4-1-2010

Immediate Aftercare Program for Survivors and Families of Homicide Victims: The Case of Cobb County Government

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A Practicum Paper
Submitted in Partial Fulfillment of the Requirements for the

Master Public Administration

Kennesaw State University
May 2010

Department of Political Science and International Affairs

Master of Public Administration Program

College of Humanities & Social Sciences

Kennesaw State University

Kennesaw, Georgia

Certificate of Approval

This is to certify that the Capstone Project of

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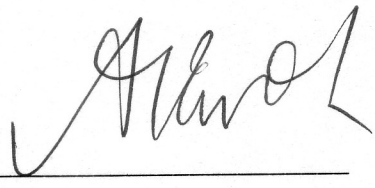
Has been approved by the Program Director

For the capstone requirement for the Master of Public Administration

Professional exercise in the Department of Political Science and International Affairs

At the May 2010 graduation

Capstone Director:



Immediate Aftercare Program for Survivors and Families of Homicide Victims: The Case of Cobb County Government

Executive Summary

Cobb County, Georgia is a rapidly growing, upscale, suburban county in the metro-Atlanta region. However, the County lacks the ability to provide a comprehensive array of services to family members of homicide victims and other non-natural death cases. While various counseling and service programs exist in the area, there is no singular focus on the delivery of services to homicide survivors, families, and friends. Other than the general information provided to surviving family members by the Medical Examiner's Office at the time of death, there is little to no emphasis currently placed on services to or the needs of those persons and families affected by non-natural deaths such as suicides or non-criminal related car crashes.

Cobb County implemented a specialized service delivery program in October of 2009 through the Victim Witness Assistance Unit of the District Attorney's Office. The program established a case management system with services provided by a victim advocate staff in the Medical Examiner's Office. The victim advocate implemented an intensive case management plan and provides direct services for all members of the deceased victim's immediate family, other family members, or friends of the deceased victim requesting services. The program also developed and disseminated a comprehensive resource guide and obtained other tools to assist families in dealing with trauma, grief, and coping after the loss of a loved one.

The purpose of this study is to obtain information about current practices in the area of homicide survivor support, identify the conceptual framework guiding the interventions of homicide bereavement caregivers, and evaluate whether immediate aftercare to homicide survivors' families greatly impact the healing process. Based on the data collected, the study also examined the effectiveness and efficiency of services coordinated through the program implementation. Although immediate aftercare positively affects the healing process, the Cobb County program is in the beginning phase and requires more data and research to determine its efficiency and effectiveness.

Acknowledgments

I would like to thank Dr. Barbara Neuby and Dr. Ulf Zimmerman for their confidence in my ability to continue my education to receive my Master of Public Administration degree after many years outside of the classroom. Their teaching styles made it possible for me to apply my work and real life experiences, while gaining the knowledge of how I may better serve those who work for and with the public. Thanks to Dr. Andrew Ewoh for his time and review of this paper, his encouragement provided the light at the end of a long journey of seeing my dreams of furthering my education fulfilled. All of his comments were appreciated and helpful not only in the research and writing of this paper, but will also help me in my career and future endeavors.

Thanks to my friends and co-workers, their support and encouragement sustained me through those long days. They told me that it would be worth it, and they were right. To my mother, thank you for all your love and support. Your belief in me is truly appreciated. You always inspired me to be the best that I can be, and have given me the confidence to do all things. Without your faith in me, I would not be where I am today; I hope I have made you proud. Finally, to my husband, Scott, I am so thankful for your love and support while in Iraq, I am so glad you were here by my side to encourage me during the last few months and to witness my graduation.

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Introduction

Cobb County is a diverse, resource-rich, and innovative community. With a population close to 700,000, it is one of the largest of the five Atlanta metro-area counties in the State of Georgia (Georgia Department of Community Affairs, 2008). However, the County lacks an ability to provide a comprehensive array of services to family members of homicide victims and other non-natural death cases. While some agencies and resources exist, to date there has been no all-encompassing effort to structure and streamline such services to victims with the exception of those where criminal charges are sought against an identified perpetrator. Other than the general information provided to surviving family members by the Medical Examiner's Office at the time of death, there is currently little or no emphasis placed on services for the needs persons and families affected by non-natural deaths, such as suicide or non-criminal related car crashes.

Through the Victim Witness Assistance Unit of the District Attorney's Office, Cobb County recently implemented a grant funded project for a specialized service delivery program that provides for a comprehensive and coordinated array of services to streamline access to vital support services for family members of homicide victims and other non-natural death cases. The program implementation required the establishment of a project case manager. The project case manager goals are as follows: 1) to implement an intensive case management plan for all members of the deceased victim's immediate family and any other family members or friends of the deceased victim who are requesting services, 2) to provide for the delivery of direct services to family

members and friends of homicide victims and other non-natural death incidents such as suicide, murder/suicide, and traffic-related incidents, and 3) to develop and disseminate a comprehensive resource guide and obtain other tools to assist families in dealing with trauma, grief, and coping after the loss of a loved one. Community collaboration is necessary since it provides comprehensive, specialized, and coordinated services to victims of homicide and non-natural death cases, and facilitates a victim's healing from trauma. This study provides an answer to the question: Does immediate aftercare with victims positively impact the healing process? This evaluation is critical to ensure that this project is operating pursuant to the goals and objectives set forth by the federal grant mandate to ensure services to crime victims.

