Psychotherapy of Bereavement After Homicide: Be Offensive

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After a homicide, those surviving family members who fail to recover and present for therapy are unable to adjust to the trauma of the dying. They present with persistent reenactment images of the dying, which are frightening and nonconformable. This article suggests a strategy that specifically focuses on the encouragement of psychologic offenses to begin the mastery of the traumatic responses of avoidance and intrusion. Mastery of the trauma of the dying is a necessary first step in therapy before resolution of bereavement distress can begin. This article introduces some guiding principles that can be of pragmatic assistance during treatment.

- *traumatic bereavement*
- *psychologic offenses*

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My purpose is to outline some guiding clinical principles for assessment and therapy after the homicidal death of a family member. In 1990, the Support Project for Unnatural Dying was initiated (Rynearson, Purrington, Sinnema, & Olson, 1994), which offered a supportive intervention program for each family in Seattle that had experienced a homicide. To date, the project has worked with over 200 families, and descriptive findings and therapy recommendations have been reported in several recent publications. This project has served as the database for some generalized findings regarding psychotherapy (Rynearson, 1994). To date, there has been no controlled study of the efficacy of any form of psychotherapy or pharmacotherapy in bereavement after homicide. This article offers preliminary recommendations about therapy that appear to have clinical relevance and utility, but are as yet unconfirmed by standardized study.

A homicide demands an acceptance of the traumatic circumstances of the dying as well as the death itself. This duality of trauma and bereavement is a complex synergism and several authors has suggested that the traumatic response to the dying takes precedence over the bereavement response to the loss (Rynearson & McCreery,1993). The homicide of a family member forces each remaining member to imagine how the murder took place and to identify psychologically with the terminal thoughts and feelings of the victim, even though they were not present at the time. These intense "reenactment fantasies" present as intrusive, repetitive flashbacks during the day, and sometimes are recurring dreams during sleep. Although reenactment phenomena spontaneously subside in the majority of family members, their persistence as intense daily occurrences accompanied

by high emotional arousal is associated with risk for nonrecovery and the need for intervention (Rynearson, 1995).

RECOVERY AND NONRECOVERY

In this article, I focus on specific cases to illustrate the dynamics of recovery and nonrecovery. These cases are notably extreme in their presentations, so extreme that they exaggerate some of the underlying psychologic mechanisms. After considering cases that illustrate recovery and nonrecovery, I will describe a third case engaged in ongoing psychiatric treatment, whose response is a synthesis of these mechanisms of recovery and nonrecovery.

I will try to clarify adaptive mechanisms rather that maladaptive. Indeed, the initial task of therapy in this highly charged and traumatized context will be the identification and reinforcement of adaptive capacities. At first, the family member cannot summon an adaptive response. There is an elemental horror and fer associated with homicide that overwhelms. The terror of homicide registers at a preverbal, psychophysiologic level: Words and abstraction cannot contain or comprehend it. Initially, there are inchoate waves of emotional numbness, denial, or disbelief, flooded by intrusive states of horrific awareness, imagery, and affect.

In this context of overwhelming trauma, I would suggest that the clinician develop a conceptual differentiation of psychologic "offenses" as distinct from psychologic "defenses." The understanding of psychologic defenses pivots on coping mechanisms that compensate for internal drives or conflicts. The familiar mechanisms of denial, projection, reaction formation, and sublimation represent a partial list of mechanisms that "defend" against unacceptable internal drives. By contrast, psychologic offenses may be viewed as coping capacities that compensate for overwhelming external stressor.

