentioned perspectives there is disagreement as to what constitutes “abnormal” bereavement and what is considered normal given the circumstances associated with the death and the survivor’s ability to cope with such a traumatic loss. Some researchers look at grief from the psychological perspective as a reaction to a traumatic loss.

Traumatic Loss

Until recently, traumatic death has been approached as either exclusively as a trauma or solely as a loss. Those specializing in bereavement overlooked the trauma brought on by the circumstances of a death, and the trauma experts failed to recognize the loss issues. Rando contends,

In fact, it’s not too much of a stretch, if any, to state that in general traumatologists know little to nothing about loss and, conversely, thanatologists know about the same amount regarding trauma [quoted in 70, p. xv].

Rando goes on to say that thanatologists overutilized the models and treatment expectations of bereavement and that the models and expectations

. . . may be quite inappropriate for a traumatic death, hurting, rather than merely not helping, the bereaved survivors [quoted in 70, p. xvi].

And that the thanatologists’ focus on “loss” misses “the post traumatic sequelae that eventuate when the death involves traumatic characteristics” [quoted in 70, p. xvi].

Traumatic loss includes: 1) deaths that occur suddenly or without warning; 2) deaths that are untimely, including the death of one's child at any age (parents do not expect to outlive their children); 3) deaths involving violence, mutilation, or destruction; 4) situations involving multiple deaths; 5) deaths viewed as random; 6) deaths perceived as "unnecessary" or preventable; and 7) deaths that involve a direct threat to the personal safety of the survivor. In most cases, traumatic loss involves one or more of these factors [54, 71].

Although there are numerous studies dealing with bereavement, only a handful have addressed the unique problems encountered by those who have endured the sudden, traumatic death of a loved one [36, 72, 73].

Rinear [74] lists the most common reactions to the traumatic loss of a loved one as: 1) feelings of shock or numbness; 2) preoccupation with the loss of the deceased; 3) concern with the brutality or suffering associated with the crime; 4) anger toward the suspect(s) or criminal justice system; 5) intense need to know the details of the death; 6) appetite disturbance; 7) disturbance of sleep patterns; 8) feelings of depression and hopelessness so intense there is a feeling of unreality; and 9) inability to put death out of one's mind. These reactions can last several years following the death [75, 76]. Van der Kolk says trauma occurs "when one loses the sense of having a safe place to retreat to within or outside oneself to deal with frightening emotions or experiences" [77, p. 32].

Generally there are affective, cognitive, behavioral, and physiological responses associated with traumatic deaths such as murder [54, 73, 75]. Affective responses include rage, terror, numbness, and feelings of devastation and irritability [4, 78]. Cognitive responses include confusion, memory impairment, and inability to concentrate. Behavioral responses refer to anxiety about the safety of the family and one's self, phobic avoidance of trauma-related stimuli, and social isolation [79]. Physiological responses include appetite and sleep disturbances [8, 81], gastrointestinal, cardiovascular, and immune system changes [82], and increased startle responses [82, 83].

Sudden traumatic death forces the bereaved to question the basic assumptions they previously took for granted [30, 84-88]. These assumptions include that the world is predictable and controllable, that the world is meaningful and operates according to the principles of fairness and justice, that one is safe and secure, that the world is benevolent, and that, generally speaking, other people can be trusted. These assumptions are shattered when a loved one is murdered [89].

Recently there has been a movement for the development of a diagnostic criterion for "traumatic grief" [90, 91]:

The term Traumatic Grief was chosen as it (a) describes more precisely the disorder encompassed by the consensus criteria, (b) is less vague than other terms such as complicated grief or unresolved grief, and (c) is less negative in terms such as morbid or pathologic grief [90].

Traumatic grief is a descendent of the concept of pathological grief, with associations to attachment behavior, separation distress, and traumatic distress. The proposed criteria for traumatic grief includes:

Criterion A

1. The person has experienced the death of a significant other.
2. The response involves intrusive, distressing preoccupation with the deceased person (e.g., yearning, longing, or searching).