Approximately 16.4 million people have been affected by homicide. Five million adults have experienced the murder of an immediate family member; 6.6 million people have experienced the murder of a relative other than an immediate family member, and 4.8 million have experienced the murder of a close friend (Hertz, 2005, 289). Often, for the families left behind, the cause of death is not as important as finding resources to bury loved ones and the strength to go on, write obituaries, plan funerals, and find financial and mental resources to guide them through their grieving process. According to a 1989 report by the National Center for Victims of Crime, homicide grief expert Lu Redmond estimated that for every homicide, there are 7 to 10 close relatives deeply affected (Holmes, 2004, 184). Homicide survivors are faced with numerous time consuming and tedious tasks at a time when they are emotionally incapable of attending to them. After the homicide of a family member, there is an immediate need for concrete and pragmatic

services to aid the survivor and their immediate family with many aspects of preparing for a funeral along with many legal and financial situations (Horne, 2003).

In 1975, the first national organization to assist and advocate on behalf of crime victims, the National Organization for Victim Assistance (NOVA), was formed, and held its first national conference a year later. In 1981, the year before the convening of the President's Task Force on Victims of Crime, the number of people victimized nationwide reached a historic high point. In 1982, the President's Task Force on Victims of Crime provided leadership at a critical time for the victim assistance field. It highlighted the lack of services to victims and underscored the need for all participants in the justice system to respond sensitively to victims. The victim assistance movement has grown rapidly into a full-fledged advocacy and service field dedicated to meeting the physical, financial, and psychological needs of victims, and their families. As the victim assistance field has grown, so has its awareness of the complex needs of crime victims, and the demand for coordinated multidisciplinary responses (U.S. Department of Justice, 1998).

Most interventions designed specifically for homicide survivors provide either short or long term group treatment. Trauma is addressed supportively by providing empathy, information, and coping skills training (Hatton, 2003). A majority of homicide survivors who seek counseling are assisted by self-help organizations, victim advocates, or other paraprofessionals. For a variety of mental health problems, counseling outcomes are comparable for services provided by paraprofessionals, self-help groups, or experienced clinicians. Paraprofessional counselors, however, may be perceived by trauma servicers as less accepting and helpful than professionals. In the early 1980s, psychologists were urged by the American Psychological Association (APA) to support

paraprofessionals who provide services to crime victims and to assess the effectiveness of victim assistance. Although mental health services for homicide survivors have greatly expanded since the APA mandate, formal outcome evaluation has been limited to two treatment programs designed for survivors by clinicians, one of which yielded substantial negative results (Hatton, 2003, 428). This paper begins with the purpose of the study, and followed by a review of the literature and methodology. The analysis provides a brief discussion and concludes with future research recommendations.

The Purpose of the Study

The purpose of the study is to obtain information about current practices in the area of homicide survivor support, identify the conceptual framework guiding the interventions of homicide bereavement caregivers, and determine whether immediate aftercare to homicide survivor families greatly impact the healing process in homicide bereavement. In some cases, murder may occur as a final violent act after many years of escalating spousal, elder, or child abuse. It may be used as a solution to gang-related hostilities, or to silence a robbery or sexual assault victim. Homicide can kill dozens of victims through one terrorist act or a series of victims by one serial killer. This study also addresses other non-natural deaths such as suicide and car crashes. Traffic related incidents as a direct consequence of drinking and driving add up to 18,000 lives that are lost each year (U.S. Department of Justice, 1998).

Along with murder cases, there are more arrests daily for impaired driving than for any other crime. Although deaths and injuries resulting from drunk driving are well documented in the criminal justice system, drunk driving is not considered a violent

crime. Victims of drunk driving crashes were, until recently, not considered to be victims of crimes, and their needs and rights to participate in the criminal justice process were often ignored. Changes in public understanding of and response to the crime of drunk driving can largely be credited to the extraordinary work of grassroots groups such as Mothers Against Drunk Driving (MADD). Survivors of drunk driving have, through MADD, developed death notification trainings and protocols for those who must carry the wrenching news of the death of a loved one to family members or friends (U.S. Department of Justice, 1998).

Sometimes the best assistance is getting the patient to help him or herself. As with trauma patients generally, the best immediate intervention with homicide survivors is usually the most practical and self-empowering. Much aid to crime victims and survivors is not what would ordinarily be considered "therapeutic" from a clinical point of view; rather, it involves directing patients to appropriate self-help groups and support organizations (Miller, 2009b, 94). Workers in the victim services field offer certain general advice for survivors of a murdered family member (Miller, 2009b, 94). In addition, there are non-therapeutic services offered such as assistance with financial situations as well as working within the court system.

Along with referrals to outside sources, victims often rely on personal coping strategies including: staying busy, physical exercise, and reading. Actions of others have been found to have varying meaning to homicide survivors. Many survivors report that other people are not seen as helpful when they act with impatience and irritation around the length of the grieving process (Asaro, 2001). For this reason, a follow up mechanism with the client is essential to the overall healing process.

Once a survivor seeks assistance, a prerequisite to productive counseling relationship is an attitude that communicates acceptance and understanding to the clients. While loss of a loved one is not easy, grieving alone can be especially painful. It will be important to define and describe issues that are directly related to traumatic death. Robert Weinbach categorizes survivors into two groups: (1) primary, and (2) secondary. The primary survivors consist of spouse, children, siblings, and parents; the secondary survivors are close friends (Weinbach, 1989, 57).

The case manager needs to properly develop a needs assessment questionnaire that recognizes factors that are common to traumatic death. Traumatic death, which is sudden, unexpected, and often violent, affects survivors. Usually, the assumptions by which they lived their lives are completely shattered. Loss of control and a sense of powerlessness often result in feelings of guilt and blame among survivors because it is easier for them to assume responsibility for the death than admit they were powerless to change the outcome. In addition, since the outcome is so unacceptable, survivors may want to "rewrite" it, so that it will be different and less painful. The common pattern for experiencing traumatic grief includes: an initial period of numbness, lasting for several weeks, and a period involving reconciliation with death, lasting for the life of the survivor.