Unlike the mechanistic function of defenses (to change or transform unacceptable drives), the offensive capacities function as protective buffers (to prevail over external, catastrophic change). Presumably, the function of psychologic offenses is to provide a substrate of neuropsychologic stability that is basic and essential: basic in establishing sufficient autonomy from what has happened premonitory to accommodation and adaptation. I would propose at least three capacities that comprise basic autonomy during trauma:

1. Pacification

This is the capacity to calm oneself while experiencing horrific, self-disintegratory fear. Homicidal death is sudden, horrific, and cannot correspond with experience that is familiar or coherent. Overwhelming fear is an involuntary response that is so inchoate that verbal defenses are useless in changing or transforming what has happened. The ability to calm oneself, to relax, are words we use to describe something that is beyond or before words. Because pacification is an experiential and preverbal state, we invoke nonverbal analogy and imagery in defining it. Pacification is being held or nurtured, or lulled or soothed, or safe. After a homicidal death, a family member needs to maintain a

state of safety while immersed in the disintegratory horror of the dying.

2. Partition
This is the capacity of separate or distance oneself from horrific imagery. Psychologic theorists have referred to object differentiation as the cognitive basis for establishing what is "me" from "not me." This capacity buffers by distancing oneself from homicidal dying by a metaphorical boundary or membrane through which one can communicate and empathize with out oneself being murdered.

3. Perspective
This is the capacity to transcend beyond incorporated horrific experience toward a future that offers hope and recovery. This capacity buffers the sudden horror of the homicidal dying by introducing the context of time. Who I was, who I am, and who I will be are stretched and interpenetrated by this event. Perspective allows a beginning for accommodation, that the self can transform and change to prevail over this trauma.

Whereas these capacities are simultaneous and mutually reinforcing, the most basic is pacification. Self-disintegratory terror primarily undermines any adaptive response, resulting in a frozen helplessness. Presumably, this state of terror precludes a balanced presence of partition and perspective. Instead, the horrific image of dying is numbly denied, only to register as a brutal dream, flashback, or irrational fear. Once the state of terror is reduced to a tolerable level, the conscious acceptance of what has happened will allow accommodation through a beginning partition (which allows a separate connection with, rather than disintegration in, what has happened) and perspective (which allows a metabolism of this event so that it becomes a conscious ingredient of identity). In trauma therapy, the reinforcement of pacification will be the initial strategy.

As this article proceeds, I clinically detail these capacities and techniques for their clarification and strengthening in treatment. Before doing so, I will present a case that illustrates the difficulty in initiating therapy when psychologic offenses (particularly pacification) are deficient.

A CASE OF NONRECOVERY

Presenting Problem/Case Description

Alice, a 44 year-old woman, was referred by a bereavement support group after attending two sessions because "I can't stand to hear other people's tragedy when I can't handle my own." She had no previous history of psychiatric disorder or treatment. Two years before, her mother had been murdered by her brother, who was schizophrenic. Alice was overwhelmed by reenactment fantasies and nightmares, often accompanied by panic attacks. Unable to concentrate, she had stopped working as a secretary and had become agoraphobic and increasingly dependent upon her husband.

Alice asked to leave our initial 1-hour appointment after 30 minutes because of the terror

she anticipated in talking with me about her mother's murder. I tried to reassure her that she retained primary control over the way that the time that she talked about that. I recommended that we try to enhance her trust and her support system, and together we would initially diminish her panic attacks.

During the second session, Alice felt compelled to tell me about her role as primary caregiver during her childhood. When she was 5 years old her father abandoned the family, after which her mother decompensated and began to drink. For the next 45 minutes, Alice wept and raged about her mother's death, about the physical and sexual abuse she and other family members had suffered from her alcoholic stepfather, and her inability to protect her mother and her four younger half-siblings during her childhood and adolescence. At the end of that session, Alice felt unrelieved: as if this childhood terror of unremitting abuse and her inability to control were an inevitable preface to her mother's murder. My efforts to comfort or divert her during this monologue had no apparent effect. She agreed to a short-term trial of an antianxiety agent (clonazepam, 1 mg, twice a day).