Criterion B

In response to the death, the following symptom(s) is/are marked and persistent:

1. Frequent efforts to avoid reminders of the deceased (e.g., thoughts, feelings, activities, people, places);
2. Purposelessness or feelings of futility about the future;
3. Subjective sense of numbness, detachment, or absence of emotional responsiveness;
4. Feeling stunned, dazed, or shocked;
5. Difficulty acknowledging the death (disbelief);
6. Feeling that life is empty or meaningless;
7. Difficulty imagining a fulfilling life without the deceased;
8. Feeling that part of oneself has died;
9. Shattered worldview (e.g., lost sense of security, trust, or control);
10. Assumes symptoms or harmful behaviors of, or related to, the deceased person; and/or
11. Excessive irritability, bitterness, or anger related to the death.

Criterion C

The duration of the disturbance (symptoms listed) is at least two months.

Criterion D

The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning [90, p. 189].

Grief has also been examined as a different phenomenon with the different types of death. For the purpose of this book, I have limited the review to death by homicide.

Homicide Bereavement

“The symptomatology and management of acute grief” published in the *American Journal of Psychiatry* [9] is regarded as a classic in the field of bereavement. Lindemann worked with family members whose loved ones were killed in Boston’s Coconut Grove fire where nearly 500 people lost their lives. His findings were based upon sudden unexpected death of a loved one and are considered fundamental in the field of post traumatic stress. In his work, Lindemann defined the “bereavement syndrome” as a pathological grief reaction characterized by: 1) somatic disturbances; 2) preoccupation with the image of the deceased; 3) guilt resulting from the deceased or circumstances of the death; 4) hostile reactions; and 5) an inability to function as before the death. Lindemann suggested pathological grief occurs as a result of avoiding intense distress experience(s).

Many homicide survivors have adopted the popular stage model of dying as a means of trying to understand their emotions following the death of a loved one. Kübler-Ross’ stages of dying are: 1) denial and isolation; 2) anger; 3) bargaining; 4) depression; and 5) acceptance [25]. Sprang, McNeil, and Wright [81] identified five stages, similar to the stages identified by Kübler-Ross [25], of grieving for homicide survivors: 1) shock, denial, and isolation; 2) emotional release; 3) guilt, anger, and resentment; 4) depression; and 5) acceptance, resolution, and adaptation. The bereavement process is dependent upon many factors such as personality, previous experiences with death, and mental health history.

Clinicians working with homicide survivors have noted disproportionate numbers of complicated grief reactions such as anxiety attacks, suicide ideation, and overwhelming rage triggered by trivialities [92]. Noted behavioral changes include phobic avoidance of homicide-related stimuli and increased self-protective measures [36, 93]. In his 1993 study, Parkes states that homicide 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, are bound to interfere with normal grieving [94, p. 52].

Parkes goes on to say that homicide bereavement interferes with normal grieving by: 1) inducing post traumatic stress—a kind of emotional shock that generates anxiety, depressive avoidance, and vivid mental imagery; 2) evoking intense rage toward the offender and all associated with him or her at a time when there may not be an opportunity to vent that rage effectively; 3) undermining trust in others,

including the family, the police, the legal system, and God; and 4) evoking guilt at having survived and at failing to protect the deceased.

Although grief is a common human experience, mourning for families of murder victims is more profound, more lingering, and more complex than normal grief [3, p. 159].

Homicide presents at least three peculiarities that differentiate it from natural dying: 1) the death is violent—a forceful, suddenly traumatic act; 2) the death is a volition—an intentional act; and 3) the death is a violation—a transgressive act. Rynearson [95] suggests that violence, violation, and volition are associated with syndromal effects. The responses include: 1) post traumatic stress disorder (experiences of intrusive reenactment and avoidance); 2) victimization (rage and a sense of defilement); and 3) compulsive inquiry (a social and psychological need for investigation and punishment of the killer). In the case of homicide, compulsive inquiry may last long after the crime has been solved and the perpetrator punished.

Homicide bereavement has presented a psychological challenge that cannot be avoided . . . homicide will have a lasting impact on his or her [the survivor's] life, and there is no therapy that is going to offer complete relief [95, p. 343].

