

## Crisis Intervention and Psychotherapy in Traumatic Bereavement after a Child's Death by Homicide

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*The article presents parents' reactions to the death by murder of a grown-up child. The authors provided them with assistance in the form of crisis intervention and psychotherapy. Three kinds of reactions to a child's sudden death have been analysed. They include the emotional, cognitive and behavioural ones. Some recommended therapeutic practices have been described with reference to various stages of traumatic bereavement.*

*Key words:* traumatic bereavement, crisis intervention

In the last few years, the number of child murders has increased in Poland. The murders have been widely commented on by the media and have shocked the public because of their brutality and incomprehensibility. More and more often, the relatives, and particularly, the families of the victims seek psychological assistance. Practising therapists have begun asking questions as to the aims, forms and limits of psychotherapy for this group of people. On the basis of their own experience of psychotherapy of the victims' families, the authors consider the traumatic bereavement model, which comprises the concept of bereavement and posttraumatic disorders, as useful in their work.

The article presents the following issues:

- a description of three cases from the authors' clinical practice,
- an account of reactions to the trauma of a child's death by murder basing on the literature of the subject and the authors' own experience,
- implications for therapy,
- questions arising in connection with the subject.

## Description of selected cases

### Case 1

Mr A., aged 55 was the father of a 23-year-old son murdered two years ago. He has been receiving psychological assistance for two years. He complains of persistent deep sadness, irritability, impaired concentration, and loss of the sense of life. He also reports hallucinating (he walks in the street and sees his son), recurrent images of the murder of his son and of other children whose deaths have been related to him by the parents he stays in touch with. Moreover, various objects evoke in him associations with his son (e.g. a dress with butterfly pattern reminds him of his son's liking for butterflies). He speaks bitterly about the minimum punishment for the murderers and the trauma of the trial when, e.g., the judge forced him to listen to perfunctory apologies of the murderers in the courtroom. Mr A. helps the families of other victims giving them support and information; he is one of the founders of the Association of the Families of Murdered Children. Since he often appears in the media, he has faced criticism from both acquaintances and strangers who claim that he makes too many public references to his son's death. He has also been verbally attacked and threatened by the father of one of the murderers. His case is not unique in this respect. He gives an example of Mr X., the father of another murdered child, whose acquaintance, on meeting him in the street, criticised him for giving a TV interview, saying 'You are using his death to make a career'. That made the father so angry that he hit the man, and is now facing a trial for assault.

### Case 2

Mr B., aged 70, was the father of a son murdered two weeks before hospitalisation. Psychological consultation took place in an internal medicine clinic where Mr B. had been under observation due to circulatory insufficiency. Despite treatment, his condition did not improve. It was only during a conversation with the psychologist that he revealed the fact that 2 weeks before he was admitted to hospital, his son had been killed in mysterious circumstances. He kept the information about the murder to himself and told his wife that their son had died of a heart attack. Mr B. suffered from acute bereavement. He was in a shock caused by the character of his son's death and its circumstances. The shock was aggravated by his efforts to keep it secret from his wife. The crisis intervention in this case consisted in helping abreaction and supporting him in his bereavement as well as motivating him to maintain contact with the psychologist and informing medical staff about the effects of the trauma on his health.

### Case 3

The C. family consisted of the mother of a 31-year-old man killed by his wife, his father, his sister and a 7-year-old daughter who witnessed the murder. The mother visited the Crisis Intervention Centre two months after her son's tragic death. The immediate reason was intensified symptoms of posttraumatic reaction during the trial

over the custody of the daughter in juvenile court: the daughter-in-law, who was the murderess, asked to be allowed to see her daughter and tried to thwart the grandparents' efforts to obtain the custody of the child.

Each of the family members showed very acute symptoms of bereavement. They remained isolated from one another and neither gave nor received support within the family. Another traumatising factor was the reaction of the neighbours and the priest (he made scathing comments to the effect that the son must have been aggressive if his wife killed him, and refused to accept the family's suggestions about the funeral). Secondary victimisation was also caused by the attitude of the female judge during the sessions of the family court. The parents of the deceased had an impression that it was them who had to prove that they were good grandparents while the judge tended to believe the aggressive letters of the mother-murderess. The crisis intervention consisted in intense supporting contact with the therapist, elements of psycho-education concerning the bereavement process and assistance in understanding and coping with the custody procedure in family court.

