The dilemmas of homicide co-victims

> The card said briefly that she was thinking of me, but did not want to intrude...I had counted on Val's warm presence to help me fight the ice that was locking me in, but I could not ask. I had thought that she would understand. If I did not have her, then I had no one.
> — Mykyta (1987:111)

This recollection of Anne-Marie Mykyta in her grief following her daughter's murder, encapsulates the problems society can have in relating to those affected by a homicide. This difficulty is apparent at many levels, and can have a great impact upon the successful coping and long-term well-being of these people, who can genuinely be seen as co-victims. The rise of the victims' movement in the 1970s prompted recognition of a significant population that had previously been neglected. In this context the position of non-primary victims evolved from ambiguous to important (Skogan, Lurigio and Davis 1990:8; Spungen 1998:8). Co-victims can be powerful in interest-group and political contests, due to the dramatic and emotive nature of their experience. However, they also are vulnerable to exploitation, and to abuse by many individuals, services and institutions through lack of understanding or due care.

While homicide crime statistics are the 'gold standard' (Indermaur 2000), and accurate numbers of primary victims are available, quantification of the secondary victims is difficult (Ruback & Thompson 2001:29; Cook, David & Grant 1999:xi). Homicide-related trauma causes ripple effects felt throughout communities, friendships, work circles, and most acutely, for the surviving family of the primary victim (Spungen 1998:78; Thompson, Norris & Ruback 1996; Mezey, Evans & Hobdell 2002; Read 1995). Only a small body of literature deals with this subject, and there is no identified 'best practice' of service provision for assisting co-victims of homicide (Mezey, Evans & Hobdell 2002; Ruback & Thompson 2001:133; Thompson, Norris & Ruback 1996; Resick 1987; Murphy 2000; Spungen 1998:138). What follows is a summary of the literature on the effects of homicides on co-victims, and strategies for best addressing service provision needs.

In many respects, the response of homicide co-victims is similar to victims of other serious violent crimes, albeit with additional levels of severity and complexity (Ruback & Thompson 2001:87; Spungen 1998:18; Cook, David & Grant 1999:21; Levy & Wall 2000; Rando 1996; Weiss 1993:283). Mourning is a lifelong process, and the rawest trauma can persist for months (Williams 1999:52; Schuchter & Zisook 1993:25; Maguire & Corbett 1987:30). Capacity to respect and respond to individual victim responses is essential when providing appropriate support and information (Read 1995:89; Maguire 1985).

In the immediate aftermath of a homicide, the first many co-victims will know of the event — unless they are witnesses to the event — will be the death notification, usually performed by the police (Stewart, Harris Lord & Mercer 2000). The nature of this contact is important for the co-victim, and can set the scene for future mourning (Spungen 1998:119–121). Strategies such as training for police officers in sensitivity and crisis management may minimize the exacerbation of trauma (Cook, David & Grant 1991:41; Shapland 1983). Co-victims need assuring that their responses are normal and valid (Williams 1999:21). Spungen suggests multi-disciplinary teams of advocate, police officer, and counsellor to respond to individuals' needs.

Physical reactions to the loss are common, with manifestations ranging from racing heart, shaking, and a sensation of slow motion to gastrointestinal complaints and vomiting (Cook, David & Grant 1999:16; Spungen 1998:18; Williams 1999:51). Existing health problems are typically exacerbated post-homicide. Men are less likely to seek professional support, and substance abuse and self-medication issues can emerge long-term (Ruback & Thompson 2001:93). Murphy (2000) reports that fathers often experience deteriorating health while mothers' health typically is less impaired.

A range of practical problems, such as financial loss for dependents (Joint Select Committee on Victims Compensation 1997:13), and immediate issues of funeral expenses and possible crime scene clean up, arise for co-victims (Resick 1987). A proportion of co-victims of domestic homicides subsequently wish to relocate, while childcare and custody, security and property issues, and insurance, legal, and medical bills can all be unexpected concerns (Williams 1999:51; Spungen 1998:83; Cook, David & Grant 1999:15). High rates of job loss, absenteeism, and reduced productivity in the workforce also are common consequences for co-victims (Murphy 2000). Assistance and advice about immediate practical concerns, compensation, insurance and legal matters is required, and the Victim Liaison Officers employed by police in Victoria and a number of other Australian jurisdictions can be effective in this context.

