How Children and Their Caregivers Adjust After Intimate Partner Femicide

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Approximately 3,300 children are affected by intimate partner femicide each year. Despite the multitude of stressors and the potential for negative outcomes, little is known about these children or their caregivers. This in-depth interview study used family stress theory to explore caregivers’ and children’s adjustment after intimate partner femicide in 10 families. Data were analyzed qualitatively using framework analysis. Results suggest that children and their caregivers manage numerous health and adjustment challenges in the context of ongoing hardships, resource-poor environments, and continued efforts to come to terms with the loss of their loved one and its effects on their family. Future directions are provided, with a specific focus on family-centered, strengths-based, and advocacy approaches.

Keywords: child exposure to violence; domestic violence; family crisis; family stress theory; intimate partner femicide

Intimate partner femicide (IPF) refers to the murder of a woman by a current or former intimate partner. Each year in the United States, an

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estimated 2,000 to 3,000 women are victims of IPF (Lewandowski, McFarlane, Campbell, Gary, & Barenseki, 2004). IPF is the leading cause of death for African American women aged 15 to 45 and the seventh leading cause of premature death for women overall (Greenfield et al., 1998). Women are more likely to be killed by an intimate partner (40%-50% of femicides) than by any other type of perpetrator, and the majority (67%-80%) of these murders are preceded by long-term battering of the female by the male partner (Campbell et al., 2003). In as many as 29% of IPFs, the perpetrator commits suicide (Dawson & Gartner, 1998). Although intimate partner homicide of a male partner also occurs, it is far less frequent (approximately 6% of the cases; Campbell et al., 2003) and is likely to be preceded by physical abuse of the female, sometimes for years (Websdale, 1999).

Although there are no national prevalence data, estimates indicate that about 3,300 children are affected by IPF each year in the United States (Lewandowski et al., 2004). Death of a parent or parental figure is traumatic for any child. The trauma is compounded to an unknown but potentially catastrophic extent when the death is caused by another parental figure in the child’s life. Children lose their mother, witness violence before the murder, and lose their father or father figure to jail or death (in the case of murder–suicide). Children also may lose their home and school if forced to move (Lewandowski et al., 2004). In a study of 146 children affected by IPF, Lewandowski and colleagues (2004) found that 87% moved from their homes after the incident and that their new caregivers included maternal kin (47%), paternal kin (12%), both maternal and paternal kin (e.g., when siblings were split up; 10%), and other caregivers, such as foster parents (9%).

Despite the multitude of stressors and the extreme potential for negative outcomes, little is known about these children or their new caregivers after IPF (Parker, Steeves, Anderson, & Moran, 2004). Therefore, the purpose of the current study was to explore children’s and caregivers’ adjustment after IPF, in a sample of 10 families. Using family stress theory (Hill, 1949), our objectives were to examine how the following contextual factors shape adjustment: pre-IPF stressors, IPF-specific stressors and hardships, resources and coping strategies, and perceptions of the situation. Family stress theory is particularly useful for exploring adjustment after IPF within internal (e.g., family system) and external (e.g., neighborhood) contexts and how these contexts may foster or inhibit the recovery process (Boss, 2002).
Existing Literature

Limited empirical evidence and anecdotal and clinical reports document the trauma and grief experienced by children whose parent is murdered by the other parent (Burman & Allen-Meares, 1994; Eth & Pynoos, 1994; Lewandowski et al., 2004; Parker et al., 2004). The potential for long-lasting mental and physical health effects are great. Posttraumatic stress symptoms are most commonly reported in the literature, particularly among children who witness the murder, and include recurrent intrusive thoughts, images, and sounds of the incident; nightmares and sleep disturbances; emotional detachment and anxious attachment; denial; chronic fear of recurrence; and poor concentration and academic performance (Burman & Allen-Meares, 1994; Eth & Pynoos, 1994). Depression, anxiety, aggressive and passive behaviors, problems with peer relationships, feelings of anger and guilt, and somatic complaints are also reported (Burman & Allen-Meares, 1994; Freeman, Shaffer, & Smith, 1996). A lack of relief from these symptoms may impede children’s ability to grieve and recover from their traumatic loss (Eth & Pynoos, 1994). Clearly, and not surprisingly, IPF poses significant risk to children’s long-term health and adjustment. Nonetheless, over time, some recover and do quite well, although the recovery process is difficult (Parker et al., 2004).

