

ESCAPING VICTIMHOOD  
EVALUATION OF A RESIDENTIAL  
PSYCHOEDUCATIONAL PROGRAMME FOR  
HOMICIDALLY BEREAVED INDIVIDUALS

F. Alves-Costa, C. Hamilton-Giachritsis & S. Halligan

January 2018

## Contents

Contents .....	1
About the authors .....	3
Acknowledgements .....	4
Conflict of Interest Statement.....	4
Section I - Executive summary and key recommendations .....	5
Context.....	5
Overview of aims and methods .....	5
Generalisability.....	6
Key findings .....	6
Recommendations for meeting future needs .....	8
Section II - Main report.....	10
The Escaping Victimhood charity and programme .....	10
Prior and current evaluation.....	10
Existing literature.....	10
Definitions.....	11
Homicide: Prevalence .....	11
Outcomes.....	11
Psychological Interventions .....	11
Overall method .....	12
Procedure.....	12
Ethical approval .....	12
Participants .....	13
Empirical studies conducted: Key findings by study.....	14
Study I - How do individuals describe the post-homicide reality? A qualitative study .....	14
Aim.....	14
Tools.....	14
Participants .....	14
Data treatment .....	15
EV applications.....	15
Main findings .....	15
Study II - How do homicidally bereaved individuals progress following the EV intervention? A longitudinal quantitative study .....	17
Aims .....	17
Participants .....	17
Tools.....	18

Data treatment .....	18
EV applications.....	18
Main findings .....	18
<i>Psychological difficulties</i> .....	18
Study III - How do homicidally bereaved individuals perceive change following the EV intervention? A longitudinal qualitative study.....	20
Aims .....	20
Tools.....	20
Participants .....	20
Data Treatment.....	21
EV Applications .....	21
Main Findings.....	21
<i>Figure 5. Main themes and subthemes.</i> .....	24
Discussion.....	25
General views of the programme .....	25
Profile of participants and their unique needs .....	25
Short and long-term impact of the programme .....	26
Intervention and support needs .....	26
EV applications.....	27
Limitations of this research.....	28
----- .....	28
Research contributions .....	28
Conclusion.....	29
Appendices .....	30
Appendix 1: Brief literature Review .....	30
Psychological Interventions: What is known? .....	31
Appendix 2: Ethical considerations .....	32
Appendix 3: Research tools.....	33
Measures used .....	33
Appendix 4. Data treatment.....	34
Quantitative approach .....	34
Qualitative approach .....	34
Appendix 5. Psychopathology, resilience and coping progression. ....	35
References.....	36

## About the authors

**Filipa Alves-Costa** has a Degree in Psychology and (Hons) Master's Degree in Justice/Forensic Psychology (University of Minho, Portugal, 2011). She has been working in a variety of fields in Psychology, both from research and intervention point of view (e.g., domestic and sexual abuse, risk assessments, cognitive stimulation and adult resilience) in Portugal and in the UK. She has just completed<sup>1</sup> a funded PhD degree at the University of Bath (Department of Psychology, UK) looking at homicidal bereavement experiences together with a national charity (Escaping Victimhood). Filipa has recently joined the Institute of Psychiatry, Psychology and Neuroscience, King's College London as a Research Associate exploring experiences of domestic violence and abuse among military personnel.

**Dr Catherine Hamilton-Giachritsis** is a forensic and clinical psychologist with over twenty years' experience in child protection and family violence. Previously a Psychologist in Birmingham Social Services undertaking family risk assessments, Catherine is now Reader in Clinical Psychology at the University of Bath, UK. Catherine has an extensive body of research published in peer-reviewed journals focused on child maltreatment, trauma and risk assessment, considering victims and offenders. She is co-editor of the Wiley book "What Works in Child Maltreatment: An Evidence Based Approach to Assessment and Intervention in Child Protection" (2017).

**Dr Sarah Halligan** was the second supervisor on Filipa's PhD. She is a Professor in Child and Family Mental Health at the University of Bath. Her research has examined the development of psychological disorders, particularly posttraumatic stress disorder (PTSD) and depression, with a focus on young people. In the PTSD field, Dr Halligan has examined the cognitive-behavioural, biological and social factors that contribute to disorder following trauma exposure; and has studied both national and international populations. Dr Halligan's research has been funded by UK funding bodies including the ESRC, MRC, British Academy, Nuffield Foundation, NIHR, Wellcome Trust, and the Royal Society.

---

<sup>1</sup> Viva voce passed; PhD awarded subject to minor corrections.

## Acknowledgements

The authors are enormously grateful to all the individuals who took part in this research. Thank you very much for sharing your unique stories with us, and we hope that through this research your voices will be heard to stimulate positive change.

We would also like to thank Debra Clothier, Clifford Grimason and Barbara Tudor for all of their support recruiting individuals for this research. Thank you for all the pivotal work you do to help those bereaved through homicide, for which we hope this research will prove to be helpful; and to Professor Anthony Beech for his inspiring thoughts.

Thank you also to Andrea, Beth and Theo for their generous assistance with data entry.

Note that the authors take responsibility for the material in this report and that any views expressed are their own.

## Conflict of Interest Statement

Filipa's PhD<sup>2</sup> was co-funded by the national charity, Escaping Victimhood, which aims to help individuals overcome grief as a result of murder or manslaughter across the United Kingdom (UK) as well as providing programmes for other serious crime victims. The research team worked independently to the Charity, maintained their academic and scientific rigor, followed standardised ethical principles and, have been as objective as possible in constructing this report. The Charity also sees the need for the research to remain independent and able to report all outcomes, all of which can help their programme develop.

---

<sup>2</sup>To evaluate the EV programme, Catherine Hamilton-Giachritsis negotiated a PhD scholarship co-funded by Escaping Victimhood and the University of Bath (from September 2014 to September 2017). This was awarded to Filipa Alves Costa and Dr Sarah Halligan at the University of Bath was appointed as second supervisor.

## Section I - Executive summary and key recommendations

The purpose of this report is to outline the findings of a study evaluating if, and how, the EV programme is helping individuals who have been homicidally bereaved. This was one element of a wider study looking more broadly at what is known about homicidal bereavement and, as such, appropriate reference will be made to the wider study throughout.

### Context

As yet, there has been no formal evaluation of the efficacy of generic treatment outcomes (e.g., NHS or other offered by third sector mental health services), and very little it is known about the post-homicide reality for victims' families and individuals' adjustment over time. Therefore, this research project was the first UK-based longitudinal mixed method study to consider these questions, with an overall aim of informing the services provided by Escaping Victimhood (EV), as well as other mental health services in the UK that offer professional support for those individuals.

The EV intervention aims to deliver informative workshops where new coping tools can be accrued to help individuals who present with significant difficulties, often even after getting support from other services. Hence, the participants in an EV programme usually have long-term or severe negative outcomes

following the homicidal bereavement. The EV intervention is not a clinical 'treatment', but has a broader aim of empowering individuals by providing accurate information about overall psychological responses and adaptive coping strategies for them to begin a new journey.

### Overview of aims and methods

In terms of Escaping Victimhood, this research sought to develop an understanding of:

- Who is attending EV residential psychoeducational programmes and what are their unique needs?
- Did individuals benefit from the EV residential psychoeducational programme
  - immediately after the intervention
  - four to six weeks' post-intervention
  - six to nine months' post-intervention
  - in the longer term (i.e., two to five years' post-intervention)
- What were the specific elements (if any) highlighted by participants as useful or not?
- What were the elements (if any) highlighted by participants as not useful or unhelpful?
- What messages were there for the EV team about future developments of the programme, how best to meet participant needs and how support could be improved in the future?

**To achieve these aims**, a longitudinal mixed methods exploratory study was conducted. This means that participants' views about the programme were collected during and after the programme through interviews (qualitative data) and their well-being was assessed at four different time points using psychometric measures (quantitative data). The study received ethical approval from the Psychology Ethics Committee at the University of Bath (Ref. 14-186), with British Psychological Society plus Health and Care Profession Council ethical guidelines followed.

More detail on methods and participant numbers are described in Section 2. In brief, quantitative data collection was collected at four-time points (i.e., before the EV intervention, immediately after, four

to six weeks later, and six to nine months post-EV intervention). Interviews were performed during the EV intervention, as well as six-to nine months and two to five years after the EV programme.

### Generalisability

Despite the research's value in the field of homicidal bereavement and important implications for practice and policy in the UK, it is important to note that the ability to generalise beyond to other individuals' experiences of homicidal bereavement is limited somewhat due to the absence of a control group, in that all participants in this study attended the EV intervention. In addition, the sample was mainly female and predominantly white UK, so again this limits how widely the conclusions can be drawn.

### Key findings

- EV participants are a **unique group of participants** who reported **prolonged and severe difficulties**, even despite having received prior support (from other services, such as the Victim Support Homicide Service).
- Participants reported **high levels of psychological symptoms** e.g., overall psychological difficulties, Post-traumatic stress responses [PTSD] and Complicated Grief [CG] at baseline (before the EV intervention).
- The majority of the participants were **very satisfied with the EV intervention** and **would recommend it** to someone else with similar experiences.
- Participants' high levels of psychological symptoms **decreased over time and following the EV intervention** (four to six weeks and six to nine months after the EV intervention) demonstrating a better grief adjustment
- Despite the **significant decrease over time**, symptoms remained clinically significant at all the time points. However, this should be considered in the context of the high level of difficulty at the start plus the type of intervention (i.e., significant changes were made possible by a four-day residential, non-therapeutic programme).
- EV participants reported relatively low levels of coping responses both before and after the EV intervention. Nevertheless, **cognitive and emotional coping** (two of the coping domains accessed) **increased** between follow-ups after the EV intervention.
- EV participants reported relatively high levels of resilience both before and after the EV intervention, showing that difficulties and resilience can actually co-exist.
- Qualitatively, participants **reported finding benefits 2-5 years' post-programme**.
- The **residential and nurturing environment**, as well as **the small group nature** of the EV programmes are crucial domains that **increased wellbeing and adjustment**.
- The EV workshops decreased psychological responses post-homicide and increased active and **adaptive coping strategies**.
- EV workshops were described as **crucial tools to empower individuals** and give them alternative views to look at their changed realities post-homicide.

- The EV experiential activities (e.g., therapeutic massages, art and photography) are also important elements of the programme and gave the individuals the chance to learn **‘new’ coping strategies**.
- Overall use of **positive coping strategies has increased since the EV intervention**. Looking at the sub-elements, both cognitive and emotional domains of coping **significantly increased between follow-ups**
- EV played an important role in decreasing individuals’ levels of psychological distress and slightly improving coping resources and resilience.
- Participants appeared to be **more skilled to cope with their experience following the EV-programme**, in particular **they understood their emotional and psychological responses and were more able to understand the different grief processes**.
- Keeping in touch with other EV participants (but this seems to lose importance as the time passes by), **relaxation techniques** (e.g., breathing exercises), and **art/photography** were important elements described by the participants.
- Participants reported some examples of personal change that occurred over time in terms of **emotional adaptation, psychological functioning** where individuals identify their **‘new normal’ in a changed reality**.