In addition to realizing that a loved one has died, homicide survivors also must come to grips with the fact that the death was the result of an act, usually purposeful, by another person. Without realizing it, other people avoid homicide survivors because of the idea that homicide may be "catching" and that if a person was murdered; surely he or

she is responsible in some ways. Homicide survivors also are forced into contact with law enforcement and criminal justice systems, a foreign culture to many.

The social and legal reverberations following homicide, along with the lack of information about the legal process, can compound and prolong the grieving process for surviving relatives. Homicides associated with severe pain or mutilation and uncertainty about the whereabouts of the body or the circumstances surrounding death tend to cause greater psychological damage to survivors. In many police forces now, contact information for the next of kin is passed to a worker who will make contact by telephone and to offer further visits. No relative data exist on the proportion of individuals affected by homicide who are put into contact with this resource, or on how many take up continuing help (Mezey, 2002, 66).

This study from the Cobb County Homicide Survivor Case Management data, along with other information will determine if immediate aftercare positively affects the healing process for survivors of homicide victims and their families. In addition to the data, the resources guide implemented by the program was reviewed. By reviewing protocols and existing agency services, the case manager was able to provide data to determine existing gaps in services to survivors in homicide and other non-natural death cases.

First, this study defines and describes the common and atypical symptoms, syndromes, and reaction patterns shown by families who have experienced the murder of a loved one. This study addresses the needs assessed by a review of the existing services and programs currently provided to homicide victims, and related protocols to determine the effectiveness and efficiency of services provided to homicide victims and their

families. This study provides a practical model for treating family survivors of homicide and incorporates local community resources as well as a resource guide provided to those who work directly with the current and future caseload.

The program under review was implemented in October of 2009, the study examined data on cases thus far in the project. During the program implementation, the case manager developed a management plan and service delivery plan for all members of the victim's immediate family and any other family members or friends of the victim who requested services. Based on the implementation method, this study will first examine whether the coordination of program services ensured effective comprehensive delivery.

Second, the data provided by the case manager on established protocols and procedures will serve as a base line to determine if immediate aftercare provides positive results. Throughout the process, the advocate should understand the importance of being equipped with a sufficiently broad range of community resource tools to treat these survivors flexibly, effectively, competently, and compassionately (Miller, 2009, 67).

Third, after reviewing the current program's initial phase, this study will determine if the Atlanta-based grief support group can be maintained locally in the Cobb County community. The section that follow examines the literature.

Literature Review

The term survivor is traditionally used to refer to those left behind after a homicide, however, it is more far-reaching than just surviving. These people are also victims of homicide, suicide, and other non-natural sudden deaths. Homicide is considered universally as one; if not the most, horrific experience any person

experiences. Homicide embraces our strongest emotions, our sense of justice, and our concept of death. Most singularly, homicide devastates and annihilates the lives of family members, friends, neighbors, co-workers, and acquaintances of the murdered victim. A common perspective recognizes that family members and individuals who had special ties of kinship with murdered victims experience a complex and complicated range of reactions to the deplorable act of homicide (National Victims Assistance Academy, 1999, 481). While the term “survivor” describes the circumstances that family and friends enter following the homicidal death of a loved one, the term is generally used to describe the level and intensity of their reactions as "co-victims" of homicide.

There is always one more victim than the deceased. The term "co-victim" is used to emphasize the depth of the homicide infliction. In the aftermath of a murder, it is the co-victim who deals with the medical examiner, the criminal or juvenile justice system, and the media. The term co-victim may be expanded to any group or community that is touched by the murder: a classroom, a dormitory, a school, an office, or a neighborhood. Most of the individuals who make up these communities are wounded emotionally, spiritually, and psychologically by a murder, some more deeply than others. Homicide leaves behind many co-victims (National Victims Assistance Academy, 1999, 482).

A number of bereavement studies conducted after homicidal death indicates that co-victims of homicide experience vicarious trauma associated with the murder. On psychological and mental levels, trauma refers to the wounding of one's emotions, spirit; will to live, beliefs about self and the world, dignity, and the sense of security (Matsakis, 1996). Co-victims find that their normal ways of coping and handling stress in the past are no longer effective. Co-victims of homicide are initially confronted by the

helplessness and finality of the unexpected, unwarranted, and undeserved death of a loved one. The ensuing collection of perceived or actual insensitivities, indignities, and intrusions imposed by police, prosecutors, media, family, and friends constitute an additional wounding. Secondary wounding also occurs when the people, institutions, caregivers, and others to whom the trauma co-victims turn for emotional, legal, financial, medical, or other assistance respond by discounting, denying, and disbelieving (Matsakis, 1996).

No one is exempt from the complexities associated with homicide. For law enforcement officials, homicide presents the dual challenge of regard for and attention to the investigation of the murder events while; at the same time, recognizing and addressing the overriding needs of co-victims of homicide. In view of this, law enforcement officials must become more attentive to the needs of co-victims and more collaborative with victim service providers. Victim service providers are the essential link for co-victims to begin the long journey of regaining normalcy in their lives. To be more effective, victim service providers must be knowledgeable about reactions and needs of victims as well as the investigative and judicial processes involved in homicide cases.

The National Victim Assistance Academy (NVAA) has established a manual for service providers to educate them on the many dynamics that coincide when working with homicide victims. In order to understand the breadth and depth of homicide, it is necessary to recognize that: (1) death by homicide differs from other types of death for a number of specific reasons, and (2) cultural attitudes toward death and spirituality influence societal perceptions of homicide. Just as there are unique physical, mental, emotional, social, and financial components to every sudden death, there are spiritual

ramifications as well. Those who have never thought much about God before will often do so after a loved one has died under traumatic circumstances. Persons of faith who assume that what happens to them is God's will are forced to reshape their faith positions to incorporate the fact that bad things do indeed happen to good people (Lord, 1996).