Resilience refers to the successful adaptation of individuals and families despite exposure to significant risk factors (Garmezy, 1981). Although more research is needed to fully understand the processes of resilience, existing studies suggest a number of protective factors that contribute to resilient responses over time for children exposed to violence. For example, a stable relationship with a caring and consistent adult (e.g., a grandmother) has been found to be an important contributor to later adjustment among children exposed to domestic violence (Humphreys, 2001; Parker et al., 2004). Thus, the ability of new caregivers to provide a supportive and secure environment may be critical for children’s recovery after IPF. Protective factors external to the family system are also thought to be important, including supportive friendship networks and schools, as well as access to resources (Humphreys, 2001). Furthermore, individual-level factors, such as child abuse, the child’s sex, and his or her developmental stage, may also influence outcomes (see Edleson, 2004).

Although no studies (to our knowledge) have examined caregivers’ experiences after IPF, studies of adult family members of homicide victims, often referred to as co-victims (e.g., Thompson, Norris, & Ruback, 1998),
lend insight into the struggles that they likely face in their recovery process. For example, research documents the prevalence of traumatic grief among co-victims (Thompson et al., 1998), which can be prolonged and extreme. The need to block intrusive thoughts related to the trauma often interferes with their ability to grieve (Armour, 2002a). Distress reactions in the immediate aftermath are similar among homicide co-victims and other trauma victims (e.g., those who lose a family member in an accident); however, co-victims of homicide may be unique in that the passage of time does not seem to alleviate their distress symptoms (Thompson et al., 1998). Compared to those who lose a family member because of an illness or accident, co-victims of homicide may be more likely to attribute their loss to a particular perpetrator, which is associated with more feelings of anger, vengefulness, and thoughts that their life is less comprehensible and manageable (Stuckless, 1998). Distress is compounded by the public nature of the loss, feelings of social stigma, and lack of support from the criminal justice system (Armour, 2002b).

Co-victims also report higher degrees of distress and posttraumatic stress symptoms when parenting and economic role changes occur after IPF (Thompson et al., 1998). For example, adult family members who suddenly become caregivers after IPF must manage their trauma and grief reactions in addition to the needs of traumatized children. Doing so likely compounds levels of stress and heightens the caregivers’ risk for negative physical and mental health effects. Furthermore, when the homicide of a family member is perpetrated by someone within the family, recovery may be complicated by estranged family relationships, emotional impasses, and conflict between victim’s and perpetrator’s extended families (Armour, 2002a). How well the children’s caregivers cope with the loss and the changing family structure and dynamics will likely affect how well children adjust (Becker & Margolin, 1967; Simons, Lin, Gordon, Conger, & Lorenz, 1999). Considering the unique dynamics and effects of intrafamilial homicide, we used family stress theory to explore how children and caregivers adjust after IPF. This theoretical perspective emphasizes the need to view families as a whole along with the individual members and their contexts (Boss, 2002).

**Theoretical Perspective**

According to family stress theory, a family’s ability to manage a stressor event (in this case, IPF) is influenced by the family’s perception of the event and how well the family members believe that they can manage the accompanying changes. In conducting research with families who were coping
with a loved one missing in action, Boss (2002) concluded that perception may be the most important factor in predicting how well a family will manage and recover from crisis. For co-victims of homicide, however, making meaning of the situation may be one of the most challenging aspects of recovery. In fact, Armour (2002a, 2002b) contends that making sense may not be an appropriate or useful goal for co-victims of homicide. The homicide of a loved one often destroys core meaning systems for co-victims, resulting in a loss of trust and faith in the world (Janoff-Bulman, 1992). Family members may not be able to find meaning in such a traumatic event, and they may not wish to let go, which has been traditionally considered a necessary part of the grieving process (Armour, 2002a). However, in analysis of interviews with adults who experienced IPF as children, Parker and colleagues (2004) found that co-victims did try to make sense of their past and find meaning in what happened, which helped them cope. For example, making sense of the murder by believing that perpetrators were sick and not responsible for their behaviors helped co-victims persevere and overcome feelings of anger and blame. Parker et al. posit that over time, children who experience IPF may need to replace anger with forgiveness in order to live psychologically tolerable lives.