During the third session, she was grateful for the medication, which now controlled the panic attacks, but the reenactment flashbacks and nightmares persisted. I inquired about cohering belief systems and learned that her religious faith and her faith in the future had been dissolved by the murder. She then began to talk about her incapacity to trust her husband and her disparate emotional commitment to her male lover, with whom she had been involved for 5 years. At the end of that session, she handed me a copy of her brother's written confession, detailing the specifics of the murder. She asked that I read the accounting before our next scheduled session. It was an appalling document, not only because of its brutality (he had decapitated the mother), but because of it absurdity: He believed that he was saving the family from the mother instead of being traumatized or remorseful about his act.

Alice failed to keep her fourth appointment and when contacted by phone, said she was angry at me. She felt that I was critical and uncaring. She had decided that she needed to recover with the support of her male lover, who would mutely reassure and comfort her in his embrace.

Outcome and Comment

Since that brief contact 4 years ago, Alice continues to call every 6 to 12 months to ask for a refill of a minor tranquilizer when her panic attacks recur. There has apparently been no substantive change in her skewed support system, but her traumatic response has diminished to the point that she can now leave home and has returned to work. Although I continue to offer active treatment, she still feels too threatened, but acknowledges that she probably will return at some point.

Alice's incapacity to calm or distance herself from the reenactment of her mother's murder both pushed her toward and pulled her away from therapy. Knowing that she

needed help was counterbalanced by her disintegratory fear and collapse of identity as therapy began to focus on the tragedy. He saying, "I can't stand this" as she bolted from her support group meeting was a metaphor for the reenactment of her mother's terror are primary and her compulsive approach and avoidance in therapy as secondary. If "I can't stand this" is a metaphor for her impasse in therapy, the "You don't have to" would be a reassuring response. Encouragement of suppression of terror and diversion from murderous imagery promotes a beginning autonomy. Knowing that she had been unable to tolerate therapy, I was active in promoting a reassurance that "We can stand this together when you are better able to calm yourself." Her incapacity to do so became more manifest during the second session as the described her abusive and chaotic family history. It seemed that because of her incapacity to calm herself, she compulsively sought comfort in he embrace of her lover. Unable to pacify or partition herself from the murder of her mother, she was left with the nonadaptive responses of escape and avoidance of therapy. Recognizing that her disintegratory anxiety met criteria for panic disorder, I offered her medication, which gave symptomatic relief. Possibly, the early dependency upon me as her therapist was so threatening that she had to escape at the same time that she offered, but could not directly share, the traumatic description on her mother's murder. Perhaps the brutal death of her mother realized a long-suppressed fear that occurred in this family context of chronic violence. Time and her private processing of the homicide have allowed a resolution that I suspect is very tenuous.

How might I have better engaged her in therapy? I doubt that I could have, but she and other avoidant cases suggest the priority of assessment and re-establishment of basic offenses as requisite in therapy.

ASSESSMENT AND STRENGTHENING OF PSYCHOLOGIC OFFENSES

Although homicide is the reason for seeking treatment, the patient and therapist are in the ironic position of delaying its consideration. It seems counterintuitive to avoid such an intense story of death, but the patient and therapist must first establish a basic alliance that promises enough security that they can accommodate to what has happened. The security rests upon the nonverbal capacity to modulate intense fear and divert one's mind from horrifying imagery. The therapist might begin by saying, "What a terrible time for you. First lets work on giving your mind a rest. You have told me that you can't stop thinking and dreaming about the murder, even though you didn't really see it. That's just too much to bear. How can we help you to relax and allow a more peaceful place for your mind to be?"

At this point, there are a number of techniques that may be used to strengthen pacification (relaxation strategies) and partition (cognitive strategies). These strategies have reported success in trauma therapy. Meichenbaum's (1994) recently published manual on the

assessment and treatment of posttraumatic stress disorder (PTSD) includes a comprehensive description of researched techniques (systematic desensitization, guided imagery, cognitive restructuring) as well as unresearched (eye movement desensitization and reprocessing, art and movement therapies, ritualistic approaches, and reintegration therapy). There is no study that has compared the efficacy of these various techniques by themselves or in combination (Soloman, Gerrity, & Muff, 1992); the selection of which combination to use in a given case needs to be developed by the clinician and the patient.