**FOR INDIVIDUALS WITH HIGH LEVELS OF PSYCHOLOGICAL DISTRESS (EVEN FOLLOWING OTHER SUPPORT), THIS FOUR DAY RESIDENTIAL PSYCHOEDUCATIONAL PROGRAMME WAS POSITIVELY RECEIVED BY ALMOST ALL PARTICIPANTS AND SIGNIFICANT DECREASES IN LEVELS OF PSYCHOLOGICAL SYMPTOMS WERE SHOWN EVEN 6-9 MONTHS POST-INTERVENTION.**

**THIS IS A SIGNIFICANT ACHIEVEMENT FOR A SHORT-TERM INTERVENTION.**

## Participants’ Voices:

### Why it was helpful

*“EV seem to have had basic needs of what we needed all in one pack, the massages were a very important element, I think.” (P025)*

*“The trauma sessions and relaxation things were excellent as well, you know, and I could really feel the knots in my back coming out and things like, when she was doing the massage and I keep doing them here and then.” (P020)*

*“I think being away as well, from home and from everything, and in the environment that was chosen for the course, that was a big help as well.” (P024)*

*“Definitely I would recommend the EV [programme]. I think it’s well thought out and with the right people, with the right qualifications, both on a professional level and also from dealing with people over a period of time to do that, you know, you’ve got to have a certain aptitude to deal with people.” (P10)*

*“It was like an oasis time, to understand and to reflect.” (P025)*



## Recommendations for meeting future needs

Table 1 provides more detailed recommendations, but a summary is listed below:

- EV could include additional information and CBT-based exercises to promote coping mechanisms even further, as well as increase the ability to plan for the time post-programme on their return to “cold reality”.
- Participants would benefit from support on how to deal with the media and reminders (e.g., special occasions and media platforms).
- Dual victims (related to both victim and offender) were a minority but had additional complexities and may need additional aspects of intervention.
- EV could offer workshops in the community (e.g., companies) about grief responses to homicide to increase empathic informal support.
- EV could also get involved with other national services and together design a ‘plan of action’ to make care nationally more uniform.
- In terms of other services, overall EV participants were satisfied with the professional support received previously (e.g., Victim Support Homicide Service, NHS, charities). However, they reported (and their symptoms show) that this was “**not enough**” and too short-term considering their prolonged and severe psychological difficulties. Although this varies around the country, many participants felt that support ended when the court case did; yet for them, they “started grieving”.

### Participants’ Voices

*“They [sources of support] leave you when you need them the most [when legal process is completed].” (P09)*

*“When the court is over, we start grieving! We need more support when the legal side is over.” (P020)*

*“They [family and friends] don’t know what to say, they don’t say anything then, which is even worse.” [P11];*

*“They [family and friends] avoid the topic and I don’t like that, I want her [deceased] to be remembered and not a taboo. I would rather be asked about what my needs are and what they can offer to help me.” (P03)*

### Participants’ Voices:

#### EV helped

*“I think it, out of all the treatments I had ... [EV] helped me more than anything else.” (P010)*

*“Well, it did me so much good, I’ve got to be honest. I just came away feeling...lighter than what I did when I went there.” (P025)*

*“I think some of the input that we’ve received, you can try and look at your emotional distress in a more clinical way.” (P017)*

*“I was given much more understanding at [EV programme] than what I had before. I was able to, I don’t know, work things out.” (P023)*

*“Overall, it was just so helpful, so informative. It came across with a sort of, like, project - a life’s project.” (P025)*

*“I felt compelled to listen to people and sort of, like, try and help them and, you know, and be like a shoulder to, to cry on sort of thing.” (P014)*

*“It does do you good. I suppose people get different things out of it.” (P022)*

*Table 1.* Contributions for practice and policy – based on participant responses and expressed views of existing support received.

EV could consider/continue the inclusion of:	Clinical practice / services	Policy
Goal setting (return home and more long term) and how this will be addressed during the intervention	Individuals appreciate having help with day-to-day practicalities in the aftermath	Services or funding for longer support (post-court hearings) should be available
More coping, resilience-based training	Psychoeducation about trauma, grief, criminal justice system and meaning is crucial for an individual's adjustment	Development of a national protocol where key information could be shared by the different professionals (streamline process):
Exercises to increase future planning	High levels of psychopathology and possible ongoing psychological difficulties should be expected and this might require long-term clinical interventions	Rigorous assessment tool where potential protector and risk factors could be identified (in early stages)
Formally include information to their workshops about the Criminal Justice System	Clinical interventions should consider trauma, grief and meaning elements	Type and avenues of support for homicidal bereaved individuals (although this is offered by the Homicide Service, notably most participants still noted that this was something they needed).
Offering support to deal with media (e.g., intrusion and deactivation of the victim's accounts) – or supporting participants to access this support from other services	Residential interventions might offer a good alternative for some individuals, as they feel looked after and this gives them the 'space' to understand their experiences	Standardised 'plan of action' and individual formulations at different times (i.e., post-homicide, during the criminal & legal proceedings, before, during & after court). Increased specialised training for those working with homicidally bereaved individuals
Preparing for reminders (e.g., special dates)	Coping, resilience and growth should be included in case formulation and set as intervention goals	Social awareness campaigns about how to respond to bereavement and homicidally bereavement, in particular
Reinforcing the mapping document (the 'Directory') provided to each individual by the Homicide Service that will enable contact between individuals and other services (if needed)	Group interventions with individuals with similar experiences of loss	Media: awareness about how the stories can impact on the individuals' lives should be considered
<b>Note:</b> At the date of this report, EV has already added some of these needs to the programme	Dual grief (close relationship with victim and offender) might result in more distress and more practical issues	Promote knowledge exchange (KE) among national researchers, clinicians and other professionals (e.g., EV and research team)

## Section II - Main report

### The Escaping Victimhood charity and programme

Founded in 2005, Escaping Victimhood (EV) is a national charity that offers<sup>3</sup> a four-day residential, experiential group intervention<sup>4</sup> across the United Kingdom (UK) for those affected by serious crime, including homicide. These interventions are funded by different organisations covering the costs associated with the intervention (i.e., accommodation, subsistence, travel expenses, meeting rooms and facilitators). Individuals can be referred by a practitioner (e.g., medical practitioner, Victims Support services) or self-refer, and usually attend following the completion of court procedures. Elements of the programme include informative workshops about responses likely to occur post-homicide (e.g., trauma), coping strategies, as well as experiential activities (e.g., therapeutic massages, art and photography).

In addition to the residential workshops, a one-day (non-residential) follow-up is held six to eight weeks after each residential workshop<sup>5</sup>.

It should be noted that individuals referred into an EV programme have usually received significant input from other services (including Victim Support), but continue to have significant ongoing difficulties.

### Prior and current evaluation

There was anecdotal evidence of change for participants but the EV programme had not been systematically evaluated. Despite the very positive feedback provided by the individuals at the end of the workshops and follow-up day, there was no clear evidence related to whether the EV programme is

effective at helping individuals to better cope with their experiences, as well as whether improvements were maintained or not over time.

This report focuses on the elements of the research related to Escaping Victimhood, specifically:

- How the EV programme fits with other interventions for homicidally bereaved individuals;
- Identifying the unique needs of the participants who attend the EV residential programme;
- EV participants' views of their experience post-homicide, particularly in terms of change, perceived support and coping strategies (both immediately and after attending the EV intervention);
- The degree of change (if any) following the EV programme, specifically in terms of psychological difficulties, coping and resilience, pre and post intervention, and over time (four to six weeks and six to nine months, post-intervention);
- To evaluate participant perspectives about the impact of the EV programme, including potential benefits and areas for development;
- Suggestions for the future, both for EV and others.

Thus, this report begins with an overview of the literature, explores the methodologies used, provides a summary of individuals' views and experiences post-homicide, and outlines change.

### Existing literature

International research looking at experiences of homicidal bereavement is growing.

<sup>3</sup> More information about the EV programme can be found on their website: <http://www.escapingvictimhood.com/>.

<sup>4</sup> EV intervention/programme, EV residential intervention/programme and residential workshops will all be used.

<sup>5</sup> The one-day follow-up aimed at reviewing the information delivered at the EV programme, but primarily putting in place a future plan and identifying on-going needs (covering some of the points you mention earlier! . Therefore, data was not collected, in order to avoid possible bias.

However, although research from other countries is increasing (e.g., the Netherlands), almost all the previous studies conducted on experiences of homicidal bereavement were USA-based. Within the UK, with the exception of a few notable studies (Casey, 2011; Dawson & Riches, 1998; Gekoski, Adler, & Gray, 2013; Mezey, Evans, & Hobdell, 2002; Mueller-Johnson & Lanskey, 2014; Paterson, Chaston, & Malone, 2007; Rock, 1998; Wright, 2015), there is limited empirical evidence on the views and experiences of homicidally bereaved individuals. Thus, this research project is the first longitudinal mixed methods study conducted nationally to inform policy makers, practitioners and researchers about individuals' post-loss responses and the efficacy of the Escaping Victimhood (EV) intervention.

## Definitions

According to the statutory principles in the United Kingdom, (UK; April, 2015) homicide is defined as an act of killing one person by another. *Murder* is defined as a premeditated act of killing, while *manslaughter* is without a premeditated intention to kill.

Within the literature, a diversity of terms is used to describe individuals bereaved by homicide, including surviving family members (survivors), co-victims of homicide, and secondary victims (e.g., Asaro, 1992, 2001; Spugen, 1998). The term '*homicidally bereaved individuals*' has been suggested instead, as it provides a more suitable definition of the phenomenon by addresses the cause of the death (i.e., homicide) and is broad enough to include the different relationships any person may have to the victim. Thus, this research report will use the term '**homicidally bereaved individuals**'.

## Homicide: Prevalence

Many people are bereaved through homicide each year, both in the UK and internationally. Recent figures demonstrated that over a quarter of a million individuals were killed by homicide in 2015<sup>6</sup> (United Nations Office on Drugs and Crime [UNODC], 2017). United Kingdom figures demonstrate that in 2015, 571 homicides occurred in England and Wales, 57 Scotland and 21 in Northern Ireland; equating to 1.8 homicides per day (Home Office Homicide Index, 2017).

## Outcomes

In terms of psychological outcomes, research has shown that individuals are at risk of developing severe and prolonged psychological difficulties post-homicide. These include PTSD, on-going grief responses, depression, self-blame and guilt, and these negative outcomes are more likely following sudden and violent loss (see Appendix 1 for a summary of relevant studies). Other outcomes include physical health and financial difficulties, as well as changes in self-perception, views of the world and feelings of safety.

## Psychological Interventions

A systematic review conducted as part of this research (Alves-Costa, Hamilton-Giachritsis, Christie, & Halligan, in submission) identified a lack of specifically adapted interventions and available evaluations for children, adolescents and adults bereaved by homicide. The small number of studies included in the review demonstrates that limited evidence-based research has been conducted. In addition, comparisons between the included studies was difficult due to the unequal samples sizes, different interventions and study designs. Nevertheless, this review demonstrated that the psychological interventions reviewed were effective at decreasing psychopathology in terms of PTSD, CG and

<sup>6</sup> Cross-national comparison should be conducted carefully due to the differences that exist between the legal definitions of offences in countries, the different

methods of offence counting and recording and differences in the share of criminal offences that are not reported to or detected by law enforcement authorities.

depression, but that these are not widely available. Notably, time since loss did not impact on the outcomes.

### Overall method

To achieve these aims, a mixed method approach (quantitative and qualitative data) was used, with both prospective [*as it happens*] and retrospective [*looking backwards*] elements. Participants were recruited:

- a) from Escaping Victimhood programmes that were run between 2014 to 2017, with data collected pre-intervention, post-intervention, 4-6 weeks later; 6-9 months later)
- b) from EV programmes run 2-5 years previously, i.e., 2011-2014).