It is now widely accepted that there are specific elements associated with homicidal deaths that distinguish the impact upon the surviving family members from other forms of dying. They include:

- *Intentional harm*. One of the most distinguishing factors between homicidal death and other forms of dying is the intent of the murderer to harm the victim. Co-victims must deal with the anger, rage, and violence that have been inflicted upon someone they love.
- *Stigmatization.* Society sometimes places blame on murdered victims for their own death which translates into blame on the victim's family when it is believed that they should have controlled the behavior that led to the death.
- *Criminal or juvenile justice system*. Unlike family members of individuals who die of natural deaths, co-victims of homicide are the most likely population of victims to be thrust into a complex system of legal players and jargon. Co-victims must quickly become acquainted with a world of crime scenes, evidence, and autopsies. Co-victims of homicide have much to learn about the investigative, prosecutorial, and judiciary branches of the criminal justice system in a very short time. They are often expected to quickly comprehend a system that may in some instances be insensitive and specifically designed to protect the rights of the accused (with little regard for the victim). In addition, co-victims may encounter

E. K. Rynearson and J.M. McCreery research determined that bereavement after homicide is so prevalent that it deserved clinical attention. Rynearson's (1984) clinical studies involving the family members of murder victims revealed that all his subjects had previously experienced bereavement following the natural death of a relative; and the psychological processing of homicide was accompanied by cognitive reactions that differed from previously experienced forms of bereavement. Rynearson's (1984) research forms the basis for the shift from viewing the co-victims' grief issues separate and apart from the impact of trauma associated with the death of a family member. Traumatic grief over homicidal death distinctly differs from other forms of grief (Rynearson and McCreery, 1993, 259).

It is a myth that there are stages of grief. Grief is a very personal journey that has no timetable. Everyone grieves in his or her own way and in his or her own time. There are also many factors that can affect how a grieving person grieves: coping skills prior to the death; quality of the relationship with the person who was killed; circumstances surrounding the death; emotional support from family and friends; and cultural background. In general, society is uncomfortable with the process and emotions of grief. A grieving person might have well-meaning family and friends saying that it is time to

"move on" or to "snap out of it." This is no reflection or comment on their grief; it is simply that family and friends are unprepared to support a person while grieving. Many people who attempt to comfort drunk driving victims/survivors, including some professionals, do not understand that intense and long-lasting grief is appropriate.

To help regain a more accurate perspective, many survivors of vehicular homicide attempt to work toward a better understanding of the crash. Many will seek answers to questions where there are no answers; however, it is important to get as many answers as possible. Asking specific questions about the crash and obtaining a copy of the crash report are good ways to begin the healing process. Mothers Against Drunk Driving suggests that investigating potential financial resources help alleviate some of the financial stressors a grieving person may be experiencing. Researching the criminal and civil justice systems can also empower someone who is grieving.

The 2009 American Foundation for Suicide Prevention publication reports that nearly 30,000 suicides that occur every year in the United States leave many people profoundly affected and bereaved. Although many people in the last few years have discussed their experiences as survivors of suicide and its aftermath, very little systematic research has been designed to study and help the bereavement that results from suicide. Suicide survivors frequently experience a protracted period when they struggle to overcome the feeling that they themselves were responsible for the suicide. They feel intense anguish that the person committed suicide instead of seeking other approaches for managing distress; they feel helpless for not recognizing the seriousness of the deceased person's emotional state, and for not preventing the suicide. Although suicide survivors may feel driven to find some explanation for the suicide, stigma can prevent them from

discussing it with others. Denial, distortion about the cause of death, and lack of open discussion, may exacerbate pathological problems in adults (American Foundation of Suicide Prevention, 2009).

Definitions, descriptions, and interpretations of death have been around since the beginning of recorded time. There is no absolute explanation for death as each culture offers its own interpretation. Nevertheless, death is ingrained in an individual's beliefs, values, and thinking and determines how he or she experiences life. Spiritual values of life are shaped by one's attitudes about death. Various views of death, as in different religions, influence the lives of those who hold those views. Attitudes about death are complex because death is so integral to human life that its finality without spirituality is difficult to accept (American Foundation of Suicide Prevention, 2009).

Grief is a normal response to loss. The word "grief" signifies one's reaction, both internally and externally, to the impact of the loss. The term arises from the grave or heavy weight that presses on bereaved co-victims (Simpson and Weiner, 1989). One's response to loss is not merely a matter of feelings, but a highly complex and deep-seated human response. Grief can manifest itself in numerous ways:

- *Feelings*: sadness, anger, guilt, self-reproach, numbness, and fatigue.
- *Physical Sensations*: hollowness in the stomach, tightness in the throat or chest, oversensitivity to noise, and shortness of breath.
- *Cognitions*: disbelief, confusion, preoccupation, and a sense of presence of the deceased.

- *Behaviors*: sleep or appetite disturbances, absentmindedness, social withdrawal, dreams of the deceased, crying, and loss of interest in activities that previously were a source of satisfaction.
- *Spiritual*: searching for a sense of meaning, and hostility toward God (National Victims Assistance Academy, 1999, 488).

For those experiencing grief in the aftermath of criminal homicide (including deaths caused by drunk driving), the grief reactions are intensified because of the wound or trauma inflicted by the death. Historically, the focus of caregivers has been on the co-victim's grief issues, often without considering the impact of trauma issues that may also be present. Without recognition of the traumatic components of the experience, co-victims have been provided with services and treatment that primarily emanate from the grief model. This often causes co-victims to feel uncomfortable and anxious because their type of grief is not addressed by current models of treatment (Spungen, 1998, 23). Spungen suggests that treatment and support to co-victims of homicide must be an amalgam developed from the fields of both trauma and grief. She notes that "the co-victim's grief is different not just complicated but different: a traumatic grief" (Spungen, 1998, 23).