Another principal focus of assessment is the patient's matrix of perceived support. Early inclusion of family members and friends allows the therapist to begin educating these figures about strengthening coping responses, the long-term nature of recovery, and the supportive role they can serve. This not the time for uncovering conflicts or hidden agendas in family dynamics. Instead, the clinician will emphasize that recovery will involve the entire family because everyone will be influenced. Instillation of hope that this traumatic death can be mastered, respect for the divergent responses of different members, and patience in the recovery process that will take many months (sometimes years) can help the family in remaining empathic and flexible. When homicide is an intrafamily event (where on family member kills another), psychotherapy is enormously challenging. Not only will the entire family identify with the victim, but they are identified with the murderer as well. Intrafamily killing accounts for 25% of homicides and often occurs in families with a long history of dramatic dysfunction. These families need specialized intervention from clinicians who have had extensive training in family and trauma therapy. Even with this specialized care, the prognosis for these families remains guarded, as it probably was before the homicide.

Inquiry about the patient's private perception of death is another early task of assessment. Nihilism and despair are common early responses, and helping the patient recover or develop sustaining spiritual beliefs or actions will buffer the disintegratory effects of homicide. Asking directly about the concept of death clarifies whether the family member has some belief in a spiritual,cosmic, or natural coherence of life and death. Once identified, that coherent schema may be an ingredient in counteracting the incoherence and emptiness of a violent death. Encouraging a return to church, a silent sojourn to the ocean, or renewed commitment to caring for other might help in counterbalancing the nihilism of homicide.

Pictures of the deceased can serve as comforting images. In reviewing family picture albums together, the therapist and patient can summons nurturant, positive imagery that may counterbalance the imagery of the homicide. This is another nonverbal techniques to apply during the initial phase of strengthening psychologic offenses.

Once the psychologic offenses of self-calming and distancing from the horrific imagery are strengthened, we can begin to confront the traumatic imagery more directly. The assignment to draw the scene of the death provides a nonverbal expression of reenactment that can be directly viewed and shared by the therapist. The mutual process of

responding to the horror and helplessness are followed by questioning where patients place themselves in the drawing. It is rare that patients portray themselves at all, and this presumably a sign of their traumatic overidentification with the dying itself. Efforts to place themselves with the reenactment drawing allows a beginning distancing instead of mute participation. It is not unusual for patients to imagine themselves beside the deceased; sometimes defending, sometimes holding, sometimes rescuing. This exercise allows a more active and supportive presence and a counterbalancing identification as enclosed and active.

At this point, the patient has sufficient autonomy from the trauma of the homicide to begin addressing less immediate issues that would include: (a) self-esteem enhancement; (b) acceptance of survivor guilt; (c) delineation of previous vulnerabilities; and (d) the relationship with the deceased. These four coordinates of support are well established in grief therapy. Together they allow a strengthening of autonomy (by increasing self-efficacy and diminishing self-derogation) while compensating for the lost attachment (by increasing self-sufficiency and diminishing ambivalence).

I will now describe a case that illustrates an exaggeration of psychologic offenses, so exaggerated that the rapidity of recovery obscures and avoids the underlying trauma.

A CASE OF RECOVERY

Edith, a 64 year old woman, came to our attention because of her lack of reported difficulties after her husband murdered her son. She was enrolled in our research and completed measures of grief and trauma. Her scores on all of the standardized measures were the lowest recorded by any of the bereaved patients.