A brief outline of the methods used in this research will be given. Full details of the methods used in this research project can be found in Alves-Costa, 2017; Alves-Costa, Hamilton-Giachritsis, & Halligan, accepted; Alves-Costa, Hamilton-Giachritsis, Pintos & Halligan, in submission; Alves-Costa, Hamilton-Giachritsis, Christine, & Halligan, in submission.

[Note: Significant efforts were made to recruit a control group (non-EV participants). A call for volunteers was launched through the local and national media in the UK (i.e., supported by the media services at the University of Bath, plus the College of Policing). This aimed to establish a comparison between homicidally bereaved individuals who attended to the EV intervention and a community sample. Unfortunately, this strategy was unsuccessful.]

### Procedure

People were asked to take part in one of two ways:

- a) **Prospective data:** individuals were given information about the research aims and invited to take part in the prospective studies at the beginning of each EV programme.
- b) **Retrospective data:** individuals who attended an EV programme previously (2011 – 2014) were contacted by the EV team first (a randomizer software was used to select 50 participants from the EV data bases) and invited to participate in an interview study. Those who were interested contacted the research team.

Figure 1 summarises the data collection process. Appendix 3 offers more details of psychometric measures and data treatment procedures.

### Ethical approval

Following ethical approval from the Psychology Ethics Committee, University of Bath (Ref. 14-186; Appendix 2) data collection occurred from September 2014 to June 2017.

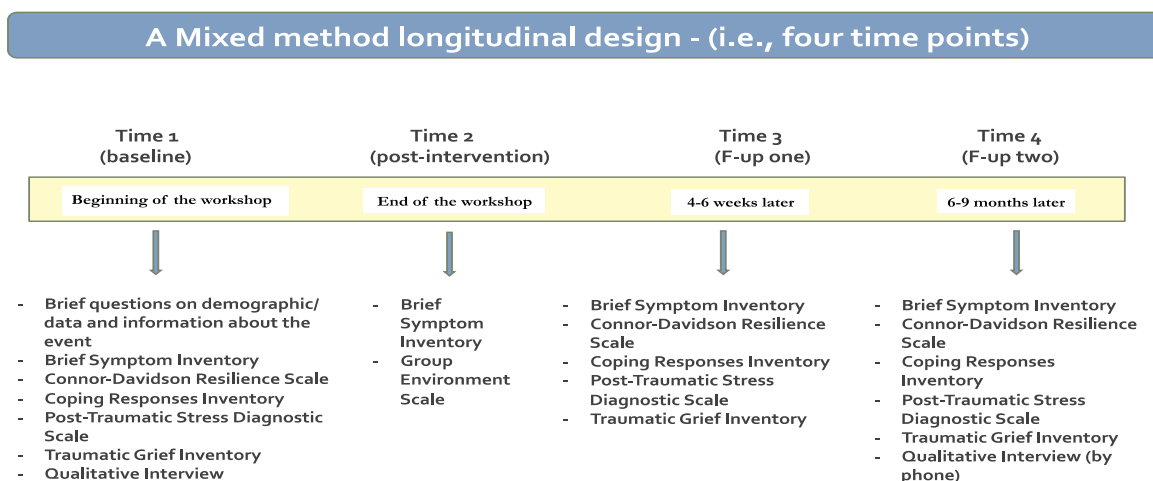


Figure 1. Data collection procedure.

## Participants

### Quantitative element

Overall, 74 individuals took part in eight EV groups and were invited to take part in the research. Of these, 68 individuals<sup>7</sup> (91%) agreed to take part in the *quantitative element* of this research at pre-intervention (i.e., before the programme). It is important to note that the number of participants decreased over time, as is frequently reported in other studies of this nature. Nevertheless, response rates were relatively high (post-intervention: 75%, follow-up I: 54.4%; follow-up II: 48.5%; figure 2)

Regarding sample size and reliability it is important to note that the sample size might be considered small/medium. 'Power analysis' allows us to calculate the required sample size needed to identify likely effects (e.g., how many individuals are need to answer our questions?). For the current research it was estimated that 120 respondents would be the ideal number to identify the effects. Having a smaller number than 120 increased the changes that a change that existed would be missed. However, effects of the intervention were shown even with this a smaller sample size. This means that the effects were 'strong enough' to be seen.

	Pre-intervention	Post-intervention	Follow-up 1	Follow-up- 2
Demographic, medical and context information	69	n/a	n/a	n/a
BSI	64	60	38	33
PDS	60	n/a	34	37
GIS	50	n/a	26	34
CRI	52	n/a	34	35
CD-RISC	62	n/a	37	34
GIS	n/a	50	n/a	n/a

Figure 2. Number of participants by time-point and questionnaires answered.

<sup>7</sup> One participant was excluded from the analyses as he/she dropped-out at the beginning of one of the EV interventions.

## Qualitative element

Theoretical saturation<sup>8</sup> informed the number of participants included in the qualitative studies, i.e., when no new themes arose from new interviews, participants were no longer invited to take part in the quantitative study. Thus, for the prospective study, 21 participants took part in the interview conducted during the EV programme and 14 took part 6-9 months, post-intervention. An additional 15 took part in the retrospective qualitative study, which included participants who attended the EV intervention two to five years previously.

## Empirical studies conducted: Key findings by study

In brief, three empirical studies were conducted: two qualitative and one quantitative in nature. The different studies were conducted between 2014 and 2017 and each one will be reported separately, followed by a discussion related to each aim. Four academic papers have been submitted to relevant journals, providing more detail of the work. (Three are under review, one paper has been accepted: Alves-Costa, Hamilton-Giachritsis, & Halligan).

### Study I - How do individuals describe the post-homicide reality? A qualitative study

#### Aim

This study sought to understand individuals' experiences post-homicide, including support and coping strategies.

#### Tools

Semi-structured interview during the four days

#### Participants

21 people took part in an interview: 3 males and 18 females with an average age of 48 years old (range 29-66) residing in the United Kingdom. They had a range of educational achievement from leaving school at 16 years, to professional degrees. Twelve were parents, five siblings, one partner, one daughter, one friend and one grandmother. The length of time since the bereavement at the time of interview varied from 12 months to 18 years (average = 2.5 years).

## Participants' Voices

*"I just cannot get my head around the [victims'] last hours, her body was, and her body was, the blood, her face, her face. She was in agony."* (P07)

*"You have to fight and fight and fight to get some information about the court."* (P06)

*"Their [the State] job is over when the legal process finishes, when they caught the person who killed your loved one", however, as noted by participant 08 homicidally bereaved individuals "start grieving when the legal side is finished."* (P020)

*"The media are at your front door and you just want to hide yourself from the society. And do they really care about you? No, they do not! They want to get a sensationalist story that sells, that is what they want."* (P021)

*"The shock, the trauma, the trauma, you just see everything happening again and again in your head, no matter if you are asleep or not."* (P019)

*"You think you are going crazy, you just do not know what it is happening, your body has this very strange reactions, your mind is never in silence and then you just think that you are mad and that all is a matter of your imagination."* (P015)

*"I think before I didn't think about crimes and things like that, because you do not have to, you see things on the news and you read things in the newspapers, but it is always very distant from you."* (P020)

<sup>8</sup> Theoretical saturation occurs when new data does not lead to more/new information related to the research questions (Seale, 1999); thus, when no new themes arose from new interviews, data collection stopped (e.g., as per Braun & Clarke, 2006).



### Data treatment

Interviews were analysed using an inductive *Thematic Analysis*<sup>9</sup> method (Braun & Clarke, 2006). All the analyses were completed using *QSR NVivo10* software.

### Main findings<sup>10</sup>

Figure 3 shows the three main themes that arose from this study, which are expanded in Figure 4.

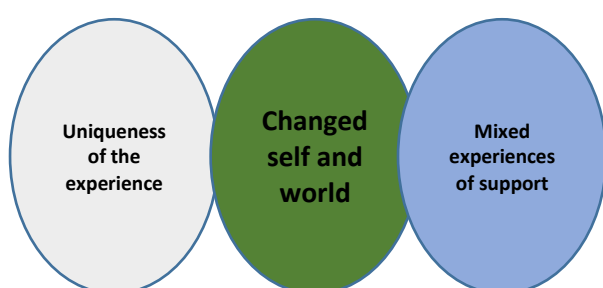


Figure 3. Main themes post-homicide.

Participants described their **unique experience of being bereaved by homicide when compared to other potential traumatic experiences**. The nature of the homicide itself (often sudden, unexpected, premeditated and violent) followed by the **legal-criminal proceedings and public exposure** (from media attention/intrusion) leave them with ongoing needs. Bereaved individuals described a changed reality post-homicide.

Participants identified areas affected by the experience. Nineteen of them spoke of severe and **prolonged psychological responses**, such as intrusive images of the homicide/body (even when they did not witness the homicide), overall lack of energy/exhaustion, apathy, depressive symptoms and sleep difficulties. Most of the interviewees described **a co-occurrence of those difficulties**. Participants also described changes in their **emotional system**, where they often feel guilty for having a life without their loved ones (n=9),

### EV applications

It is useful for the EV team to have a clear understanding of the individuals who attend their programme and their perspectives of their own needs as a group, the level of difficulties they currently experience and what they have previously found helpful or not.

#### Normalising the grief reactions

*"EV reassured me I wasn't doing any wrong or doing anything to make things worse, and that it was all natural reactions."* (P015)

*"EV helped me understanding how the body and the brain work. I could quite easily have seen me spiralling out of control into depression because it was just like taking over everything, and going on the course, being away from it all, just cleared your mind. It made you stop and think, and helped you realise, you know, what you were going through, that you weren't going mad."* (P023)

*"I remember we were given a camera to take photographs with, and yeah I don't carry a camera around with me, but often look at things and think: Oh, I wish had a camera now. And it made me start looking at the nature and look up again. I was very down, constantly just looking at the ground."* (P043)

*"Now I know that I'm allowed to have good days, I'm allowed to laugh, I'm allowed to smile, I'm allowed to have a normal life, and therefore, since the programme, of course I still think about dad, of course I do, yeah, I'm allowed to be normal. I can go back to being me without feeling guilty."* (P012)

<sup>9</sup> External validation (e.g., blind coding) was considered to insure academic rigour.

<sup>10</sup> Figure 4 offers visual perceptions of the individuals' post-homicide experiences.



as well as “feeling irritable, frustrated and overly angry”. In addition, nearly half also spoke of the severe **psychological difficulties post-loss were linked with economic issues**, as some were not able to work for long periods of time.

Interviews (n=15) noted that their experience have changed their worldviews and their beliefs regarding overall safety, such as lack of trust and an increased awareness of criminal activity and how ordinary people (such as themselves) can be affected by it.