It is with such cases in mind that Edward Rynearson, a psychiatrist with vast experience in giving assistance to the families of murdered children, writes: 'As a clinician I have been touched by the particular agony of the parent who has lost a child. It is so painful and emphatic experience that I am often struggling with my own tears' [8]. Having learnt from the papers about a murder of a 13-year-old boy, Catherine Sanders, another therapist, did not hesitate to write that she was sick after reading the newspaper. 'It was such a waste after all the years of bringing him up and caring. Their son was dead leaving them with emotions and feelings that were too horrible to talk about.' [9] Argentinian therapists like Diana Kordon, Lucila Edelman, Dario Lagos and others, also write about their difficult emotional experience gained while helping the victims' mothers known as the Mothers of 'Plaza de Mayo Group' in Buenos Aires. Their adult or adolescent children were kidnapped by the junta security services in the 1970s and their fate has been unknown ever since. It is commonly known that the victims were tortured and their bodies were destroyed [5].

The cases of families A, B and C we describe show, on the one hand, psychical reactions of the bereaved and, on the other hand, the social context that overlaps them. The examples also show that the environment wants to cut off from the horror and tragedy while empathy is difficult and painful. Lack of empathy from the environment, in turn, enhances the parents' suffering and makes them feel lonely, often rejected, put to shame, censured, betrayed. And it is precisely these families that must not be left alone with their misfortune [9]. The greater the emotional load of the tragedy, the greater the professional knowledge about psychical reactions to traumatic death and the principles of psychological assistance should be possessed by those who provide assistance.

### **Reaction to the trauma of a child's death by homicide**

#### **Reaction to the death of a close relative**

It is not our purpose to present the rudiments of the psychology of bereavement in the article. All we want to do is to point out that this knowledge is both indispensable

and insufficient to understand and help the families of murdered children.

Bereavement as a normal reaction to the loss of a close relative (object of attachment) is a process that comprises a whole range of internal states and behaviours. The description of a typical course of bereavement is relatively consistent. The three typical stages include: 1. numbing followed by crying and anger; 2. depression - with concomitant anxiety, fear, despair and concentration of thoughts and memories on the deceased; 3. absence of the deceased is considered a real fact and contacts with others are resumed.

A typical bereavement process takes about a year. Its course, intensity of emotions, and length of the process of farewell are highly individual phenomena. They certainly depend on the circumstances accompanying the death, relations with the deceased, individual features of the bereaved and their ability to cope with the loss [1].

### Reaction to a child's death

According to Sanders [9], a child's death is the worst nightmare that can happen to parents. Although the descriptions of bereavement after a child's death and after an adult's death include some similar elements, there are significant differences between these two kinds of loss. 'The intense relationship of attachment between parent and child is unduly sensitive to threatened or real interruption. Parents identify with the vulnerability, helplessness, and innocence of their child and respond with attention and protection. The reflexive distress, crying, searching and protest behaviours stimulated by separation are poignant in their immediacy and depth' [3]. 'It is presumably this fundamental uniqueness of attachment between parent and child that promotes a relational substrate of intense and enduring need and distress with loss - whatever the age of the child [Wass and Corr, 1984], [8].

A child's death is always a cognitive dissonance. It is discordant with the permanently shaped cognitive scheme of a life cycle (that of an individual, a family - including one's own - the life of other creatures - animals, plants, and finally of the whole nature that observes a seasonal rhythm) and with ideas about the future. A common desire of parents to witness their adult children's successes, to see grandchildren and to expect care in old age remains painfully unsatisfied. A child's death destroys the natural course of matters.

Studies on the reactions of parents and other members of families with children suffering from terminal diseases reveal a high risk of emotional disorders. According to the studies by Binger et al. (1969) and Chodoff et al. (1964) cited by Rynearson [8], in half of the families, at least one person required psychiatric help after a child's death and the most common reactions included emotional withdrawal, denial and increased motor activity.