Although Edith's husband had always been an angry, autocratic man, his volatility dramatically increased after the neurosurgical removal of a meningioma 3 years earlier. During a physical fight with his 33 year-old son, who lived with the family, the husband became paranoid and murdered the son with a shotgun. This happened 11 months before we contacted the family. Her husband had been imprisoned and declared temporarily deranged because of his organic brain syndrome and was placed in an anger management program. After 6 months of incarceration, he returned home and was in residence at the time of our one and only interview.

Most important to Edith was her faith in God and the firm belief that there were lessons in all of this for her entire family. She believed that "God has given me the challenge to save this family." She was sure that this was not a punishment. Instead, there was a more positive reason behind this tragedy that was to be discovered. Edith reported that she had been able to maintain a sense of altruism toward her husband; indeed, during her

description of the murder, she was firmly identified with the husband rather that her murdered son and could understand how her husband's paranoia had forced him to protect himself. She was enraged at him for what he had done, but forgave him for what he could not control.

Edith had noted reenactment imagery during the initial weeks of her recovery, which she was able to transform by visualizing her son's death as a release from his pain and terror into heaven, where he await the remainder of the family in peace. She was persuaded that God had created this crisis as a challenge for her to establish enough harmony within the family that they would welcome one another when reunited in heaven. Edith felt that at some point in the future, the entire family might benefit from some therapy to resolve the hurt and anger she recognized in everyone.

In this seemingly intolerable conundrum of violence and family disintegration, Edith was able to remain nurturant and hopeful. She felt that this was because of her belief that God would reveal a purpose and healing to the murder. Although her overidentification and need to nurture her murderous husband may be viewed as defensive in nature, she was quite candid about the rage that she and other family members experienced and was open to the need for therapy at some point. Her religious belief was so intense in providing a transcendent perspective that she remained serenely removed from the trauma. As our purpose during the interview was to understand her recovery, we did not challenge or question her efforts to cope so much as celebrate how well she was doing.

A THERAPY CASE

In this last case, we shall visit a more common clinical dynamic where the trauma of homicidal death of a family member is more approachable because of more resilience, but more problematic because of more vulnerability.

Presenting Problem/Client Description

Fran, a 35 year old woman was referred by her psychiatrist who had been unsuccessful in treating her depression the previous year despite weekly outpatient visits and therapeutic levels of antidepressant medication [fluoxetine (Prozac), 40 mg/day]. In addition, she had been inconsistently attending AA meetings and a bereavement support group since the homicidal death of her mother 3 1/2 years before.

Fran's mother was killed by her father. He had become psychotically depressed and paranoid after the neurosurgical removal of a brain tumor 2 years before the murder. Her mother and Fran's three younger sisters had sought multiple consultations with the father's physicians because of his pathologic jealousy and threats. Entreaties to the police and efforts to commit the father failed to prevent the shooting. The mother died instantly from a head wound and the father survived a self-inflicted gunshot wound to the chest.

Case Formulation

Although her sisters were able to mourn openly and recover, Fran began to drink while compulsively caring for her close friend who was dying of cancer, and visiting her father several times each week at the state hospital where he had been committed. The combination of alcohol and compulsive caregiving diverted her from the acknowledgment of her mother's death. The alcohol also distanced her from the repetitive reenactment flashbacks and dreams of her mother's dying. Within months of the murder, Fran also joined a conservative and fundamentalist church that offered social support and an absolute promise of eternal salvation for her mother and a simplistic explanation of her father's murderous behavior as an act of the devil.

Course of Treatment

The initial objective was to assist Fan in mastering the traumatic imagery. It appeared that her daily use of alcohol was an effort to tranquilize and divert her from her terror. I insisted on sobriety and attendance at AA meetings as a condition of ongoing assessment and treatment. Once sobriety was established, she felt relief in sharing the traumatic reenactment imagery, which had heretofore remained a dreaded secret. She had misinterpreted these flashbacks as hallucinations and fear that she was "going crazy like my dad." It was explained that the flashbacks and dreams were a common experience. Clonazepam (1 mg, twice a day) was added to the fluoxetine to control the anxiety an panic that accompanied the flashbacks.