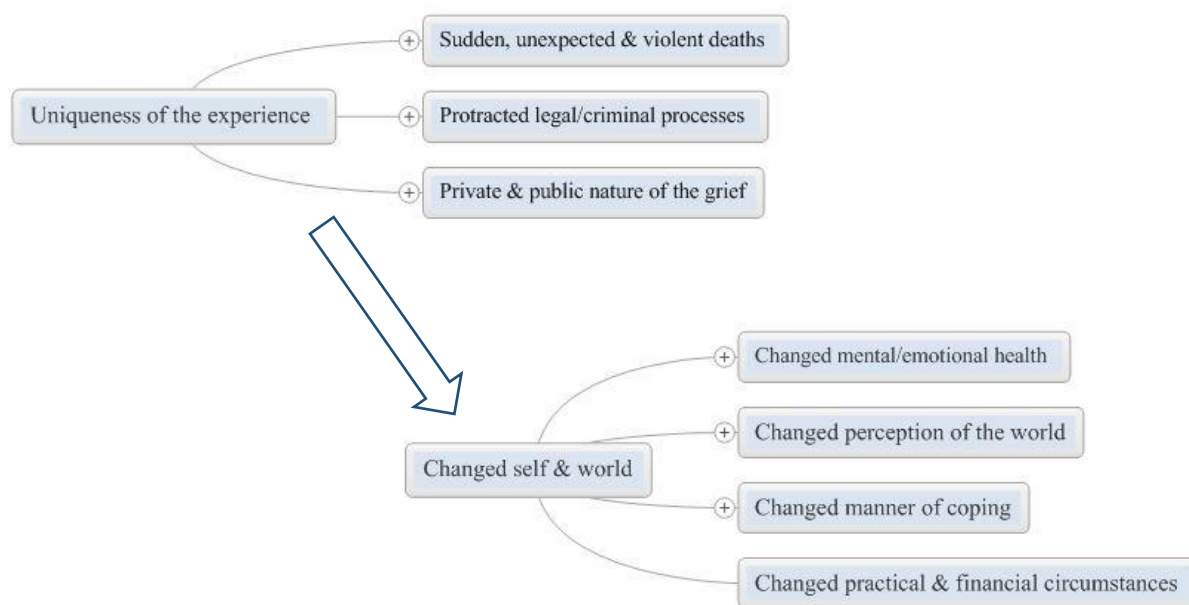


Figure 4. Participants' perceptions about their post-homicide experience.

### How do people cope?

Individuals' changed lives post-homicide (self and world) appeared to be linked with an increased difficulty to cope. Nearly half the participants (n=10) listed a number of active strategies adopted post-homicide, such as spending time with family (n=10), having short-medium term aims and goals (n=5), accepting help (formal and/or informal; n=5), sports and exercising (n=4), and accessing information about the legal process and post-homicide responses (emotional and physical). Nevertheless, self-protective or avoidant coping strategies were also described, including: taking things 'day by day' as the future seems unpredictable and uncontrollable (n=15), keeping busy and avoiding thinking about the homicide event (n=10), avoiding places and/or activities in order to avoid possible reminders (n=11), alcohol consumption (n=5), and hiding feeling

and emotions in order to protect relatives (n=10). And this could be further integrated in the EV intervention.

### Formal and informal support received in the past

All of the individuals (n=21) have received previous professional support (e.g., from the NHS and other third sector organisations; not necessarily structured psychological interventions), as well as informal (n=15) from family and friends. Overall, participants were satisfied with the quality of support, however it was often described as 'not enough'. Participants' narratives have also highlighted their different needs at different time points. Thus, in the aftermath, they (n=15) appreciated having received help with practicalities (e.g., paying bills, planning

meals): *“this is important, because you just don’t care about anything really”* (participant 07). Nevertheless, the **end of the legal proceedings is a turning point where attention needs to be paid to their mental health**, as they *start grieving* at this point. This highlights the need for ongoing support. In fact, the EV workshops were mentioned for the majority of those participants (n=15) as extremely useful, as it provided the ‘right tools’ to help them understand post-homicide responses and which strategies, interventions and/or treatments might help them better adjust over time.

Many participants (n=15) mentioned having felt supported by relatives and/or friends post-event. However, for others, offered support was not always perceived as effective, as *“people don’t know what to say, they don’t say anything then, which is even worse”* (participant 011), or *“avoid the topic”* when individuals *“would*

*rather be asked about [their] needs and what they can offer to help”* (participant 03).

Participants believed that without having been through the ‘same experience’, individuals cannot fully and holistically understand their experiences. Furthermore, the perception of not being understood was linked with a tendency for isolation post-homicide, as it seemed to be an easier and safer path to take. This can be problematic and increase their difficulties to reintegrate and adjust to their “new reality”.

In summary, this study supported previous somewhat limited research and highlighted new pathways to understand the experiences of those bereaved by homicide. Avenues of clinical support were discussed and future practice could consider the individuals’ voice in order to help them/promote their adjustment to a possible *new normal* (Alves-Costa et al., in submission) in a changed reality.

## Study II - How do homicidally bereaved individuals progress following the EV intervention? A longitudinal quantitative study

### Aims

The quantitative longitudinal study aimed to understand what psychological difficulties individuals reported before the EV programme and evaluate the progression of clinical symptoms, coping strategies and resilience patterns over time (at the end of the workshop, 4-6 weeks and 6-9 months after). Furthermore, this sought to estimate if the relationship with the victim and offender, as well as time since loss predicted the symptoms.

### Participants

Sixty-seven participants (predominantly female, White UK<sup>11</sup>, of relatively low to medium income and with mixed occupation status) took part in the study at pre-intervention assessment, 61 at post-intervention (91% retention), 37 at follow-up I (55%) and 33 at follow-up II (49%) aged 18-75 years. More than half of the participants were on long term medication (e.g., depression, anxiety, sleeping pills). A minority had a past history of receiving interventions for psychological difficulties specifically, but the vast majority had some kind of support in the past (e.g., GP, police, victims support services). Murder (rather than manslaughter) was the most frequent cause of death that occurred mainly from 12 months to 10 years prior to the data collection. For the majority, the offender was unknown (strangers to the deceased) and participants were mainly the parents of the victim (half of the sample).

<sup>11</sup> The most recent Census in 2011 highlights that in England and Wales, 80% of the population were white British.

## Tools

Validated questionnaires were used to measure the different psychological domains (Appendix 3).

## Data treatment

Multilevel modelling for repeated measures was the most suitable technique to analyse the data, due to its longitudinal nature.

## EV applications

Results demonstrated that EV participants showed on-going clinical symptoms post-homicide. EV played an important role in decreasing individuals levels of psychological distress and slightly improving coping resources and resilience. It is important to note that the individuals' psychological issues remained at clinical levels post-intervention; however, the degree of improvement was statistically significant and the EV programme does not aim to deliver clinical treatments. Hence, the results are encouraging, particularly when considered in the context that this is a four-day intervention, not a longer-term psychological intervention.

## Main findings<sup>12</sup>

### *Psychological difficulties*

EV participants reported high levels of psychological difficulties, such as Post-traumatic stress disorder (PTSD) and Complicated Grief at baseline (day 1). This reminds us that the participants of EV interventions are those individuals who continue to struggle significantly even after other forms of support, such that their difficulties appear quite entrenched. Despite that, post-intervention assessments (end of programme, 4-6 weeks and 6-9 months later) revealed a statistically significant decrease of psychological difficulties over time showing that individuals demonstrated a better grief adjustment following the EV programme. (Appendix 5), albeit not to below clinical significance. Thus, the findings highlight that severe and **ongoing psychological difficulties are likely among this population, but significant reductions can occur with the EV-intervention** (see Figures 4a-e for psychological symptoms, resilience and coping over time).

### *Coping*

Overall use of positive coping strategies has increased since the EV intervention. Looking at the sub-elements, both cognitive and

emotional domains of coping significantly increased between follow-ups which highlight that *time* might also be an important element to consider following interventions, as the development of 'new-selves' and changed coping responses is likely to not occur immediately after.

### *Resilience*

Individuals reported reasonably high levels (scoring >50) of resilience at all time-points, including before the EV programme. The initially quite high rates of resilience in this groups is interesting, particularly given that the individuals referred to EV are those who had ongoing needs over and above the previous support they had been offered and who had high levels of psychopathology at baseline. Although there is limited research estimating resilience among homicidally bereaved individuals, it has been noted that maladaptation is only one possible outcome following many forms of trauma (Futa, Nash, Hansen, & Garbin, 2003) and some individuals demonstrate an overwhelming ability to cope and show resilience (Kalisch, Muller, & Tuschert, 2015; Mancini & Bonanno, 2009). Interestingly, therefore, this group is both

---

<sup>12</sup> Time since loss and the relationship with the victim and offender did not impact on the outcomes.

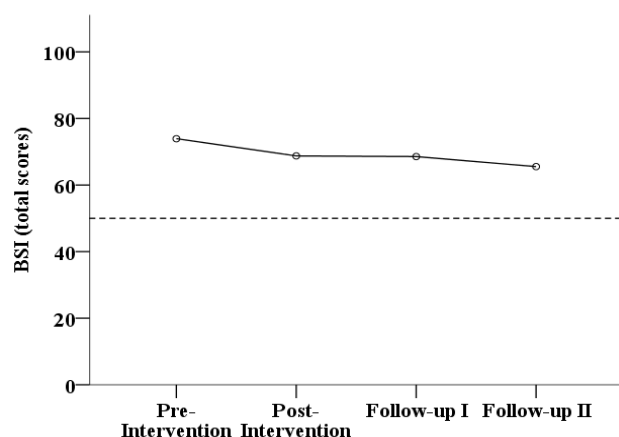
showing moderate to high levels of psychological difficulties but also some level of resilience.

#### *Participants' satiation*

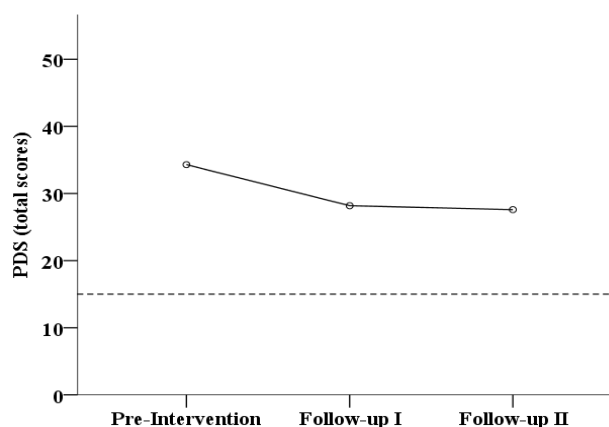
In addition to the highlighted results, participants reported positive satisfaction with

the groups, peers, facilities, and EV team of facilitators and leaders. The experiential activities (therapeutic massages, photography and art sessions) were also very well rated considering the qualitative nature of the research. However, control trials would be needed to evaluate it further.