### Reaction to a sudden and unanticipated death of a child by homicide

The period of dying has an important effect on the form and course of bereavement. A long, terminal disease that often precedes death is frequently connected with the so-

called anticipatory bereavement. The emotions typical of bereavement (sadness, anger and feeling of guilt) appear, periodically, earlier and can thus be ventilated. There is time for a gradual process of mutual farewell between parents and child. On the other hand, members of families in bereavement due to a sudden and unanticipated death of a child - according to Lundin's studies quoted by Rynearson [8] - showed a significant increase in symptoms as compared to family members in bereavement following an anticipated death.

According to Rynearson, a psychiatrist who helps the families that have lost a child due to homicide, the nature and course of bereavement after the homicide of a child is complicated not only by its object (the child) and a unique, intense relationship between the parents and child. Its character is so complex not only because the death is unanticipated and sudden, but also because of the traumatic mode of the death. 'The manner of dying determines the meaning of death. With murder, dying is both violent and transgressive. The dying is a brutal, purposeful assault forced on an unwilling victim. The resultant bereavement must somehow embrace these elements of dying that invoke personal terror and social censure.' [8]

In our opinion, Rynearson's comments made in the 1980s and based on his earlier clinical experience have not been widely accepted in Poland. The behaviour of the families that seek retribution, express anger and rage is often confronted with misunderstanding and resentment in the current social context. The families are expected to quickly cope with their bereavement and forgive the malefactor. This kind of attitude is clearly manifested in a comment by judge M.A. on the actions of the Association of the Families of Murdered Children: 'I can't understand the actions of the harmed parents. After all the malefactor has been punished and is now in a corrective institution' [Gazeta Wyborcza July 4/5, 1998] We think it is very important to analyse the reactions of the murdered children's families, which are often socially unacceptable.

A review of literature and our own experience let us make an arbitrary division of reactions to the traumatic death of a child by homicide into the reactions in the emotional sphere, those in the cognitive sphere and those in the behavioural sphere.

### **Emotional reactions**

The parents of murdered children show intense emotions generally associated with bereavement. They include sadness, despair, anxiety, anger and guilt. Their intensity makes the empathy of a helping professional difficult and painful. Family members and friends also experience difficulties in providing support. It seems that even people with high emotional intelligence can be helpless when it comes to a more detailed description of the feelings for which the words such as 'sadness' or 'despair' become insufficient and the more adequate ones cannot be found. The feeling of guilt results from the thought that one failed to help the child even though in fact the parents had done all that could have been done or even though absolutely nothing could have been done. For example, the mother of a murdered boy whose social functioning and moral development level were optimum since they resulted from his upbringing in a normal, loving family, after his death, accused herself in public of being a bad mother. She

claimed that because she had not taught her son brutal aggressiveness, she was also to be blamed for his death at the hands of a group of young people. The words of an Argentinian mother quoted by Kordon et al. sound similar: 'I feel guilty for having taught my son to worry about all men; if I hadn't taught him this, today I would still have him with me' or 'I taught him to love his equals, today I don't know if I would do it again' [5] Apparently, both being an imperfect parent and a perfect one can evoke guilt. However, it is worth pointing out, following the Argentinian psychiatrists' example, a strong influence of social mechanism on the triggering and escalating of the feeling of guilt in relatives. In the case of the Mothers of 'Plaza de Mayo Group' the social manipulations partly resembled the Stalinist ones. The professionally developed propaganda methods of the totalitarian regime were to transfer the responsibility for the crimes from the persecutors to the victims' families. In the case of the Polish families, on the other hand, we can speak of a negative influence of the more and more widely shared social convictions such as the environment's pressure on the families to cope quickly and effectively with the bereavement. Humphrey and Zimpfer [4] also write about it when they discuss the phenomenon of secondary victimisation of the murdered people's relatives.

Fear is an integral part of every case of bereavement. In case of homicide there is also fear of assault by the murderer on the remaining family members. The fear often reaches the level of terror. Significantly, what all the cited authors point out, the fear is not entirely irrational. Often the threat to life and health of the family is real. Apart from the threat from the murderer or his partners, profound violation of the feeling of security and destruction of the accepted order of the world cause a natural reaction of a prolonged mistrust of people. According to Rynearson [8], 'a pervasive fear begins with awareness of the murder and lasts for several years'.

Murder is associated with humiliation and abhorrence. Sanders [9] writes that the trauma of the violent death suffered by our children remains inside us for years; it is often life-long. The feelings pervading the family are so much unlike normal human experience that all the formerly developed mechanisms of coping with negative emotions fail to work and become useless. There is nothing in the course of a normal human life to prepare a man to accept something equally horrible, so the assimilating of such painful emotions is extremely difficult and takes a long time, if it can be accomplished at all, at least to a certain extent.