Another resource of reenactment imagery came for the media coverage of her mother dying. Fran had a collection of newspaper articles and a tape of the TV news report of the crime scene. It showed her mother's body in a large bag being loaded into a coroner's van (a repetitive, senseless, and degrading TV image) while the police ringed around her parents' apartment where her father had barricaded himself. While distraught neighbors were interviewed on camera, there was a loud gunshot from the apartment. Her father had attempted suicide while the camera followed the SWAT team breaking in the door. This videotape became a focal point for her mastery of the trauma. She viewed this taped with her individual therapist and finally the support group of family members unrecovered from homicide.

Initially, there was an obsessive need to replay and reexperience the trauma without any reflective response. In fact, these images composed the reenactment flashback and recurring dreams she began to experience after curtailing her drinking. As her individual therapist, I noted that "your flashbacks keep you away from what went on inside the apartment. We need to help you consider what you mother went through just before the shooting." I recommended that she draw her fantasy of the death scene. The drawing allowed us a metaphorical means of placing ourselves in the more crucial reenactment of

her fantasy of the homicidal quarrel between her parents. She believed that her father's psychotic jealousy had catalyzed the murder and viewed her mother's screams for help and terror as she was cornered and gunned down by her raging father in the drawing. As she was presenting this drawing to the support group, one of the members remarked upon the irony that "you're the one who is feeling the fear- your mother isn't feeling that. She's dead and gone, but you can't stop feeling for her. I know because I did the same thing where my sister was murdered. But give it up- your mother's not feeling that way anymore, so why should you?" This blunt, rhetorical question was helpful, not only because it untracked her obsessive focus on her mother's fear, but allowed a constructive reframing of the image with a beginning perspective: her mother and the patient no longer belonged in that moment.

I recommended that she curtail her visits to her father. Fran was incapable of integrating her feeling of nurturance and rage toward her father, whom she loved as a caring parent but feared and hated as a murderer.

Fran no longer felt comfortable with the demands of the conservative and fundamentalist church and returned to her former church and supportive congregation. Within a short time, she was able to express the longing and sadness for her mother's loss, which was a milestone in her recovery. During subsequent group and individual therapy, we learned of her lifelong dependency upon her mother (chronic alcoholic) and her masochistic relationship with men (two unhappy marriages). Her vulnerability to separation and her inability to accept her own anger in relationships had persisted since her childhood. Her supportive psychotherapy attempted to delineate these long-term vulnerabilities in relationships, the guilt she experienced with her mother's murder, and the repressed anger toward her father. At the same time, therapy attempted to enhance her sense of self-esteem and to soften her punitive judgment of herself. Individual and group therapy anticipated how these vulnerabilities and this traumatic death might complicate future romantic commitments with fear, distrust, and acting out. We recommended that she protect herself from such an entanglement until she achieved more stability. Despite her improvements after 6 months of treatment, we were apprehensive about her impulsive decision to marry a 53 year old disabled construction worker who lived in a remote area of Alaska.

Outcome and Prognosis

Four months later, Fran returned for several outpatient visits while separating from her new husband, who had physically abused her in a fight she had provoked after several weeks of mutual heavy drinking. She could see that this was a limited reenactment of her mother's death. He enrolled in an inpatient alcohol rehabilitation program, but she refused to do so. She denied any persistence of traumatic imagery or depression, however the images of reenactment would fleetingly recur. Eventually, she decided to return to Alaska and her marriage.

A year later, she returned for emergent care. She and her husband continued in their drunken quarrels. In the last quarrel, he had threatened to shoot her with his hunting rifle, "so I could see what I was doing to myself and I knew I had to get out." She was somewhat diverted from active treatment because of her father's death that same week; he died from undiagnosed lung cancer. Over the next 6 months, she and her sisters won their two lawsuits against the state government; the first for failing to commit their homicidal father, and the second for failing to diagnose his obvious cancer. During those 6 months, she was able for the first time to begin grieving for her father. She initially grieved for his death and then for his loss as her father. Since the neurosurgery 5 1/2 years before, "he was a different person after the surgery and I lost him as my dad."