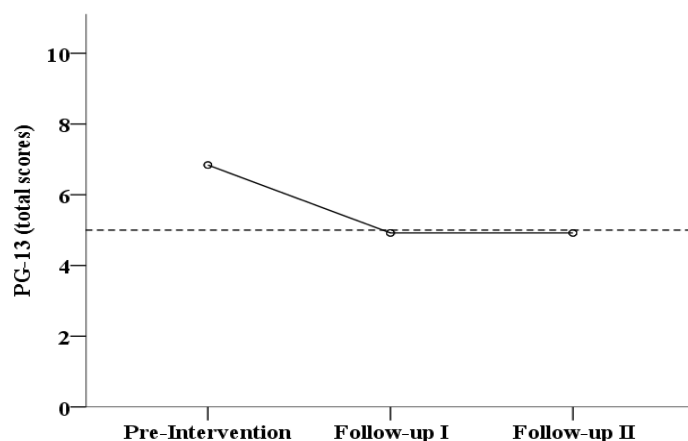
a) *Overall psychopathology.*



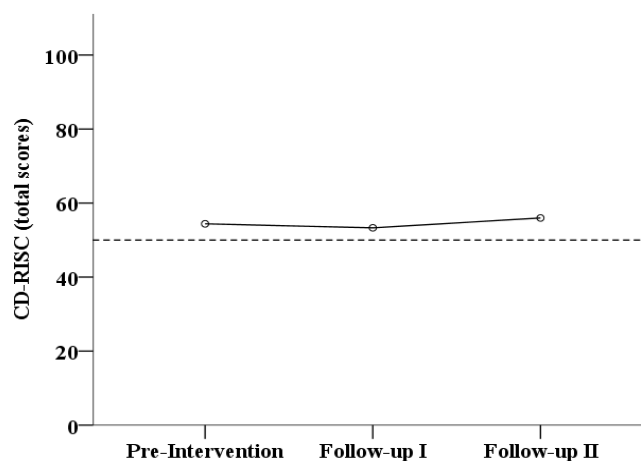
b) *PTSD patterns.*



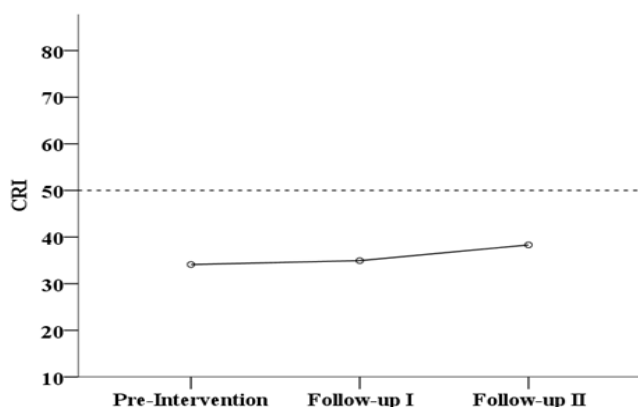
c) *Grief responses.*



d) *Resilience trends.*



## e) Coping patterns.



Figures 5a-e. Mean scores at all-time points (baseline, post-intervention (for BSI) and follow-ups I (4-6 weeks) and II (6-9months)).

**Interpretation:**

Reference line represents the clinical cut-off point. This means that scores above 50 are clinical measuring psychological difficulties (figures 5a-c). On the other hand, scores above 50 for coping and resilience represent more satisfactory resources (figures d and e).

### Study III - How do homicidally bereaved individuals perceive change following the EV intervention? A longitudinal qualitative study

**Aims**

The longitudinal qualitative study explored what changes occurred since the EV programme, as well as how individuals perceive the benefits of the EV residential intervention and their perceptions about future.

**Tools**

Telephone semi-structured interviews were conducted with participants who had attended an EV intervention six to nine months and two to five years previously.

**Participants***Prospective.*

In total, 14 individuals (12 females, 2 males) were interviewed six to nine months after the EV programme. They had an average age of 46 years (range 25–70). The sample was comprised of parents (n=10), siblings (n=2),

daughters (n=1), and partners of the victim (n=1). The length of time since the bereavement varied from 19 months to 18 years at the time of interview (mean= 3.85 years). Five participants from this group also participated in an interview conducted immediately following the EV intervention.<sup>13</sup>

<sup>13</sup> Six to nine months prior the interview. The paper has been submitted to a journal for consideration.

<sup>14</sup> External validation (e.g., blind coding) was considered to insure academic rigour.

### Retrospective

Another 15 female participants were interviewed two to five years after they completed the EV-programme. They had an average age of 49 years old (range 37–73). Participants were parents of the deceased (n=10), partners (n=2), siblings (n=2) and grandmothers (n=1). The length of time since the bereavement at the time of interview varied from 2 years to 32 years (average of 8.59 years).

Both groups (N=29) had a past history of receiving structured interventions for psychological difficulties specifically, but the vast majority had some kind of support post-homicide (e.g., GP, police, victims support services).

### Data Treatment

Interviews were analysed using an inductive Thematic Analysis<sup>14</sup> method (Braun & Clarke, 2006). All the analyses were conducted using QSR NVivo10 software.

### EV Applications

This study provides information about the EV elements most beneficial, as well as the barriers they felt there were to prevent them benefitting and how they perceive their future needs (see Figures 6a-c for an overview). This

***“EV seem to have had basic needs of what we needed all in one pack, the massages were a very important element, I think.” (P025)***

is likely to help the EV team focus their intervention.

### Main Findings

No significant differences were found between both groups; therefore findings are reported together. It is interesting to note, however, that all individuals who reported self-growth had attended an EV programme 2-5 years ago, suggesting that the programme’s benefits continue over time. This is something that would be useful to research to a greater extent. Nevertheless, almost all of the individuals (28 of 29) felt that they had made **positive changes and following the EV programme** and were **very satisfied with the intervention** (n=27). This was for both those who had done the programme recently and, those who had done it a long time ago.

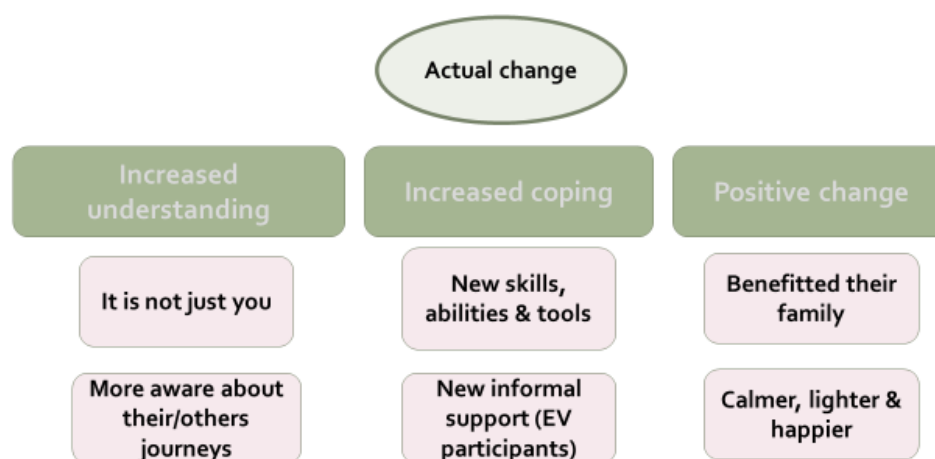


Figure 6a. Actual changes reported by the participants.

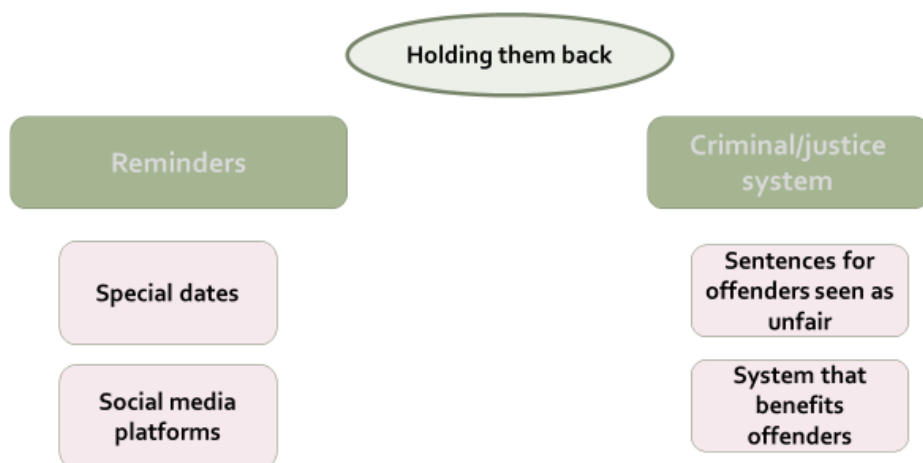


Figure 6b. Barriers to improvement.

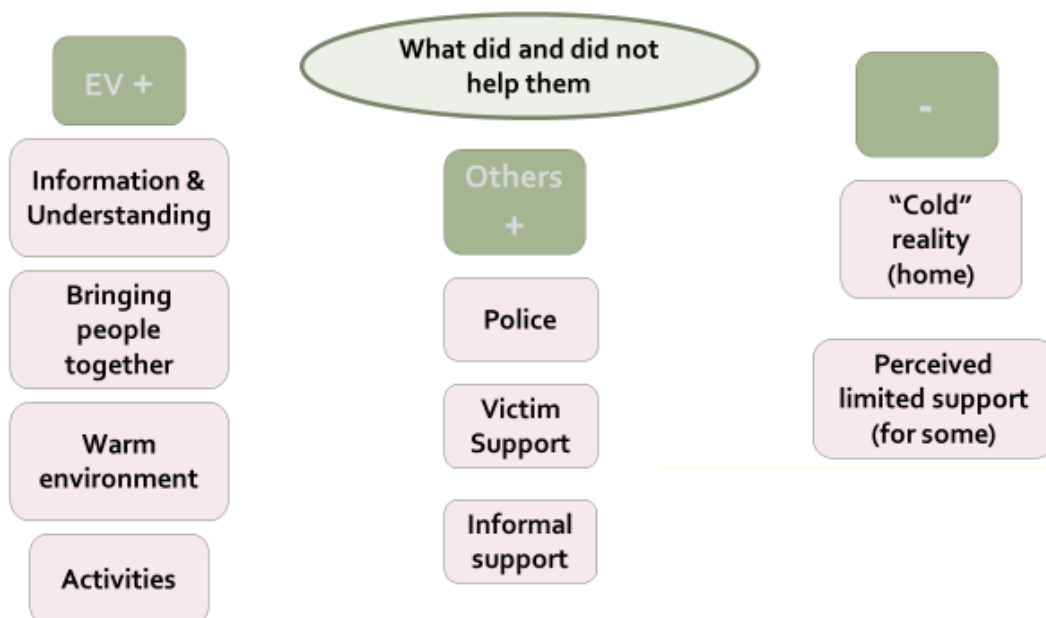


Figure 6c. Perceptions of support.

Participants identified key EV elements that they felt contributed to their overall wellbeing post-intervention, including the group psychoeducational nature of the EV intervention, the more personalised one-to-one sessions with the facilitators, as well the experiential components of the programme (i.e., therapeutic massages, art and photography). Finally, the residential, warm and nurturing environment provided by EV was highly praised by the participants. Almost all of the interviewees (n=28) stated that they would recommend the EV programme to other individuals who had experienced similar trauma.

Thus, participants appeared to be **more skilled to cope with their experience following the EV-programme**, in particular they understood their emotional and psychological responses (n=20), and were more able to understand the different grief processes (n=20).

Other techniques were mentioned by a few individuals, such as keeping in touch with other EV participants (but this seems to lose importance as the time passes by), relaxation techniques (e.g., breathing exercises, n = 15), and art/photography (n=8).

In fact, participants reported some examples of personal change that occurred over time in terms of emotional adaptation, psychological functioning where individuals identify their 'new normal' in a changed reality.

Furthermore, a few (n=4) individuals (all of whom took part in the programme two to five years previously) reported self-growth, i.e., development as an individual over and above learning positive coping styles and where they were before).



## Self-growth

*"Everything is taken for granted. They [people, in general] should not take it for granted, because it's not. It [event] made realise that we just cannot take life for granted, love and care as much as you can." (P033)*

*And do you know, looking back, I think I'm a better person since [event] I'm stronger, I understand more, I value life, I value every day I live. When you lose a child, everything became so precious, every second that you spend with people that you care about, your loved ones, people close to you, treasure everything that they say and do." (P032)*

## Future needs

*"It would be lovely if there was somewhere like [EV] where you could go maybe every six months or whatever." (P030)*

*"Something like Samaritans that you can ring up if you need to. (P027)*

*"The future's good. It's not, it's not going to be easy. I mean, the past three years haven't been easy, but, you know, every day, every week, every month, it's getting better. You can never forget anything like this [homicide], but you have to deal with what's in front of you, you know, and I think, you know, like I say, with the support of my family and friends, you know, it can, you know, it can only get better." (P014)*



Despite the overall increased adjustment over time and following the EV intervention, most individuals (n=26) identified on-going and/or fluctuating psychological difficulties and need for (further) support.