Anger is another emotion constantly associated with homicide. 'The bereaved views the homicide as a purposeful, unwarranted act that by its commission characterises the murderer as deserving of censure and retaliation. A deep and justified anger toward the murderer might diminish after 12 to 18 months (sometimes coincident with trial and punishment), but it never disappears' [8] In the case of a child's death by homicide, the anger becomes rage. In the situation of extreme loss, anger and rage are normal and necessary emotional reactions. At the moment of losing control over the world and one's own fate, anger plays a positive role; it is a source of energy that has been exhausted by sadness and despair. It provides encouragement to face life's challenges. It also helps release suppressed emotions, of course, within the socially approved limits. In our opinion, strong disapproval by the environment of anger and

rage is a great threat to the health of the bereaved. On the one hand, there is a risk of such intensity of suppressed anger that it will be released in the form of violent, impulsive and dangerous acts (cf. the case of Mr X related by Mr A). This can mean even more tragedy for the victims' families (e.g. the risk of a prison sentence for an attempted murder of the murderer). On the other hand, there is social pressure on the denial and suppression of anger as well as quick verbalisation of forgiveness to the child's murderer, which probably occurs more often. This, in turn, results in a significant increase in the health risk, both physical and psychical, of the victims' family members. Lack of ventilation of anger is associated with aggravated symptoms of depression and the risk of suicide.

Anger is accompanied by the desire for retribution, retaliation and vengeance on the murderer and his family. The desire is common and normal. It absorbs thoughts and imagination. Humphrey and Zimpfer [4] cite an example of a mother who fantasised that she was cutting off the head of her daughter's murderer while she was using her lawn mower. This helped her express and ventilate her intense emotions. The authors of the article listened to parents who considered hiring of an assassin. Such fantasies, nightmares and daydreams are also mentioned by Rynearson [8] and Sanders [9] who treat them as normal emotions that, like anger, require ventilation. This can be particularly difficult due to the above-mentioned social context.

Archaeology and history of law show that in the past centuries the legal practice in Europe corresponded, to a certain extent, with the emotional reactions of the victims and their families and was much more brutal to the murderers in comparison with that of today. [6] The evolution of the theory and practice of law together with other changes in the society and its system of values have led to a situation where the victims' families are generally expected by the society to 'tune' their emotional reactions to the current 'status quo'. They are expected to restrict their emotional expression, particularly that of anger, rage and desire for retaliation.

### **Cognitive reactions**

A common and recurring reaction of parents is the appearance of intrusive images of the murdered victim's dying. The central elements of such images are the last moments of the victim's life and the concomitant feelings of terror, helplessness and desolation. According to Rynearson [8] 'The unbidden images of homicide are so central that they interfere with other cognitive operations. Concentration and thought sequencing are disrupted for 6 to 18 months.' A persistence of intense and frightening mental imagery of death is common in the victims of trauma, e.g. the Hiroshima survivors examined by Lifton [8]. Such images occur also in the victim's family members who neither witnessed the traumatic event nor saw the body. The images occur during the day and in sleep. Their content can include fantasies about revenge.

The discussed situation can be referred to as a total cognitive dissonance. The mind cannot understand what is contradictory to all previous experience. Adaptive mechanisms in the sphere of emotion, cognition and action are overwhelmed initiating the alternating responses of hyper-reactivity and hypo-reactivity [8]. The whole

system of values and beliefs adopted so far is often questioned or rejected. One's philosophical and spiritual perspective often proves insufficient in the face of the trauma of a child's murder. A result is a loss of faith and trust in providence and God to whom anger is directed.

### **Behavioural reactions**

Due to the intense fear of violence (from the murderer or other people) there occur behaviours aimed at ensuring maximum physical security of the remaining family members. It is worth pointing out that there exists a real threat to the families in many cases of murders. During the first year of bereavement, compulsive behaviours of self-protection are so strong that the usual range of territorial and affiliative behaviours is constricted. As Rynearson writes [8], 'Home becomes a protective fortress. Strangers are avoided, and there is a compulsive need for the proximity and tangible assurance of safety of remaining family members.' The authors of the article witnessed similar behaviours of the parents they provided therapy for.