During the same 6 months Fran discovered that she was pregnant. Preparing her for parenthood became another salient therapy issue. Having a child was a most positive experience. As she put it, "it's like I have another chance to live life the way I want to." In the last 2 years she has stopped drinking, is supporting herself and her baby girl, and feeling positive about her future on her own.

This case report illustrates the limitations of recovery in the ongoing psychotherapy of a patient whose chronic mixed character disorder and alcohol dependence complicated her adjustment to her mother's homicidal dying. Fran's initial response to the homicide was complicated by her alcohol abuse (a defective attempt to pacify her terror) and by her compulsive caregiving of a dying friend (unable to partition herself from the dreadful death of her mother, she desperately tried to undo its inevitability in another). Her incapacity to establish an inclusive perspective of this tragedy led to her compulsive adherence with a religious group that promised salvation and an absolute explanation of the tragedy.

Whereas focused individual therapy, group therapy, and pharmacotherapy have offered short-term improvement in her traumatic grief, the death of her father and the birth of her daughter have led to more substantial gain. Her prognosis remains guarded, and we remain available for continued support.

SUMMARY AND CONCLUSIONS

In this article I have described and differentiated the psychologic "offenses" that are basic in recovery following the homicide of a family member. These offensive mechanisms allow enough psychologic calming of terror (pacification), distancing from imagery (partition), and confidence in the future for a beginning accommodation (perspective). The clinical deficiency of psychologic offenses results in a traumatic avoidance of insightful engagement in therapy; the clinical excess of psychologic offenses results in a positive avoidance of insightful accommodation through compulsive care giving and over inclusive spiritual belief that promises transformation.

Following a homicide, those family member who seek treatment present with an increased response of traumatic intrusion and avoidance to the manner of dying. Because these intense traumatic responses are associated with diminished offensive capacities, the strengthening of these nonverbal offensive capacities is a basic therapeutic strategy upon which subsequent therapeutic alliance will rest. This article provides a preliminary protocol for the assessment and strengthening of these crucial offenses.

The emphasis upon and active, "offensive" therapy with homicidal bereavement helps to dispel the sense of meaningless impotence that invariable followed such a tragedy. Establishing a therapeutic stance that encourages pacification, partition, and perspective helps to buffer the therapist as well as the patient. Without such a buffer, working with homicidal death becomes enervating and risks becoming counterproductive and entangled in the therapist's own feelings of rage and hopelessness.

SELECT REFERENE/RECOMMENDED READINGS

Meichenbaum, D. (1994). *A clinical handbook/practical therapist manual for assessing and treating adults with posttraumatic stress disorder (PTSD).* Waterloo, Ontario, Canada: Institute Press.

Rynearson, E.K. (1994). Psychotherapy of bereavement after homicide. *Journal of Psychtherapy Practice and Research, 3, 341-347.*

Rynearson, E.K. (1995). Bereavement after homicide: A comparison of treatment seekers and refusers. *British Journal of Psychiatry, 166, 507-510.*

Rynearson, E.K. and McCreery, J.M. (1993). Bereavement after homicide: A synergism of trauma and loss. *American Journal of Psychiatry, 150, 258-261.*

Rynearson, E.K., Purrington, J., Sinnema, C. and Olson, D. (1994). Support project for bereavement after homicide. *Virginia Mason Clinical Bulletin, 48, 33-41.*

Solomon, S.D., Gerrity, E.T. and Muff, A.M. (1992). Efficacy of treatments for posttraumatic stress disorder: An empirical review. *Journal of the American Medical Association, 268, 633-638.*