Reminders (e.g., special dates, anniversaries), as well as dual grief (individuals who were close relatives both to the victim and to the offender) were described as difficult to manage and this could be included in the EV psychoeducational training, perhaps.

Almost half of the individuals were optimistic about their future. Their narratives acknowledged the chance of going through difficulties in the future, as they were living and adjusting to a changed reality. And, it also identified a perceived will to “live again” in their “new reality”.

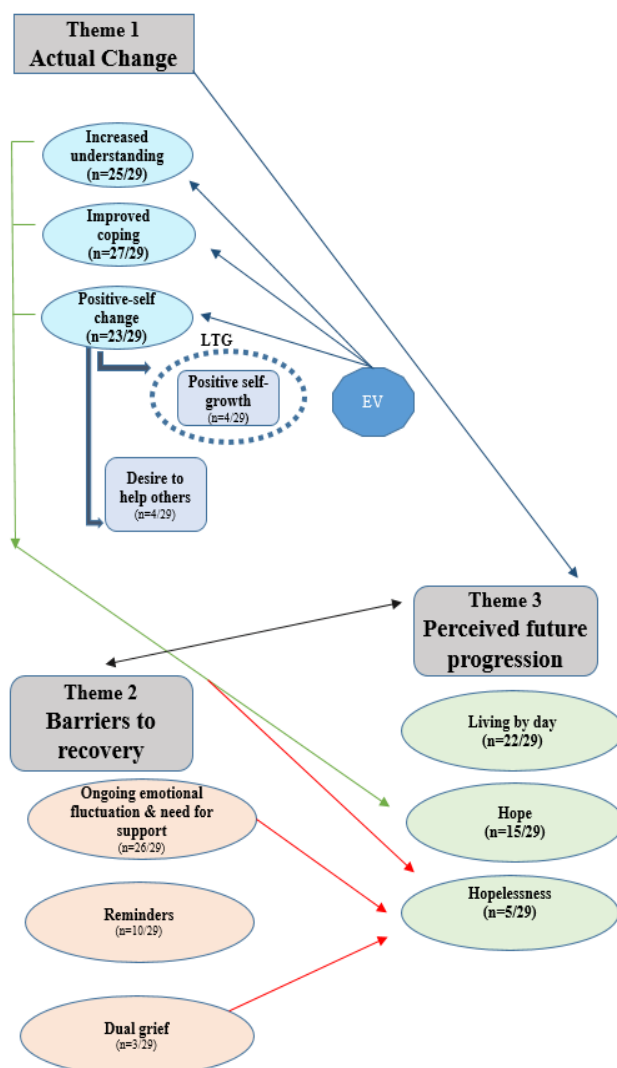


Figure 5. Main themes and subthemes.

On the other hand, five participants were hopeless about their future demonstrating greater distress and two reported that they still wish they had also died when the homicide happened. Figure 5 summarises the findings outlined.

## Discussion

### General views of the programme

Findings from the empirical studies suggested that individuals who took part in the EV intervention appear to be those who are struggling the most to adjust. In fact, for the majority of them, levels of psychological difficulties decreased post-intervention where the EV programme seemed to have had an enormous impact.

EV delivers a holistic intervention which includes a holistic approach by offering not only psychoeducational elements, but also the experiential activities (e.g., therapeutic massages, art and photography).

Firstly, the residential and nurturing environment offered by the EV programme have a great impact on how individuals feel, as soon as they arrive at the venues (aware of the EV programmes nature). They are provided with accommodation and catering, and a team of skilled professionals is with them for four days. This element was described as very important, as individuals felt looked after and it gave them the opportunity to 'just' think about themselves away from their day-to-day responsibilities. Furthermore, the experiential components (therapeutic massages, experiential art and photography) were very often described as a part of the relaxing atmosphere, but also as a possible coping strategy to manage their stress levels (research should look at this further).

Secondly, the psychoeducational element includes information about psychological responses, specifically traumatic reactions and how to deal with them. Some practical exercises are conducted to stimulate participants' ability to better identify symptoms and physiological reactions, for instance. In addition, it helps to develop coping strategies where individuals are invited to consider potential protective and risk factors,

as well as describing what adjustment means to them.

Despite the very positive views about the EV programme, a minority of participants (n=4) considered it *"too academic"* or *"school-based"* (P021), as well as too intense, as *"one was always busy from one activity to another"* [referring to the morning workshops and creative/relaxing activities in the afternoon]. This could help the EV recruitment process (i.e., aims of the programme/schedule for those four days could be sent in advance to potential participants).

### Profile of participants and their unique needs

As noted, different elements of the research all demonstrated that individuals show severe and prolonged maladjustment post-homicide. This appears to be qualitatively different from what it is known as "normal bereavement" (e.g., due to illness) in which people tend to adjust and respond with greater health levels during the first 12 months. In fact, participants that took part in the EV programmes appear to have significant difficulties in many domains even following previous support. Thus, it may be that EV is seen as somewhere to refer individuals who have persistent needs.

***"It [EV programme] was like an oasis time, and it definitely gave me time to sort of like breathe and take time out to understand and to reflect."***

(P025)

***"EV saved my life!"***

(P12)

Participants' narratives described what they called "unique needs" and how they felt it was different to other forms of bereavement. As part of that, the majority highlighted the need for longer periods of support, which did not finish when legal proceedings were complete. Furthermore, they also emphasised their different needs across time (e.g., aftermath, post-court) and this should be taken into consideration by professionals.

Unsurprisingly, both quantitative and qualitative results demonstrated that Individuals described having been changed by the homicide (changed self and world). Overall wellbeing and psychological issues (e.g., depressive and traumatic symptoms), strong feelings of anger and frustration, as well as strong physical reactions (e.g., headaches, tiredness, insomnia) were reported. The co-occurrence of symptoms and responses was actually reported very frequently, with this leaving the individuals with a perception of having an abnormal disease and "*going mad*" and impacting on family, social and financial circles.

Furthermore, their changed worldviews (e.g., trust, unfaithfulness, safety issues) following the homicide are likely to be increasing the individual's isolation and awareness about criminal activity and, how ordinary people (such as themselves) can be affected by it.

The majority of the participants have responded well to the EV group programme and showed ability to progress more positively following their attendance, as they felt more "*skilled*" to cope with their experience.

#### Short and long-term impact of the programme

Participants reported severe levels of psychopathology<sup>15</sup>, including Post-traumatic stress (PTSD) and Complicated Grief (CG) responses at all time-points.

Nevertheless, overall the group showed statistically significant reductions in psychological difficulties and increased coping following the EV four-day residential programme. Such changes are notable given that the individuals attending had unmet needs following other interventions.

Thus, results showed that psychoeducational residential interventions with experiential elements might offer a unique context for those individuals who are struggling the most, to learn more about their own emotional and psychological responses, as well as acquire new tools to improve coping, resilience and overall wellbeing. In addition, it also highlighted the need to further understand whether solid blocks of intensive interventions differ or not from the more conventional settings of weekly sessions extended in longer period of time. It would be interesting to undertake a longer term follow-up, for example 2-5 years later, as well as a control-group to better understand those results.

#### Intervention and support needs

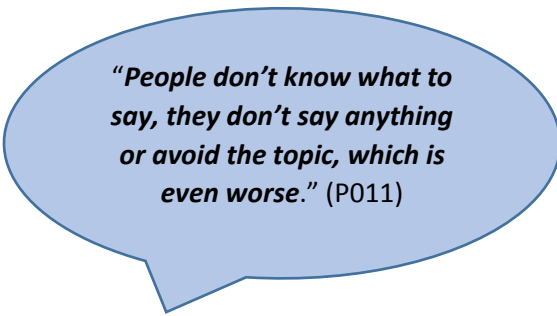
Only a minority of the participants in this research had a history of receiving interventions for psychological difficulties prior to the homicide, but the vast majority had some support prior to the EV intervention (e.g., GP, police, Victims Support services).

Participants reported overall positive satisfaction with the previous formal support received (e.g., Victims Support Homicide Services, and police liaison officers). However, they noted the need for support post-court proceedings, as this is seen as a critical period for increased distress and grief responses. Individuals identified periods of ongoing distress and further support needs or knowing where they could seek support from, in case they needed to.

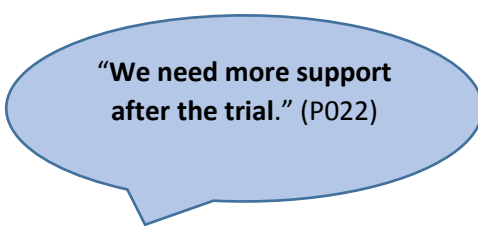
<sup>15</sup> This was measured by: BSI, PDS and PG-13.

Importantly, the EV intervention aims to deliver informative workshops where new coping tools can be accrued to help those individuals who are struggling the most (even after getting support from other services). Indeed, the EV intervention does not intend to deliver clinical treatments, but empower individuals with accurate information/tools about overall psychological responses and adaptive coping strategies for them to begin a new journey to the “*new normal*”.

Finally, it is important to note that several individuals reported a strong belief about the inability to be fully comprehended and even supported by people that have not been bereaved by homicide. Interestingly, this was not mentioned about the EV team where none of the team members have been homicidally bereaved. This should be explored further in future studies. In fact, most therapists in any field do not have direct experience, nevertheless can be very able to help.



***“People don’t know what to say, they don’t say anything or avoid the topic, which is even worse.” (P011)***



***“We need more support after the trial.” (P022)***

### EV applications

The research highlighted some practical application that could improve the EV programme/recruitment, such as:

- Leaflets for potential participants with evidence-based information (e.g., perceptions, symptoms and responses likely to occur post-homicide) to normalise responses, help people feel understood and potentially increase engagement prior to the residential programme. This could also provide an overview about goal setting.
- For those who attend the EV programmes, the legal and criminal process are generally concluded, so EV is not in a position to provide any further support. However, and since this is something that really impacts on the already complex individuals’ lives, EV could link with other organisations and NHS services to explore routes and develop effective support strategies to support individuals in earlier stages.
- EV could also get involved with governmental bodies to demonstrate the need for ongoing support (e.g., post-court). In fact, those individuals who took part in an EV intervention had received previous support, but continued to showed high levels of difficulties. Thus, the type of specialised support required following homicidal bereavement needs to be considered.
- With regards to the media coverage/intrusion, although it is covered by the Homicide Service, participants requested that EV workshops could also include training on how to deal with it.
- Regarding coping, EV could utilise Cognitive behavioural therapy (CBT) or compassion focused CBT to a greater extent to explore coping strategies with the participants and help them to understand how non-adaptive strategies (e.g., avoidance) become unhelpful in the long-term. A plan could be developed collaboratively, incorporating adaptive strategies.

Those type of exercises could also be included to prepare individual to deal with reminders (e.g., special dates).

***[It is important to note that EV incorporated some exercises (e.g., preparing individuals to go back home) since this research began.]***

- EV could also offer workshops on “how to respond to homicidal loss” to

companies and educational sectors in order to increase adequate social support. In fact, this is could also consist in a new avenue for EV gain some financial independence.

### Limitations of this research

The research conducted is one of the first empirical longitudinal mixed methods studies following homicidal loss. Nevertheless, several limitations need to be reflected on.