Since the murder of a child destroys a person's perception of the world, the period of initial shock is followed by an attempt at creating its new vision with the trauma of the child's death as its focus. It becomes a natural process to collect information about the death and its circumstances. There are tragedies when the family obtains much information from the witnesses, police or court. However, there are cases when most questions remain unanswered. In such cases we observe many kinds of persistent activity to find out as much as possible about the circumstances of the death. If, for example, the legal system places obstacles before the parents, they do not give in and try to overcome the obstacles even at the expense of additional suffering and more energy loss. The persistence is best exemplified by the Mothers of 'Plaza de Mayo' in Buenos Aires. They have been fighting for 20 years to find their kidnapped children or at least the whole truth about their fate, the place of burial or destruction of the body, and to make sure the regime representatives responsible for their death are punished. This is not an appropriate place to describe the authorities' methods used to persuade them to give up fighting and to reconcile themselves to their fate. However, it is necessary to realise the need for such behaviours in parents.

Behaviours directed towards a form of retribution are also common. They lie at the base of co-operation or attempts at co-operation with police and prosecution institutions, participation in the trial, co-operation with the media that also give information about the murderer. When the actions of the legal system do not correspond to the parents' need for retribution, there may occur instances of verbal or physical aggression aimed at the murderer.

### **Implications for crisis intervention and psychotherapy**

The description of parents' reaction to a child's death by murder justifies its treatment as a particularly traumatic bereavement. We shall discuss the resultant indications for crisis intervention and psychotherapy.



### Crisis intervention immediately following the trauma

The cases described by us and by other authors are mostly those of people seeking help some time after the trauma (two weeks to several years). Rynearson describes the earliest stage of assistance. He believes that the therapist's task is then to provide a complex assistance to the family. It should include ensuring physical and psychological security to the family, building up an emphatic and trust-based relation, giving support and helping create a natural support group, following the course and pace of bereavement determined by the family members. The therapist should be able to assess correctly an individual's ability to accept previous deaths and losses. The techniques of emotion ventilation should not be used until later stages of bereavement. Medication is often indicated (tranquillisers, sleeping pills, antidepressants) to diminish the intensity of fear, terror, intrusive death images, insomnia, depression.

The authors think it is very important to inform parents about the various legal systems and procedures they will have to or want to participate in and to make sure they are accompanied by a competent and supporting person during the trials in court. This results from the above-mentioned increased need for security in the remaining family members. For example, it is important to make sure that the mother has a company in court while her children are at the same time looked after at home.

Information and support are also important when it comes to contacts with the media, which show particular interest in the victim and the victim's family during the earliest posttraumatic stage. As Sanders [9] writes, when privacy is most needed one is deprived of it. Professionals assume their duties and take no account of the family's feelings in the face of the trauma. In the authors' opinion, at this stage, families should definitively be protected against the media and public exposure since this can result in secondary victimisation. Journalists are the last people to offer families sympathy and understanding.

### Psychotherapy in later stages of traumatic bereavement

If parents had a natural support group prior to a child's death, the group brace themselves after the initial shock. This state usually lasts for several months but it never is a sufficient period for the families of murdered children. This is when the role of professional help grows. Beside further emotional support, it is possible to discuss questions related to the trauma of death, help express all emotions within the safe therapeutic relationship (strong affects of anger, rage and fear should be verbalised and ventilated through the whole prolonged period of being experienced). It is possible to take up work on the transformation of wrong assumptions about the world, other people (e.g. all judges are corruptible) and oneself, guilt and self-accusation; to encourage full communication among family members. Sanders [9] also recommends getting closer to the family, verbalising thoughts and feelings in the family or, if there are difficulties, during family meetings in the therapist's presence.

Rynearson [8] stresses the role of psycho-education. In his opinion, understanding the natural course of bereavement and consequences of murder restores to the parents a sense of control, anticipation and direction. However, information exces-

sively and prematurely suggesting difficulties should be avoided. Finally, it ought to be born in mind that according to Rynearson [8] 'the bereaved will always maintain an attachment to the dead child. It would be a mistaken therapeutic objective to insist on decathexis. Instead, the bereaved will somehow maintain involvement with others while maintaining an internalised relationship with the child's image. Complete recovery from this traumatic form of bereavement would be an unrealistic goal for the patient and the therapist'.