Because people do not understand the loss reactions of the homicide survivor, many professionals make a premature diagnosis of complicated mourning. Spungen asks, “The unique quality of grief makes homicide bereavement different, but does it necessarily make the mourning complicated?” [4, p. 31]. Controversy exists in the literature as to what is considered “complicated” mourning for homicide survivors. Even in the symptomatology, there is considerable overlap with operationally defined syndromes such as depression, anxiety, and post traumatic stress disorder [96-98].

After a homicide, the death, police, criminal justice system, and media may overwhelm the survivor. The survivor may experience a variety of responses, which have frequently been labeled post traumatic stress disorder because currently there exists no diagnostic category for complicated bereavement. The responses could be affective, cognitive, behavioral, or psychological. Researchers looking at grief from a psychological perspective often address the traumatic reaction to loss as post traumatic stress disorder.

Post Traumatic Stress Disorder

Studies focused specifically on homicide survivors have found symptoms conforming to post traumatic stress disorder (PTSD)

presented in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. (DSM-IV). PTSD is an anxiety disorder that is precipitated by a stressful life event that would evoke distress in most people and is outside the range of normal human experience such as war, natural disasters, and violent crime (Criterion A). Three clusters capture the symptomatology. The first cluster (Criterion B) consists of cognitive or re-experiencing symptoms, such as having flashbacks, intrusive thoughts, and nightmares. The second cluster (Criterion C) consists of affective symptoms, such as feeling estranged from others, numbing of feelings, and avoidance of activities or reminders of the death. The third cluster (Criterion D) consists of physiological symptoms, such as hypervigilance, irritability, and trouble falling and staying asleep [80, 99]. Symptoms are diagnosed as a disorder if they persist over a period of one month.

Post traumatic stress disorder and associated symptoms (or pathology) are reported in those working with homicide survivors [94, 100-105].

Although there have been studies of homicide survivors, most address the symptomatology and pathology and do not address the bereavement process. The purpose of my research was to obtain a description of how homicide survivors define and process their experience of homicide bereavement. It is hoped the information gained from this research will help homicide survivors and their families understand the experience and the pain of murder in a constructive and helpful way.

The loss of a significant other, in whatever role, is painful. But only when we recognize and understand the reality and unique nature of the pain can we begin to help ease it [106, p. 75].

Most of the literature on bereavement describes grief as normal or abnormal or complicated. Homicide survivors are typically labeled as abnormal or different in their bereavement process. Since homicide is not one of the leading causes of death, those who grieve it can be seen as "abnormal." However, this does not mean that the grief process that follows is "abnormal" or that the survivors of homicide are "abnormal." The treatment or label of abnormality or differentness for homicide survivors may lead to complications in mourning, disenfranchisement, and victimization.

This book was written as an attempt to give voice to homicide survivors. It started as a search for answers to questions I had about why I felt and was treated so differently as a homicide survivor. My quest for answers became the research for a dissertation. My first attempts at getting research on homicide bereavement approved by the dissertation committee met with much resistance. Some

committee members felt the subject was taboo or too sensitive a topic for study or that the topic was too close and too personal for me to study since my husband was murdered a year earlier. Some committee members did not want to deal with the reality of murder. In fact it was not until the day of the oral review, nearly one year after the research, that one dissertation committee member finally came to understand that homicide bereavement is often different than other types of bereavement.

My dear friend Dr. Sarah Brabant encouraged me to write this book. She felt my research needed to be shared so that homicide survivors might be better understood and normalized rather than labeled mentally ill or troubled people. I met Sarah at a Sociological Association meeting. A person at the meeting was concerned that I was not “over” my husband’s death yet, so he insisted I meet and talk with Sarah about “my problem.” Sarah explained to me that sometimes other people’s difficulty accepting the reality of murder and the pain it can cause leads them to believe a person is abnormal or sick because the bereaved express their feelings rather than hide them. I was clearly saddened by my husband’s death and I often cried just thinking about him. Sarah was the first person I talked to that understood the pain of murder and the pain of being a homicide survivor.

This book is about families that have faced murder and how they have dealt with the trauma. The names have been changed and some of the experiences have been combined in order to show the variety of reactions and ways of coping. In a sense, these stories are constructed; however, they are about real people and real events, they are not fiction. Whenever possible, I have used the survivor’s own words. This book is written in a way that will allow the reader to gain a sense of what it is like to be a homicide survivor. It is hoped the information in this book will be used to help homicide survivors and those wanting to comfort them.