Rynearson (1993), Clinical Professor of Psychiatry at the University of Washington, conducted an important and consistent work in recognizing that bereavement patterns experienced by individuals after losing a loved one to homicide differed from those patterns experienced where the death was not sudden, violent, or transgressive. His observations have been consistent with some of the earlier work conducted by Adler (1943) and Frankl (1972) relative to bereavement and horrific death. Rynearson, Favell,

and Saindon (2002) developed a clinical battery to screen patients for treatment based on separation and loss, which can be used by support group leaders in working with co-victims of homicide. They observed that separation distress is associated with the loss of a relationship because of the finality of the death, while trauma distress is associated with the unnatural manner of dying. Additionally, along the way, Rynearson and McCreery discovered the following:

> Any one whose family member has been killed by a homicide will be changed. Homicide is a 'change' that is, to some extent, dialectic rather than homeostatic. The internalized trauma and reenactment imagery will diminish with time but it will not go away. It will change from a horrific and private chronicle into a bearable narrative that can be shared and revised – but it will always be. The family member may reprocess the homicide and try to connect this homicidal narrative with the narrative of the family member before they were killed and their own ongoing narrative as well. The task of somehow weaving this thread of homicide into a coherent and balanced pattern is as impossible as it is inevitable. When something within or without resonates or pulls at that homicidal thread it will kindle an inner awareness of being torn or uneven. The subjective and internalized flaw is private. It is difficult to express through a standardized measure – perhaps impossible. However, this inner confound remains and can have long term effects. Relationships, values, life purpose, hope, and confidence in the future, spiritual stability – all these idiosyncratic supports may be reassessed and challenged by the homicidal experience (Rynearson and McCreery, 1993, 259).

Victim service providers must be aware of the aspects of traumatic grief (the emotional experiences, cultural and gender influences, and mental health issues) resulting in new strategies for treating the co-victim of homicide (Spungen, 1998). To overlook or discount the importance of bereavement following homicide is to fail to understand the major impact of the murder upon family members and friends. Victim service providers need to be aware of this tremendous impact and take precautions in providing appropriate services that will not be harmful or destructive to co-victims.

Although many emotional responses are shared by family members when a loved one is murdered, each surviving family member will experience distinct emotional responses. In addition to the sudden, violent death of a loved one, co-victims may experience additional stress if the deceased was subjected to acts of torture, sexual assault, or other intrusive, heinous acts. A grieving person may have a constant need to be reassured that the death was quick and painless and that suffering was minimal. If the death was one of torture or of long duration, they may become emotionally fixated on what the victim must have felt and the terror experienced. They may fixate on the race of the offender in order to understand the motive behind the murder, and may develop a biased view of a certain race or culture based on the actions of the offender. If the offender was a family member or a friend, co-victims may experience additional interfamilial discord as family members choose sides for support (National Victims Assistance Academy, 1999, 489).

Learning to cope with loss is also another important aspect of a person's grief. Coping is an attempt to adapt to new circumstances and incorporate them into daily life. A survivor's life will not be the same as it was before the loved one was killed. Learning to cope with grief requires recognizing, acknowledging, and accepting all that is involved. The process can feel like a roller coaster ride with ups and downs along the way. But no matter how painful and difficult, grieving is necessary to heal and find new meaning in life.

Here are some coping tips which a grieving person might find helpful.

- Telling the story over and over again.
- Seeking support from a professional counselor or support group.

- Writing about the experience in a journal.
- Seeking out information about the loved one's crash to answer those unanswered questions.
- Understanding that grief is experienced individually and differently and be especially sensitive to family members who may be grieving differently.
- Reinvest in life by reaching out to others (Mothers Against Drunk Driving, 2009).

Survivors of deaths due to suicide experience some of the same feelings of grief as homicide survivors and traffic fatalities. Similar feelings of depression, grief, anger, anxiety, guilt, physical symptoms, and emotional distress develop. Clinical observations, however, consistently confirm that the experience of surviving a loss to suicide is more difficult, more complicated, and more intense. Although many suicidal behaviors may precede a suicide, its suddenness is still a shock. Feelings of abandonment and rejection are common in survivors who feel that their deceased willingly chose to separate themselves leaving behind loved ones thus permanently tearing bonds with spouse, parents, children, and siblings. These feelings are difficult to reconcile, and suicide survivors may be left with persistent and troubling concerns (American Foundation of Suicide Prevention, 2009).

The rise of younger suicide victims has encouraged protocols in schools and colleges in order to cope with the aftermath when the survivors return to school. Other feelings frequently found in excess are guilt and anger. Guilt feelings may plague the survivor with questions of “what if” and thoughts of “if only.” Constant rumination over the events leading up to the death may leave the survivor convinced that it could have been adverted if only he had said this, or done that. Sometimes the guilt is projected onto

others, and therapists, lovers, or family scapegoats may be blamed. When survivors fix blame on an outside source, their intense anger may dismiss all sources of help.

Aftercare is more than just a referral to counseling for loss of a loved one. Co-victims themselves provide the most accurate information regarding experiences during this period. Whether homicide, suicide, or deaths resulting from driving under the influence and regardless of sex, race, and age there are many common problems faced by co-victims. Groups such as Parents of Murdered Children have established a network of people who become experts in explaining problems and needs faced by others who have a death of a child. Parents of Murdered Children Incorporated developed protocols and disseminate information to help co-victims deal with a multitude of different factors. In addition to personal trauma, Parents of Murdered Children (1989) lists nine additional problem areas co-victims must endure as follows:

1. *Financial considerations*. Expenses related to funeral, burial, medical treatment, psychiatric care for family members, and other costs are all part of the aftermath experienced by co-victims. These considerations are grave and contribute in a major way to the continuing distress experienced.
2. *The criminal or juvenile justice system*. Co-victims of homicide have a vested interest in participating in the criminal or juvenile justice system and understanding the complex issues of a cumbersome legal system.
3. *Employment.* A co-victim's ability to function and perform on the job is diminished. Motivation is sometimes altered. They experience emotional bursts of crying or losing their tempers. They are impatient with trivia. Having to explain or apologize can create additional stress. Some co-victims use work as an escape

to avoid working through their grief. They resist dealing directly with their pain by placing it on hold while at work.