Co-victims may voluntarily withdraw from their social circles, or be abandoned, increasing isolation and distress (Cook, David & Grant 1999:42–43; Williams 1999:1). A 'contamination response', stemming from an inability to deal with the traumatic event and co-victim experience can become apparent (Rock 1998:32–33). 'Compassion fatigue' — fuelled by non-comprehension of the long-term nature of grieving — can result in withdrawal by support networks with co-victims pressured to 'get over it'. Stigmatisation can affect family members long into the future — especially for children who lose parents (Eth & Pynoos 1994). The mobilization of existing social resources such as other family members, social networks and the wider community is valuable in minimizing these harms. Their input may appear small, but the benefit to victims is significant and should not be under valued simply because it is not sourced professionally (Sprang & McNeil 1998). Encouraging the development of new social connections, such as through peer support groups, is important. Support groups, though not appropriate for dealing with early grief, can be beneficial long-term, providing hope, understanding and consolation for those needing support but not one-on-one therapy (Jacobs & Prigerson 2000; Rock 1998:xiii; Raphael, Middleton, Martinek, & Misso 1993:452).

Psychological responses manifest in the aftermath of a homicide range from shock, confusion, numbness and disbelief to anger, guilt, fear and hyper-arousal (Rock 1998:55; Mezey, Evans & Hobdell 2002; Cook, David & Grant 1999:25; Stewart, Harris Lord & Mercer 2000; Spungen 1998:18, 134; Williams 1999:51; Getzel & Masters 1984; Benjamin 1996:64; Sprang, Mcneil & Wright 1989). The intensity of reactions may disturb co-victims and those around them, despite being a normal reaction of the body and mind to the trauma (Williams 1999:21). Overwhelmed victims may find coping-based counselling helpful. Reaction severity should diminish with time, although some individuals may deteriorate to clinical levels (Spungen 1998:22). For this smaller, acute subset, early cognitive-behavioural interventions can reduce the likelihood of long-term post-traumatic stress disorder (PTSD) outcomes (Cook, David & Grant 1999:46). Targeting those with extreme reactions and numerous risk factors provides professional services to the most needful victims, and reduces iatrogenic outcomes and pathologisation of normal grief responses (Devilly 2002; Jacobs & Prigerson 2000). Evidence suggests that blanket Critical Incident debriefing for individuals exposed to major trauma is unnecessary and potentially

damaging (Devilly 2002; Robbins 2002). Similarly, psychotropic medications should be reserved for the most severely impaired co-victims to prevent dependence and delayed grief (Spungen 1998:59).

Higher rates of PTSD are found for co-victims than those bereaved by accident or other victims of crime (Applebaum & Burns 1991). PTSD is an anxiety disorder that can develop following major trauma outside the realm of normal human experience (including the traumatic loss of a loved one), and symptoms include flashbacks, guilt, sleep disturbances, and suicidal ideation (Ruback & Thompson 2001:38; Lurigio & Resick 1990:51).

Risk and resilience factors can aid or undermine co-victim coping, and predispose to PTSD development. Risk factors include social isolation, negative police or media interactions, grief suppression, poor prior mental health, concurrent life crises and event variables such as a child as primary victim, unknown killers, missing bodies and horrific murder (Rock 1998:51–52; Parkes 1993 cited in Mezey, Evans & Hobdell 2002; Gerber 1995; Sanders 1993; Cook, David & Grant 1999:18,40; Thompson, Norris & Ruback 1996; Ruback & Thompson 2001:140).