#### **Factors additionally complicating psychological assistance**

Bereavement becomes particularly traumatic when:

- the child is killed by another family member; a dilemma of identification and loyalty confronts the entire family;
- the child has disappeared (the case of the Argentinian mothers) - Rynearson [8] writes that the process of the acceptance of homicide cannot begin until the body is found or the family tires of searching; some families never stop - this is the case of the Mothers of 'Plaza de Mayo Group' described by Kordon and other Argentinian therapists [5]
- the murderers have not been found and the murder remains unsolved - this is the case of 28% of the homicides in the group of families described by Rynearson[8]; then 'the bereaved is left with an internalised traumatic dying that remains unbuffered by solution, punishment, retribution, or redemption'.

#### **Support groups**

According to Rynearson [8], a support group comprised of members who themselves are adjusting to bereavement after a child's murder provides a unique opportunity for support. The established members embody the promise of recovery for new members. Apart from providing emotional support, the group can perform psycho-educational and information functions.

Kordon et al. [5] also stress the great significance of support groups for the above mentioned Argentinian families. Therapists' participation in such groups is important. Without their co-operation, there may occur deviation and further victimisation of the participants. Argentinian therapists additionally stress the significance of voluntary, unpaid support both for establishing contacts with the victims' mothers and for the outcome of support. Providing support during the regime they risked persecution. When asked about motives, they said that they treated the problem of the Mothers of 'Plaza de Mayo Group' as their personal one since they were members of the same society.

#### **Some questions resulting from an up-to-date analysis of the problem**

Many questions arise in connection with the subject discussed. Some of them are of practical character. When is it best to provide families with psychological assistance

and what is the most appropriate form? How shall we suggest our assistance? Should we ask the parents we already know to help us establish the first contacts or should we do it ourselves? What forms of assistance should we offer parents: should it be a support group or individual therapy? Is it useful, from a therapeutic point of view for a therapist to get involved in the provision of legal aid and other actions related to the trial and how useful it is? How far should we go in our attempts at protecting the families against the media, which can cause secondary victimisation but can also become an opportunity for beneficial behaviours?

Practical experience can provide some answers in this respect but also give rise to further questions. For example, our article does not discuss a very significant issue of the psychological reaction of the victim's siblings as well as that of the relation between parents and children. Both theory and practice of family therapy demonstrate that a child often becomes an 'identified patient' whose symptoms help adult family members seek help. If this is the case in the situation under discussion, to what extent can family therapy prove useful?

Questions concerning the therapist are also important: what knowledge and skills and what kind of personality should he have? What sort of difficulties, particularly the emotional ones, will he encounter? Will the methods he has developed so far help him cope?

Another group of questions is connected with therapeutic actions to diminish secondary victimisation by various institutions and authorities the parents contact during bereavement, such as police, judges, lawyers, journalists, etc. What actions should be taken up and how to organise them? Similar questions would be asked about forms of influencing other people from the victim's surrounding such as neighbours, colleagues from school, parents' colleagues from work.

Finally, there remain some philosophical questions. It often happens that as therapists, intervening persons or supporters who concentrate on the solving of problems in a definite situation we find little motivation to reflect on the ethical and legal foundations of our civilisation. We mean here questions like: is Kant right to say that the idea (in the Platonic sense of the word) of law must be the idea of justice? Piotr Bartula [2], a philosopher of law, argues that the consequence of the generally accepted Beccaria's thesis that a means preventing people from committing crimes is not the severity of punishment but its inevitability, is erosion of the idea of justice as the aim of law. The idea of justice is gradually replaced by the idea of efficiency. We can ask if such a change is neutral, beneficial or harmful for the mental and physical health of victims and survivors. Is it proper to discard Kant's question about a just punishment, i.e. one equivalent to guilt, as an issue that belongs in the lumber-room of the history of philosophy? Do we agree with the modern trend, also present in psychology, to treat the very concept of guilt as an anachronism and a relic of the past? Such questions about justice, guilt, punishment, sin, etc. arise in the victims' families and, from their point of view, do not seem outdated. The therapist should also ask them regardless of any censorship, including that of 'political correctness' or intellectual fashion.

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