4. *Marriages*. It is common for marital partners to have difficulty relating, and they may even separate after a death due to homicide. (Divorces, however, are not as common as once believed.) Each partner may grieve differently. They may blame each other for the loss, particularly in the case of the death of a child. They may each wish to turn away from the memories that the other partner evokes. They are sometimes unable to help each other because they cannot help themselves.
5. *Children*. Parents often fail to communicate with their children by either ignoring them when they are preoccupied with their own issues or hoping to protect them from unnecessary trauma. The children, in turn, fear adding to their parents' pain and simply withdraw. Children who witness the killing of someone they love experience profound emotional trauma, including posttraumatic stress disorder, and may not readily receive adequate intervention.

Furthermore, young people who report performing tasks associated with the fatal injury, such as telephoning for police or emergency medical services, or responding to the immediate needs of the injured person or the perpetrator, are often traumatized. When the issue of blame or accountability for the death is not resolved through police investigation, children may re-examine their behavior, believing that if they had done something differently, they could have prevented the death. Without support and an opportunity to explore the feasibility of such alternatives, children often continue blaming themselves unnecessarily.

6. *Religious faith*. Questions for, anger at, and challenges to God surface regarding the reason for the death. How could a loving God allow it to happen? Where is the loved one? Some conclude, at least for a while, that "if there [was] a God, then God would not have let this happen. Since it happened, there must not be a God." Faithful co-victims seeking to understand sometimes look for answers from unorthodox sources. Over-simplistic comments and "answers" by clergy and church members sometimes create problems for co-victims who take their spiritual pilgrimage seriously.
7. *The media*. Many homicide co-victims are subjected to the intrusion of what they perceive to be an insensitive media. The competitive quest for sensational, fast-breaking news items may override the need for privacy of anguishing families who may be experiencing prolonged scrutiny, inaccurate reporting, and gruesome reminders of the violence associated with the death.
8. *Professionals who do not understand*. Co-victims report that too many professionals (police, court personnel, hospital personnel, funeral directors, clergy, school personnel, psychologists, and psychiatrists) demonstrate by their comments and actions that they do not fully understand the impact of death by homicide upon the remaining family members.
9. *Substance Abuse*. Working with co-victims through the Separation and Loss Services, a program he founded in 1989 to address the special needs of co-victims of homicide, Dr. Ted Rynearson estimated that 30 percent of his clients had substance abuse problems (as cited in Rynearson and McCreery, 1993, 259).

Professionals working with surviving members of homicide victims must be prepared for their own personal intense reactions to the impact of homicide, which are often frightening. Such personal reactions can be more extreme than those experienced in working with other crime victims. Victim service providers must be aware that there is no fixed way or timetable for the victim's comfort and well-being to be achieved. Experiencing a wide range of responses that may continually resurface, co-victims of homicide sometimes feel that there is no recovery, closure, or healing from the ravages of homicide. While co-victims develop the skills to cope with pain, they live with an encompassing fear of strange and new reactions that control their behavior. The grieving process can be interrupted and delayed by elements and events of the criminal or juvenile justice system. Co-victims sometimes put grief on hold to focus on the arduous task of seeing that justice is served (National Victims Assistance Academy, 1999, 493).

Co-victims of homicide report that the way they were informed about the homicidal death of a loved one affected their relationships within the criminal or juvenile justice system and their lives in profound ways. The role of the victim service provider in notifying families is one of the challenges and demands but it is essential to the family that the process be based on protocol. Victim service providers are in proximity to the criminal or juvenile justice process where they can be most effective in offering this service along with the law enforcement officers. Victim service providers can work with officers in providing notification of the death that is timely and in keeping with a protocol of sensitivity, compassion, and delivery of correct information (National Victims Assistance Academy, 1999, 493).

When life-altering information is delivered by inexperienced and untrained messengers, the results may increase the distress experienced by co-victims. There are several models for death notification training. The following are core elements of the widely used and profession-specific program developed by Mothers Against Drunk Driving (Lord, 1997, 111):

> Notifications to family members of deaths that result from violent crime are among the most challenging. Survivors may attempt to harm themselves or others, physically act out, and/or express anger. Victim assistance professionals whose responsibility it is to make death notifications can greatly benefit from focused training on the delivery of a death notification, and assistance in learning how to manage their own emotional reactions to these highly stressful situations.

In 1995, the U.S. Department of Justice, Office for Victims of Crime supported Mothers Against Drunk Driving in revising death notification curriculum to state-of-the-art status and tested it in seven sites. Seminar teams presented the revised curriculum to participants between November of 1995 and January of 1998. Those who had previous experience in death notification expressed the greatest unmet educational needs such as:

- Specific details on how to deliver a notification,
- How to manage immediate reactions of the family,
- How to manage their own reactions, and
- General aspects of death notification.

The Mothers Against Drunk Driving Network has always believed that the "voice of the victim" is most instructive in developing programs to serve them. Thus, the personal experiences of hundreds of survivors formed the development of the *Practices for Death Notification.*

Selection of the person who notifies is as crucial as the practice itself. Stressed individuals are not ideal deliverers of death notification because this focus is on them, experiencing the task as one more layer of stress. The best attitude for delivering a death notification is a positive, calm, confident one, believing that it is an opportunity to do a good job with an extremely difficult task. Theoretical development of the death notification practices is based on factors affecting stress reaction and general survivor needs during stress. Factors affecting stress reaction include (a) intensity of the event, (b) suddenness of the event, (c) ability to understand what is happening, and (d) stability at the time of the stressful event. Death notification is a very stressful event because it is highly intense and the survivors have had no time to psychologically prepare. Cognitive ability to comprehend what has happened is diminished due to shock. The only differing variable is individual stability which varies due to survivor's physical, mental, emotional, and spiritual health. General survivor needs include (a) opportunity for ventilation of emotion, (b) calm, reassuring authority, (c) restoration of control, and (d) preparation.