First, regarding the samples included in this research, the majority of the participants were UK citizens, predominantly of western cultures. It is unknown whether the results could be generalised to other non-western cultures, where rates of crime tend to be higher and support limited (South Africa, Brazil). Furthermore, this study included mostly females, hence it was not possible to estimate possible differences among genders. Besides, it is unclear if results could also be generalised to collective acts of homicide, such as war and terrorist acts.

Secondly, regarding the study design, quantitative data to estimate rates of overall psychological difficulties, PTSD and CG, as well as coping and resilience patterns were based on self-report questionnaires and this might overestimate psychological symptoms (Kristensen et al., 2012).

In addition, EV had concerns about the level of testing and ensuring participants were not put off too much at the beginning of the programme. Therefore, participants were only asked to complete one measure post-intervention (BSI) following EVs suggestion, meaning the other domains assessed (PTSD, CG, coping and resilience) were only measured in three waves rather than four. Moreover, and despite the quite unique design of the research, a longer quantitative follow-up period (e.g., 2 – 5 years) was not possible to undertake due time limitations.

Thirdly, in spite of extensive efforts, recruitment of a control group failed (non-EV participants) and, thus, it was not possible to assess the effects of recovery due to time passing rather than the intervention. In line with this, it was not possible to control for type and amount of support individuals received over time (before and after the EV intervention) was not precisely measured. However, it should be noted that some participants had been bereaved as much as one or two decades prior to the programme, hence anecdotally suggesting that spontaneous recovery was unlikely.

Finally, with the regards to the qualitative data, efforts were made to ensure rigor and reliability (e.g., blind coding was conducted by an external coder), however this aimed to describe the reality of EV participants and further generalisations need to be carefully taken.

---

### Research contributions

Despite the limitations outlined above, this research contributed to the overall knowledge about the beneficial effects of the EV

intervention, as well as about homicidal bereavement experiences from both research and clinical point of views.

In fact, this is one of the first longitudinal mixed methods studies internationally and the first one in the UK, to the best of the authors' knowledge. In addition, the sample used was exclusively with homicidally bereaved individuals, while other studies have included mixed samples following other violent-losses. Thus, the possibility of biased results was

controlled. This research has also considered not only deficits post-loss (psychological difficulties), but also measured coping and resilience patterns, with this being likely to inform clinical practice. For example, this study highlighted the need for a more structured coping/planning-training approach within those individuals.

## Conclusion

The current research suggested that an experience of homicidal bereavement is a “*unique*” experience with the homicide itself and the context post-loss likely to contribute to chronic and prolonged periods of distress where psychological difficulties, professional, financial and social issues may co-occur, with this being in line in previous studies. Those with ‘dual’ grief had particular and specific needs, which should be taken into consideration.

Considering the **impressive results for a four-day intervention**, it might be important to understand how individuals would adjust over time if they had the chance to attend the EV intervention sooner. It can be argued that since the EV intervention shows effect for those who have severe (and often long-term) difficulties, it might actually be even more effective among those with milder patterns of ongoing difficulty.

Thus, this could be adopted as a preventive approach. Future research should look at how the different services in this country support individuals and how those overlap (or not) with the EV intervention intending to build a national plan of action where services could cooperate to the best interest of their clients.

This research has inevitably some limitations that need to be considered, including the lack of a control group. A community group (seeking and not seeking) treatment could bring some more insights about not only the EV intervention efficacy, but also about potential personal variables that might moderate the impacts. Nevertheless, this is one of the **first longitudinal mixed methods studies conducted internationally and the first one in the UK**, thus this might stimulate further research and clinical practice to help individuals in their goal to begin “*looking up again*”.

## Appendices

### Appendix 1: Brief literature Review

**For full reviews see: Alves-Costa, 2017 (PhD thesis); Alves-Costa, Hamilton-Giachritsis, & Halligan, in submission; Alves-Costa, Hamilton-Giachritsis, Pintos & Halligan, in submission; Alves-Costa, Hamilton-Giachritsis, Christine, & Halligan, in submission.**

In terms of psychological outcomes, the majority of the studies have reported high levels of post-traumatic stress<sup>16</sup> ([PTSD]; Boelen et al., 2016; Rheingold & Williams; Rheingold et al., 2015; Rheingold et al., 2012). Despite unsurprising variations between studies, rates of diagnostically defined PTSD were found to be clinically significant.

Individuals are also likely to report ongoing grief responses, usually termed as complicated grief (CG)<sup>17</sup>. In particular, intense yearning, searching for the deceased, disbelief about the death, an inability to accept the loss and experiencing intrusive thoughts/images of the death. Despite limited research, some studies have demonstrated that experiencing unexpected, sudden and violent losses was linked with greater CG responses (e.g., Currier et al., 2006; Shear, 2015; Parkes, 1993).

Depression has also been reported in previous studies (Burke et al., 2010; McDevitt-Murphy et al., 2012; Rheingold et al., 2012; Rheingold & Williams, 2015), as well as intense emotional responses, such feeling upset or angry (e.g., Gross, 2007; Miller, 2009a), self-blame and guilt (Clements & Burgess, 2002; Gross, 2007; Miller 2009a), terror, shock, apathy, disbelief and powerless (Goodrum, 2005; Gross, 2007; Sharpe et al., 2013) and confusion (Gross, 2007).

In addition to the psychological difficulties described above, homicidally bereaved individuals often report a general decline in physical condition and quality of life post-loss. (e.g., Asaro, 1992). This can occur either in the form of a direct response to the homicidal bereavement or as a result of the psychological difficulties that are experienced post homicidal bereavement experience; for example, physical symptoms associated with PTSD, such as headaches, gastrointestinal problems, and increased somatic responses. In fact, those symptoms have been reported in some of the studies reviewed. These include sleeping and eating difficulties (Burgess, 1975; Mastrocinque et al., 2015; Miller, 2009a; Paterson et al., 2006; van Wijk et al., 2017), but also headaches, stomach and bowel complaints, sleeping problems, tiredness, and cardiac complaints (Burgess, 1975; van Wijk et al., 2017). Physical health difficulties also commonly involve shortness of breath, palpitations, restlessness and insomnia (Rheingold et al., 2015).

On a personal level, individuals are likely to report long-term changes to one's self-perception and role in the wider system. For some, the *"story of violent dying becomes the only narrative in their lives"* (Ryneerson, 2001 p. 21) and this has been reported as impacting on the individuals' overall worldviews, beliefs and trust. Early research highlighted that individuals may cease to trust their

<sup>16</sup> PTSD or traumatic responses/symptoms can occur post-exposure to traumatic/adverse events (e.g., rape, violence). With reference to the fifth and most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association [APA], 2013), four clusters are considered for diagnosis, including: intrusions, avoidance, negative alterations in cognitions and mood, and alternations in arousal and reactivity (APA, 2013). Symptoms are likely to include very intense and aversive details related to the traumatic event, frequent, intrusive, involuntary distressing memories and dreams about the traumatic event, dissociative reactions, prolonged and intense psychological distress, avoidance of stimulus associated with the event (e.g., memories, thoughts, feelings, people, places, objects), as well as negative alterations in cognitions and mood.

<sup>17</sup> Other terms in the literature include: prolonged grief disorder (Boelen, Van de Schoot, Van den Hout, De Keijser, & Van den Bout, 2010), complicated grief disorder (Maercker, & Znoj, 2010), pathological grief (Jacobs, 1993), traumatic grief (Jacobs, Mazure, & Prigerson, 2000), and persistent complex bereavement disorder (PCBD, APA, 2013).



previous beliefs or those of others (Currier et al., 2006; Janoff-Bulman, 1992; Rynearson & McCreery, 1993) and the world in general. (e.g., Mahat-Shamir & Leichtentritt, 2016; van Wijk et al., 2017). Finally, the reviewed literature reported professional and financial changes post-homicide (e.g., Malone, 2007a, 2007b; Paterson et al., 2006; Thompson et al., 1988; van Wijk et al., 2017; Williams et al., 2012).

Finally, data it is limited with regards to alcohol and/or drug abuse post-homicide. However, it was an outcome reported in several studies, mainly qualitative in nature (Englebrecht et al., 2016; Sharpe et al., 2013; Zinzow et al., 2009; Zinzow et al., 2011). One quantitative study (Rheingold et al., 2012) reported 14% drug use and 10% alcohol abuse among the bereaved individuals sample (N=333). Finally, another study found a link between PTSD and poorer coping strategies, including drinking (Murphy, Braun et al., 1999).

### Summary

In summary, the reviewed literature demonstrated that post-homicidal experiences are likely to be linked with psychosocial and financial issues. Furthermore, it was possible to understand that empirical-based studies looking at homicidal bereavement are growing, but nonetheless are still somewhat limited when compared with other forms of violence or trauma exposure, such as domestic violence and sexual crimes. Moreover, the majority of the empirical studies are cross-sectional in nature, not necessarily providing information about needs over time, as well as dissimilar needs as the time goes by. Thus, further research could aim at addressing those limitations.

### Psychological Interventions: What is known?

The systematic review identified a lack of specifically adapted interventions and available evaluations for children, adolescents and adults bereaved by homicide. The small number of studies included in the review demonstrates that limited evidence-based research has been conducted. Nevertheless, this review demonstrated that the psychological interventions included were effective at decreasing psychopathology in terms of PTSD, CG and depression.

Overall, the group interventions studied included psychoeducational elements, coping skills, relaxation training and emotional support, as well as exposure and death imagery. Therefore, these approaches should be considered (where possible) in clinical practice, policy and research settings. Finally, a closer relationship with the victim and having been homicidally bereaved (compared with other forms of violent bereavement) were linked with greater psychological difficulties even post-intervention. Time since loss did not impact on the outcomes. It is important to note that comparisons between the included studies was difficult due to the unequal samples sizes, different interventions and study designs. Thus, future research should focus on intervention efficacy, in order to clearly understand what elements of an intervention contribute the most to change.



## Appendix 2: Ethical considerations

The Psychology Ethics Committee (University of Bath) provided full ethical approval for the project on 4 September 2014 (Ref. 14-186). Furthermore, this research complied with British Psychological Society and Health and Care Professions Council guidelines to ensure ethical research.

Individuals were informed about the voluntary nature of their participation and that their choice would not impact on their attendance on the EV programme. They were also given the option to choose to answer some but not all questions, as well as withdraw from the study at any point without any implications for them. Finally, individuals who agreed to take part in this research signed a consent form. At the completion of their involvement debriefing forms were given to all participants. Due to the longitudinal nature of this study, it was decided to discontinue the contact (e.g., phone calls, email, post) if individuals demonstrated any signs of not wanting to carry on participating in the research.

Regarding the confidentiality of the data, names of individuals were linked to a case numbers and only Filipa knew which number related to which individual. The list of names and case numbers were stored in a locked filing cabinet and held in a password protected file. Data storage and retention are, as outlined in the University of Bath's Code of Practice for Research, stored in a locked filing cabinet at the University of Bath. The audio tapes of the interviews were destroyed as soon as the transcription were completed. These will be kept for a minimum of 10 years after completion of the study, as required by the British Psychological Society.

Data entry and analysis took place at the University of Bath and computers were password protected. Only members of the research team (Dr Catherine Hamilton-Giachritsis, Dr Sarah Halligan and Hope Christie) and the research assistants (Andrea Pintos, Beth Mason and Theo Metcalf) had access to the anonymised data.

Regarding the topic of this research, it was anticipated that some participants might feel upset or distressed when reading/listening to some questions, not least because individuals are usually experiencing quite high degrees of emotion on attending these programmes. Thus, a plan of action was developed in case individuals felt overwhelmed (e.g., normalising their emotional reactions; advising them to see some of the EV trained facilitators during the EV programme; providing information about services where they could seek support if needed when the interviews were contacted by phone). Furthermore, a brief report with the main findings of this research will be sent to all of the participants.