The next section contains an introduction of the results of my research on homicide bereavement. I present it here as a guide for the rest of the book. Figure 1 is a visual representation of what is to come. “Stick people” are used so that we do not forget the individualism, the humanness of bereavement. The stick people are joined to remind us that support from others helps homicide survivors, and others who mourn the loss of their loved ones, survive the unsurvivable. Further explanations are found in Parts Two and Three.

Homicide bereavement affects the survivor on a personal and social level. On a personal level, the homicide survivor experiences loss, trauma, and victimization. Personal loss refers to the loss or death of the loved one, the loss of the basic assumptions in life, the loss of

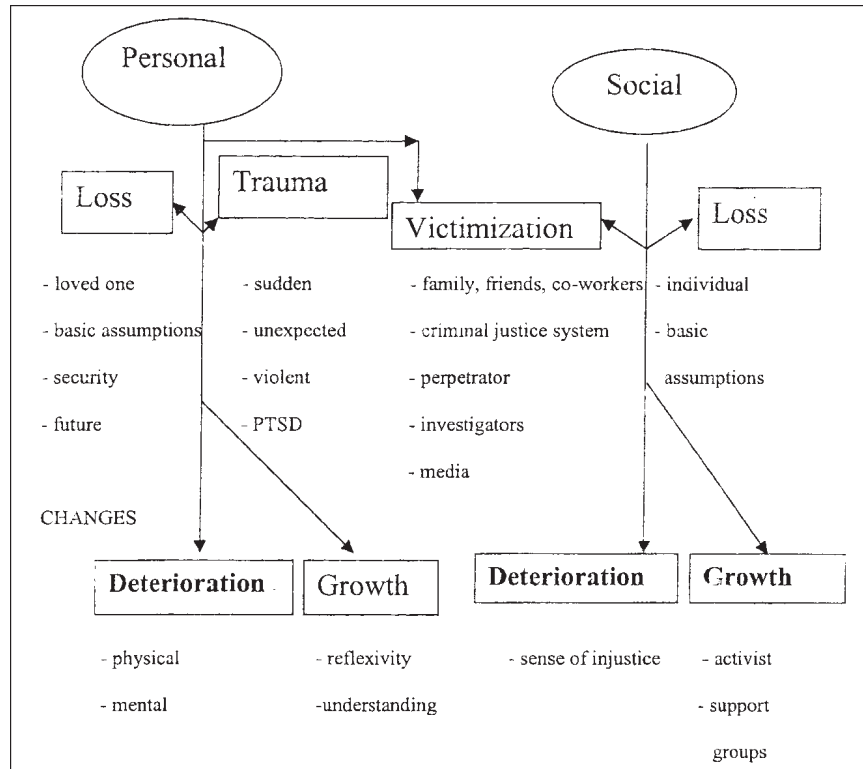


Figure 1. Homicide bereavement chart.

security, and a loss of a future. For the homicide survivor, the loss of basic assumptions in life has to do with facing the harsh reality that the world is not safe and secure, the world is not fair and just, and generally speaking people cannot be trusted. The homicide survivor abruptly learns that bad things do happen to good people, a good “Christian” life does not prevent murder, and that the world is not predictable or controllable. A homicide survivor’s personal security is violated when his or her loved one is murdered. The world is no longer considered safe and a preoccupation with the remaining loved ones’ security and the homicide survivor’s personal security becomes a primary concern. The murder creates an increased sense of vulnerability and this often results in an increase in protective measures such as locks, alarms, and personal protective measures such as traveling in pairs or the purchase of handguns. The loss of a future refers to the life that could have been—the daughter-in-law that will never happen, grandchildren and

great grandchildren that will not come, and a sister-in-law that is no longer possible. These personal losses invoke trauma for the homicide survivor.

Personal trauma results from the sudden unexpected death of a loved one. Homicide occurs without warning, there is no time for preparation. Homicide involves the intentional, deliberate act of another person. It is a violent and senseless act that often involves no remorse from the perpetrator. Trauma induces affective, cognitive, and physiological symptoms for the homicide survivor including nightmares, numbing of feelings, intrusive thoughts, and sleep and appetite disturbances. A lack of understanding of the trauma and resultant victimization further traumatizes the homicide survivor.