While the victim service provider may not be responsible for the actual delivery of the death notification, the provider needs to be aware of who delivers death notifications, and endeavor to see that they are adequately prepared for the task. Developing and delivering sensitive homicide notifications cannot be accomplished until there is greater recognition of the grief and traumatic response to homicide (Spungen, 1998).

Methodology

This study is based on the data obtained from case records of the Cobb County Medical Examiner's Office and the homicide advocate assigned to that department. The Cobb County Medical Examiner's Office in conjunction with the Cobb County District Attorney's Office received a grant to house and staff an advocate to work with homicide survivor families and other non-natural death related cases to provide immediate aftercare. The advocate provides a free resource guide, materials, implements referral of programs on services provided in Cobb County. The advocate provides these services as part of the case management system. The review of the program provides the answer to: Does immediate aftercare with victims positively impact the healing process for survivors of homicide victims and their families. This program was funded by a federal grant in October of 2009 and has been providing statistics since that time. The advocate prepares a monthly statistical report to the Cobb County District Attorney's Office Victim Witness Unit Director. The program also implemented a case tracking system and resource guide which are reviewed as part of this study.

The advocate identifies clients based on actual reports to the Medical Examiner's Office. The advocate attempts to contact survivors 24 to 48 hours after the Medical Examiner's Office receives a call from either the police or the hospital. Once contacted, survivors are informed of the available services, individual and group counseling, assistance with application for victim compensation funds if applicable, and acts as a liaison to refer to other community resources.

Data for this study were collected from all case files opened between October of 2009 and March of 2010. Although a longer time period would furnish more data, this

initial period provides a glimpse into the program's implementation, goals, and challenges. The program evaluation helps in providing recommendations for changes that are needed for the remaining 6 months. Upon completion of the 12 month period, the goal is to extend the grant to create a permanent position. Data to justify the importance of this service ensures the needs of Cobb County's citizens are being addressed with immediate aftercare for victims of homicide and non-natural death cases.

For each case file, data is collected on the relationship of the perpetrator to the victim and survivors. Information on overall utilization of counseling services, court advocacy, and case management obtained in the initial 6 month period was evaluated. Data for counseling services utilization were collected by contacting those counseling service organizations in the resource guide to determine if their services were sought based on the referrals from the advocate in the Cobb County Medical Examiner's Office. Court advocacy services were based on cases where criminal charges are pursued by the District Attorney's Office. The advocate is responsible for providing information and educating the clients on the criminal justice process. The advocate is also responsible for assisting with filing victim's compensation, obtaining other resources, and interacting with individuals or organizations outside the criminal justice system on behalf of and at the request of survivors.

Discussion

In the first six months of the program, 213 services were provided by the immediate aftercare of the Cobb County Medical Examiner's Office. Seventy-seven services were provided to homicide survivors, 2 were furnished to survivors of fatalities

pertaining to driving under the influence, and 24 services were provided to suicide survivors. The remaining services were supplied or given to survivors of natural deaths, accidental deaths, or unknown cause of death. Contact was made by the victim advocate by telephone 93 times, by mail 102 times, and in person 7 times. Services provided include from mailing resource guide, crisis counseling, assistance in filing for victim compensation, personal advice, follow up information, burial assistance, and information on Probate Court. Of the 213 contacts, 78 were residents of Cobb County, 25 were residents of other Georgia counties, and 13 were residents from other states, and residency for the remaining 116 contacts were unknown.

The grant specified services for homicide, suicide, and non-natural death cases but did not provide for all the services evaluated by this study. The victim advocate receives the information of the victim or survivor within 24 to 48 hours from the time that the Medical Examiner's Office receives the deceased. The advocate makes an initial call to the survivor's next of kin, allowing for an introduction of family members and advising them of services provided by the aftercare program. The advocate notifies them that a resource packet will be mailed to them the following day. The initial packet is tailored to the type of death (homicide, suicide, or driving under the influence fatality), and depending on the type of the death or if children, domestic violence, or elder abuse was involved, additional specific information is provided. Later, a follow up call is made to inquire whether the packet was received and if there are any general questions regarding their case. A follow up call is usually made 30 days afterwards. After this final call is made, the case is considered closed; however, the victim advocate is available for additional services.

Initially a survey was included in the packet for completion with a self addressed return envelope. Surveys were included in the initial packet three months before the program started, however, no surveys had been returned. The advocate discussed this issue with the supervisor of the Victim Witness Unit and a second survey with an explanation letter was sent asking for a feedback. This is very imperative because the success of the program cannot be adequately measured without responses from those who are in need of these services. As a secondary measure, the advocate contacted resources listed in the guide to determine if they had been contacted as a result of the resource guide or services referred by the Cobb County Medical Examiner's Office aftercare program. Services, although not mutually exclusive of contact by the referral, did not provide any additional data for review. Moreover, those services had not placed any type of measure to calculate if any services provided have a direct correlation with the implementation of this program.