In terms of the risks related to the data collection processes, this was expected to be minimal, due to the group nature of the EV intervention (when data was face-to-face collected) and Filipa's previous clinical training. Nevertheless, Filipa engaged with not only academic, but also with clinical supervision.

## Appendix 3: Research tools

### Measures used

	Brief description
BSI	Measures nine clinical dimension (somatisation, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation and, psychoticism). Global Severity Index scores range from zero to 100 (higher scores represent greater severity) with a cut-off point of 50 and a standard deviation of 10.
PDS	Aids in the detection and diagnosis of posttraumatic-stress disorder (PTSD) using DSM-IV® diagnostic criteria for a PTSD diagnosis. The PDS includes a symptoms severity score which ranges from zero to 51. The cut-offs for symptom severity rating are 0 no rating, 1–10 mild, 11–20 moderate, 21–35 moderate to severe and, >36 severe.
PG-13	It is a diagnostic tool for prolonged grief disorder. Total scores can be computed ranging from zero to ten (higher scores reflect more elevated symptoms of prolonged grief).
CD-RISC	Assesses levels of adult resilience with total scores ranging zero and 100 (higher scores represent greater resilience).
CRI	Measures coping resources in five domains (cognitive, social, emotional, spiritual/philosophical, and physical). Total scores ranging from zero to 100 with a cut-off point of 50 and a standard deviation of 10 points (higher scores represent greater coping resources).
GES	Measures participants' perceptions of a group according to nine different subscales (cohesion, leader support, expressiveness, independence, task orientation, self-discovery, anger and aggression, order and organization, leader control and, innovation). Scores range from zero to 80 with a cut-off point of 50 and a standard deviation of 10 points (higher scores represent greater perceptions).

## Appendix 4. Data treatment

### Quantitative approach

This research used structured self-administrated validated questionnaires. The measures used were either purchased or given consent to be used by the authors. Furthermore, sociodemographic, medical and crime-related information was also collected. The quantitative data was analysed using a computerised statistical package (IBM SPSS 22). Multilevel modelling for repeated measures was the most appropriate statistical technique to analyse the data, due to their longitudinal nature (i.e., measuring change across time), as well as its robust nature to address missing data (e.g., Raudenbush & Bryk 2002; Söderfeldt et al., 1997).

This type of modelling prevented Listwise deletion due to missing data, which is more common in multi-waved studies. Thus, models were created for each of the intervention outcomes (i.e., psychopathology, PTSD, grief, coping and resilience). The five models were built in stages, starting with a creation of null models (models 'without predictors') and successively adding in the fixed effects (i.e., time) and random effects (e.g., relationship with the victim, offender and time since loss; Heck, Thomas, & Tabata, 2014). 'Best-fit model' was selected by choosing the model with the lowest likelihood ratio test (LRT). In fact, multilevel modelling is increasingly popular among social sciences to analyse multiple wave studies, offering more robust alternatives to, for example, ANOVAs.

### Qualitative approach

A semi-structured interview was developed by the research team taking into consideration relevant literature, participants' views and the EV team's feedback. Interviews were conducted by Filipa Alves-Costa and phone-recorded, then transcribed by her and also by an independent agency with sufficient confidentiality clauses (due to time limitations). Duration varied from 30 to 150 minutes. Interviews were analysed using an inductive *Thematic Analysis* method and *QSR NVivo11* software was used. The qualitative data analyses followed guidelines in the literature (Braun & Clarke, 2006, 2013). External coders were involved in the qualitative process to insure methodological rigour.

## Appendix 5. Psychopathology, resilience and coping progression.

		Baseline (N=67) n    %		Post- intervention (N=61) n    %		Follow-up I (N=37) n    %		Follow-up II (N=33) n    %	
<i>Psychological symptoms</i>									
<i>(BSI)</i>									
	>50	67	(100)	57	(93.0)	32	(64.4)	27	(81.8)
	<50	-		4	(7.0)	5	(35.6)	7	(18.2)
<b>PTSD</b>									
<i>(PDS)</i>									
	>15	56				26	(70.27)	25	(75.75)
	<15			-					
		5	(16.42)			11	(29.73)	8	(24.25)
<b>Grief responses</b>									
<i>(PG-13)</i>									
	>5	67	(100)			20	(54.05)	23	(69.70)
	<5	-		-		17	(45.95)	10	(30.30)
<b>Resilience</b>									
<i>(CD-RISC)</i>									
	>50	44				21	(56.75)	17	(51.51)
		(65.68)		-					
	<50	23				16	(43.25)	16	(48.48)
		(34.32)							
<b>Coping</b>									
<i>(CRI)</i>									
	>50	6	(10.45)			4	(10.82)	8	(24.25)
				-					
	<50	60				33	(89.18)	25	(75.75)
		(89.55)							

## References

- Alves-Costa, F. (2017). Homicidal bereavement in the UK: listening to and understanding stories from those bereaved through murder and manslaughter (Unpublished PhD dissertation). Bath, United Kingdom.
- Alves-Costa, F., Hamilton-Giachritsis C., & Halligan, S. (accepted). "Everything changes": Listening to homicidally bereaved individuals' practice and intervention needs. *Journal of Interpersonal Violence* [June 2017 – Resubmitted – October 2017].
- Alves-Costa, F., Hamilton-Giachritsis C., Christie, H., & Halligan, S. (accepted). "The new normal": self-perception of progress among homicidally bereaved individuals following a psychoeducational intervention. *BMJ OPEN* [October 2017].
- Alves-Costa, F., Hamilton-Giachritsis C., Christie, H., van Denderen, M., & Halligan, S. (under review). Psychological interventions for homicidally bereaved individuals: a systematic review. *Trauma, Violence, & Abuse* [August, 2017].
- Alves-Costa, F., Hamilton-Giachritsis C., Pintos, A., & Halligan, S. (in submission). Longitudinal outcomes following homicidal bereavement and psychoeducational intervention. *Journal of Clinical Psychology* [September 2017].
- American Psychiatric Association, & American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (DSM). *Washington, DC: American psychiatric association*, 143-7.
- Amick-McMullan, A., Kilpatrick, D. G., & Resnick, H. S. (1991). Homicide as a risk factor for PTSD among surviving family members. *Behavior Modification*, 15(4), 545-559.
- Amick-McMullan, A., Kilpatrick, D. G., Veronen, L. J., & Smith, S. (1989). Family survivors of homicide victims: Theoretical perspectives and an exploratory study. *Journal of Traumatic Stress*, 2(1), 21-35.

- Armour, M. (2002). Journey of Family Members of Homicide Victims: A Qualitative Study of Their Post homicide Experience. *American Journal of Orthopsychiatry*, 72(3), 372–382.
- Armour, M. (2003). Meaning making in the aftermath of homicide. *Death Studies*, 27(6), 519–540.
- Armour, M. P., & Umbreit, M. S. (2006). Exploring Closure and the Ultimate Penal Sanction for Survivors of Homicide Victims. *Fed. Sent. R.*, 19, 105.
- Asaro M., & Clements P. (2005) Homicide bereavement: A family affair. *Journal of Forensic Nursing* 1(3): 101–106
- Asaro, M. R. (1992). *Reactions and coping experiences: Families of murder victims*.
- Boelen, P. A., & van den Bout, J. (2010). Anxious and depressive avoidance and symptoms of prolonged grief, depression, and post-traumatic stress disorder. *Psychologica Belgica*, 50(12), 49-67.
- Englebrecht, C. M., Mason, D. T., & Adams, P. J. (2016). Responding to homicide: an exploration of the ways in which family members react to and cope with the death of a loved one. *OMEGA-Journal of death and dying*, 73(4), 355-373.
- Goodrum, S. (2005). The Interaction between Thoughts and Emotions following the News of a Loved One's Murder. *OMEGA – Journal of Death and Dying*, 51(2), 146-160.
- Gross, B. (2007). Life sentence: Co-victims of homicide. *Annals of the American Psychotherapy Association*, 10(4), 39–43.
- Jacobs, S. (1993). *Pathologic grief: Maladaptation to loss*. Arlington, VA, US: American Psychiatric Association.
- Jacobs, S., Mazure, C., & Prigerson, H. (2000). Diagnostic criteria for traumatic grief. *Death Studies*, 24(3), 185-199.
- Maercker, A., & Znoj, H. (2010). The younger sibling of PTSD: Similarities and differences between complicated grief and posttraumatic stress disorder. *European Journal of Psychotraumatology*, 1(1).

- Malone, L. (2007a). In the aftermath: Listening to people bereaved by homicide. *Probation Journal*, 54, 383–393.
- Malone, L. (2007b) Supporting people bereaved through homicide, *Bereavement Care*, 26(3), 51-53.
- Miller, L. (2009a). Family survivors of homicide: I. Symptoms, syndromes, and reaction patterns. *The American Journal of Family Therapy*, 37(1), 67–79.
- Miller, L. (2009b). Family Survivors of Homicide: II. Practical Therapeutic Strategies, *The American Journal of Family Therapy*, 37(2), 85-98.
- Murphy, S. A., Braun, T., Tillery, L., Cain, K. C., Johnson, L. C., & Beaton, R. D. (1999). PTSD among bereaved parents following the violent deaths of their 12- to 28-year-old children: A longitudinal prospective analysis. *Journal of Traumatic Stress*, 12(3) 273–291.
- Rheingold A. A, Zinzow H, Hawkins A, et al. (2012) Prevalence and mental health outcomes of homicide covictims in a representative U.S. sample of adolescents: Data from the 2005 National Survey of Adolescents. *Journal of Child Psychology and Psychiatry and Allied Discipline*, 53(6): 687–695.
- Rheingold A. A., & Williams J. (2015). Survivors of homicide: Mental health outcomes, social support, and service use among a community-based sample. *Violence and Victims*, 30(5): 870–883.
- Rheingold, A. A., Baddeley, J. L., Williams, J. L., Brown, C., Wallace, M. M., Correa, F., & Rynearson, E. K. (2015). Restorative retelling for violent death: an investigation of treatment effectiveness, influencing factors, and durability. *Journal of loss and trauma*, 20(6), 541-555.
- Rock, P. E. (1998). *After homicide: Practical and political responses to bereavement*. Oxford University Press.
- Shear, M. K. (2012). Grief and mourning gone awry: pathway and course of complicated grief. *Dialogues in clinical neuroscience*, 14(2), 119.
- Shear, M. K. (2015). Complicated grief. *The New England Journal of Medicine*, 372(2), 153-160.
- United Nations Office on Drugs and Crime [UNODC] 2013.
- United Nations Office on Drugs and Crime [UNODC] 2017.

- van Denderen, M., de Keijser, J., Kleen, M., & Boelen, P. A. (2014). Psychopathology among Homicidally Bereaved Individuals A Systematic Review. *Trauma, Violence, & Abuse*, 31(2), 207 – 227.
- van Wijk A., Van Leiden I., & Ferwerds, H. (2017). Murder and the long-term impact on co-victims: A qualitative, longitudinal study. *International Review of Victimology* 23(2): 145–157.
- Wright, M. (2015). The Experience of Bereaved Family Members Contact with Greater Manchester Police during the Investigation into Homicide and Sudden Death. Greater Manchester Police. [Retrieved from: <http://library.college.police.uk/docs/Bereaved-Families-Viewpoint-Final-Report-230915.pdf>].