Society attaches a stigma to murder, leaving the homicide survivor victimized. Family, friends, co-workers, the criminal justice system, perpetrator, media, investigators, and the religious community victimize the homicide survivor on a personal and social level. Family, friends, and co-workers victimize the homicide survivor by their insensitive comments and unrealistic expectations of "recovery." Society perpetuates an expectation of returning to normal or to the way things were after a short period of mourning. This expectation is written in grief literature, self-help books, and advocated by some grief counselors and therapists. The criminal justice system victimizes the homicide survivor repeatedly with each pretrial, trial, sentencing, motions, and appeal hearings. If more than one perpetrator is involved, the series of trials, hearings, and appeals is repeated for each perpetrator. Even with the right to a speedy trial, it is not unusual for a murder case to take two years to get to trial. The perpetrator victimizes the homicide survivor first by taking the loved one's life then by the repeated contact with the homicide survivor through the criminal justice system. Even after the trial, the homicide survivor is victimized each time the perpetrator files for an appeal, leniency, clemency, and/or comes up for parole. If the perpetrator(s) is released from prison, the homicide survivor, and his or her family, become victimized again because of the uncertainty of the perpetrator, by not knowing if the perpetrator will seek revenge toward the homicide survivor or his or her family members. The media also victimizes the homicide survivor. Murders, particularly murders involving children, are generally sensationalized, often at the expense of the homicide survivor. Often without warning, articles are printed on the front page of the newspaper or announced on the television explaining in graphic detail the brutality of the murder. Movies made without the consent of the homicide survivors often change the circumstances surrounding the murder. In many instances the movie places blame on the victim or his or her family. The homicide survivors are

helpless to set the record straight or clear their loved one's name and reputation. Strangers actually make money from the murder of the homicide survivor's loved one. The religious community victimizes the homicide survivor by insisting on forgiveness. By forgiving the perpetrator, the religious community and many grief counselor and therapists believe the homicide survivor can "recover" or return to "normal" after his or her loved one has been murdered.

Besides the obvious personal loss, society also suffers a loss as a result of homicide. Society loses an individual, a taxpayer, and contributor to mankind. Society also suffers a loss of some basic assumptions about life. First, that homicide demonstrates that the world is not safe, controlled, or predictable as previously assumed. Second, that killers exist and are likely to strike any one, any time, and anywhere.

As Figure 1 indicates, homicide bereavement results in change on a personal and social level. Change can result in deterioration and/or growth. On a personal level, deteriorating change refers to the mental and physical changes after a murder. The constant high levels of stress and post traumatic stress deteriorate the survivor's physical and mental functioning abilities. Growth refers to the survivor's ability to find meaning in the murder. Through reflexivity, a process of coming to terms with the situation in spite of others and the societal expectations, a survivor can find personal meaning in the murder. The personal meaning can lead to a sense of a higher cause or a deeper understanding in the meaning of life. On a social level, homicide can result in deterioration or growth. Social deterioration refers to the sense of injustice often seen at a murder trial. Lenient punishments, legal technicalities, and plea bargains sometime portray the perpetrator as getting away with murder. This is most obvious in the juvenile justice system when the murderer can be released at the age of 21. Social growth refers to the homicide survivors who become activists seeking legislative changes in the judicial system. The homicide survivor turned activist increases the public's knowledge of the current criminal justice system and seeks change. Social growth also refers to the increase in homicide support groups and support networks. Homicide survivors are often misunderstood grievers. They are generally only understood by other homicide survivors because they are the only ones who have experienced the horrific trauma, stigma, and victimization of murder first hand.

Part One of this book contains ten stories from actual homicide survivors. Part Two contains common reactions of grieving loved ones. The reactions are listed as themes that run throughout the survivor's descriptions of their experience. Part Three contains an analysis of Parts One and Two and some suggestions for helping homicide

survivors during their grief journey. At the end of each chapter I have included notes further explaining key points in the chapter as well as references to those notes where applicable.

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