Upon receipt of a second letter requesting a feedback in the form of a survey, 22 surveys were completed and returned. Seven questions were asked. The questions germane to this study were reviewed. The question "regarding information received assisted in my immediate needs," had a response rate of 90 percent that either somewhat or agreed with this statement. The question "regarding satisfaction of the services received from the Cobb County Medical Examiner's Office Victim Witness Unit", had a response rate of 90 percent. That is about 90 percent of the respondents agreed or somewhat agreed with this statement. Two surveys included feedback on why they did not give a positive or even neutral response. The services seen as unsatisfactory were those pertaining to investigative reports from the Medical Examiner's Office which were

not read by the family. These reports included the findings of the autopsy or toxicology report which is outside the scope of the services of the aftercare program.

Another measure of the immediate aftercare program is based on evaluation of the resource guide. The Resource Guide provides information on general survivor information such as the number of death certificates that may be requested from the health department along with other certificates the survivor may need to request, including marriage or birth/adoption certificates for dependent children. This information also provides data about the probate court which will need to be contacted in the deceased county of residence. Other general information includes insurance policies, automobiles, bank accounts, stocks, bonds, and credit cards. The guide also suggests contacting the credit card bureaus in order to determine if all financial obligations of the deceased are disclosed. Information about Social Security and the process of probate court is discussed which should finalize most of the legal procedures. This information facilitates many issues which must be addressed that survivors may not be aware of in sudden death cases.

The guide provides lists of funeral homes and various community resources such as counseling outreach services that may be needed during any transitional period regarding housing and employment. Local government agencies such as Department of Family and Children Services, Cobb/Douglas County Community Services Board, Legal Aid, and various charities are listed for services and donations.

Court advocacy utilization where criminal charges are sought was undetermined. Data were not available to measure court advocacy because those cases have not proceeded far enough along in the criminal justice system to determine its effectiveness.

The cases that have criminal charges pending were turned over to an advocate assigned to such cases in the District Attorney's Office Victim Witness Unit. Notifications of status of cases along with any services are to be provided by that advocate.

Conclusion and Recommendations

The immediate aftercare program has provided a significant amount of services to survivors since October of 2009. These services have been provided to an array of persons. The principle of equity has been maintained in terms of service provisions to all survivors without bias to the age, race, gender, ethnicity, religion, or socioeconomic status. The program provides for equity and efficiency to all of those who have come into contact with the immediate aftercare program through the Cobb County Medical Examiner's Office. The policy and procedures have been changed in order to address effectiveness in the program. Due to noncompliance with survey returns, procedures were changed regarding distribution. Distribution with the initial packet was not effective since most people are in the initial stage of grief, shock, and crisis of the sudden death of a loved one. Therefore, responding to a survey so early in the grieving process is inefficient.

Secondary measures of the response of the second survey provided overwhelming positive responses. These positive responses demonstrate equity and efficiency. Effectiveness may be measured as positive based on the response alone. Overall effectiveness of the programs is unsubstantiated due to the lack of data of services and information provided by the resource guide. Statistical measurement is incomplete not only due to the lack of information from the outside referral system but also in the

manner of quantifying the number of cases that the grant is required to provide services to such as homicide survivors, suicide, traffic fatalities, and other non-natural death cases due to the short amount of review time.

Changes in the survey distribution should improve the responses but there is no guarantee. As the grant reaches its halfway mark, other changes in the advocate's role have also been implemented based on feedback from the Medical Examiner's Office. Initially the services were to provide to grant specified survivors. As of April 1, 2010, all cases that came through the Medical Examiner's Office are required to receive an initial packet of information. At that point, an investigator is the contact person not the advocate. After feedback from the Medical Examiner's Office, investigators were concerned about their loss of direct contact. The investigators believe that they should be facilitating the information instead of the advocate. The advocate will make secondary contact on behalf of the Medical Examiner's Office and will only send the resource guide to those who request direct services. This may be ineffective as well due to the loss of paper work by the survivor in the mirage of mail received. Vital information could be overlooked or misplaced. Additionally, if the survey is included and not returned this prevents the collection of adequate or accurate data in the remaining six months of the grant.

The lapse of time between the incident and when contact is made by the advocate will not provide sufficient data. Additionally, only a packet will be sent to those who request information which prevents efficiency and equity for continuation of services. Cost savings from producing the resource guide and documents does not ultimately benefit the survivors seeking aftercare. The program is not efficient in this matter

because of the gaps that will grow in those who might need services but are unsure what the role of the advocate is and what is available to them. The advocate's position is part-time, however, if it is just a matter of disseminating information or resource materials, it would be more efficient from an administrative position for the investigator to send this out. A specialized advocate does not provide a cost benefit to the program to strictly disseminate a resource guide. Finally, based on the input from the Medical Examiner's Office, the title of the position will be changed. The term "victim advocate" will be removed because there are those survivors who do not want to be referred to as a "victim," in cases of suicide or accidental deaths. Yet this change does not prevent equity, efficiency, or effectiveness to the overall aftercare program.

Although there has been a significant number of services provided in the initial six months of the program it is undetermined if immediate aftercare facilitates, and/or positively impact the healing process. Research previously discussed in this study notes that grief is very different in these types of sudden deaths but it is unclear whether this program's overall effectiveness supports this hypothesis. Upon completion of the first year of the program more data may be required to fill in the gaps and provide a better evaluation.

Recommendations to review those changes since April 1st and more community data are needed. Community outreach would better serve those in the healing process than just a resource guide which should still be disseminated. It is not effective to staff such a position for the dissemination when it is just as effective to have an administrative person send this out on behalf of the Cobb County District Attorney's Office through the Medical Examiner's Office personnel. The advocate would better serve the needs of

those requesting services by working with the services and should implement a more hands-on-approach by working with the community outreach services. Court advocacy should be handled in the main District Attorney's Office Victim Witness Unit where much of the same information is obtainable and are currently provided by access to the resource guide available to both offices. Passing this to another advocate is neither efficient nor effective to streamlining the amount of contacts the survivor has to make. This research supports the need to address these types of different dynamics for dealing with grief of a loved one, however, more data on immediate aftercare are needed.

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