Co-victims are valuable media commodities liable to experience insensitive treatment by journalists seeking sensational copy. Such encounters can generate anxiety and frustration about the inability to control media presentations of the deceased (Young 1998:xi; Cook, David & Grant 1999:73). This intrusion may continue with long-term re-reporting (Victorian Community Council Against Violence 1994:124). Victim advocates may assist co-victims through spokesperson and brokering roles in media dealings, enabling positive interactions in memorial creation, recognition of loss, and protection of co-victim interests (Spungen 1998:217; Rock 1998:86–87).

A 'second wound' can result from continued interactions with the criminal justice system during investigation, prosecution, lengthy trials and sentencing — particularly for victim-witnesses forced to relive the experience (Cook, David & Grant 1999:15; Spungen 1998:10). Victims may submit Victim Impact Statements, although some commentators argue that these can unhelpfully raise victims' expectations about outcomes (Ashworth 1993). Dissatisfaction with outcomes can stem from experiences, expectations, and misunderstandings of criminal justice system operations and sentencing realities (Thompson, Norris & Ruback 1996; Benjamin 1993; Williams 1999:51). Information from victim liaison groups can be helpful in reducing dissatisfaction. Court support should be available for family members, and victims should not be abandoned post-trial (Joint Select Committee on Victims Compensation 1997:13–14; Spungen 1998:194). Co-victims with no-arrest or no-prosecution homicides require explanations of inaction to make acceptance of this situation easier (Weis Farone 2000). Strategies of information provision, combined with practical and emotional support and advocacy should help protect victims from system-precipitated trauma (Benjamin 1995:64).

Resilience factors that bolster co-victim coping include strong supportive social networks to listen, problem-solve and be present, and access to information and material resources to enable decision-making, understanding, and support access (Sprang & McNeil 1998; Cook, David & Grant 1999:40, 42; Sanders 1993).

Many studies reiterate the potentially serious effects on children of witnessing homicides, particularly of family members (Eth & Pynoos 1994; Levy & Wall 2002). Most children will cope, but risk factor clusters can contribute to long-term developmental impairment and can predispose these co-victims to adult violence (Lewis et al, cited in Eth & Pynoos 1994; Spungen 1998:166).

Support for homicide co-victims

Funding allocation should begin with provision of practical services such as funeral costs, and of victim liaison personnel to help make such arrangements and assist in dealings with police and other services. As a start, specialist officers within the Australian police services have carried out exemplary work. Community based services should be supported to help mobilize the resources in the victim's social environment.

Mental health services need sufficient funding to provide long-term support for victims requiring it (Victorian Community Council Against Violence 1995:9). This would be more productive than offering a small amount of psychological support for all victims regardless of its likely effectiveness. Specialist interventions should target those having the most difficulty coping. Such targeting is cost-efficient in three ways:

1. Reducing un-necessary treatment provision and minimising iatrogenic effects;
2. Reducing overall treatment length; and
3. Enabling victims' (although still grieving) return to being functional members of society, and reduce their reliance on other services.

Ideally, resources should be available for research to identify what is best for victims, and the most efficient ways of providing what they need.

Professional training for police, the wider justice system, advocates and mental health/social workers needs to foster sensitivity and responsivity to the victim experience (Stewart, Harris Lord & Mercer 2000; Cook, David & Grant 1994:41). Further, adequate justice system resources need to be dedicated to providing victims with support they require, and to making information accessible.

Conclusion

Family members and other co-victims of homicide as a group often experience complex and profound distress. Such distress can arise from both the loss itself and from the unexpected and traumatic circumstances. Effects become apparent in all areas of co-victims' lives, and problems in dealing with victimisation can continue far into the long-term. Individuals close to the victims and service providers often lack knowledge of these effects and appropriate responses. Strategies for helping co-victims cope centre upon respect, sensitivity, the provision of information, and the availability of a range of services appropriate to understood needs. Special effort should be made to provide appropriate levels of 'official' support, while encouraging the natural coping mechanisms of families and other informal networks. Further research on this area is urgently needed.

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