In addition to addressing perceptions, family stress theory states that a family’s access to and use of resources for coping also influences their adjustment. Co-victims typically require practical, psychosocial, and advocacy support after IPF, and existing studies indicate that they turn to formal and informal sources for help. For example, religious-based support has been associated with reduced distress among co-victims (Thompson & Vardaman, 1997). Religion has also helped co-victims make sense of their experiences (Parker et al., 2004). Co-victims also rely on family support. Adult children who experienced IPF reported that a belief in the importance of family loyalty and continuity helped them forgive and reaccept their fathers, which in turn helped to resolve their conflicted emotions of anger, blame, and love (Parker et al., 2004). Participation in advocacy or actions to help others has also been associated with less negative feelings and better perceived quality of life for co-victims (Stuckless, 1998).

Research suggests that co-victims’ use of formal services is influenced by their familial relationships to perpetrators. Comparing co-victims of homicide by a family member (i.e., intrafamilial homicide) to co-victims of homicide by a non–family member (i.e., extrafamilial homicide), Horne (2003) found that the former used services in the initial 8-week period following the homicide more than the other co-victims did but less often in the subsequent 8-week period. Horne suggested that over time, an increased
awareness of ambivalent feelings about their relationships to the perpetrators and feelings of guilt and shame may lead co-victims to shun outside intervention in favor of keeping issues within the family, or they may limit use of formal services to avoid dealing with painful and conflicted emotions. These findings suggest that the recovery process for co-victims of intrafamilial homicide may be unique and thus require services tailored toward their specific needs.

Taken as a whole, family stress theory postulates that family members’ perceptions of a stressor event and their access to and use of resources for coping influence how well they adjust. When stress levels are high, families may experience a crisis in which previous strategies for managing stress no longer work and they must develop new strategies to regain stability and recover over time. Given the magnitude of IPF and the changes required of families, it is without question that most experience a crisis in which they must develop new roles and new ways of coping. Furthermore, the reorganization process following IPF is likely to be protracted and complicated. As Masters, Friedman, and Getzel (1988) note, recovery after IPF has a chronic quality to it because a number of other stressors follow the death, each requiring different management strategies. Indeed, studies point to the additional trauma created as families interact with formal and informal systems that block their recovery process (Armour, 2002b). Nonetheless, family stress theory suggests that adaptive perceptions and adequate resources may buffer maladaptive responses and thus contribute to resilient outcomes.

**Present Study**

The purpose of the current study was to use family stress theory to explore caregivers’ and children’s adjustment after IPF. We focused on IPF rather than homicide of a family member in general because co-victims’ perceptions, use of services, and dynamics of recovery are influenced by their relationships to perpetrators and because the almost-universal prior domestic violence in these children’s lives makes them particularly vulnerable. We sought to extend existing literature by exploring both caregivers’ and children’s responses and needs. Given that a stable and consistent adult can positively influence the long-term adjustment of children, understanding and responding to the health needs of caregivers is critical for supporting children after IPF. We also sought to identify potential protective factors, especially when considering that researchers typically identify risk factors for negative consequences following IPF, with less attention to protective factors and resilient pathways of recovery.
Method

Sample

The sample was selected from a larger 10-city study of risk factors associated with IPF (Campbell et al., 2003; see Table 1 for characteristics of the sample). Family contact information was obtained from closed police records from 1994 to 1998. Data collection began following approval by the appropriate agencies in each city and by the institutional review board at each site. Potential participants were contacted by mail and then telephone in order to identify either the current caregiver of the children or another knowledgeable informant. Telephone interviews were conducted with 10 informants from the East and Southwest regions of the United States. Each informant was asked to identify an index child, which was the child whom he or she believed to be most affected by the IPF. Each was instructed to answer questions in relation to this index child but was also encouraged to discuss the responses and needs of other children in the home.

Six of the informants were the primary caregivers of the children, including the victim’s parent \((n = 5)\) and the perpetrator’s parent \((n = 1)\). Four interviews were conducted with others who were knowledgeable of and actively involved in the children’s care following the event, including one sister of a victim, one sister of a perpetrator, one niece of a victim, and one neighbor and close friend of a victim and her family. All informants were knowledgeable of the children’s experiences before and after the IPF. Interviews were conducted 5 weeks to 5 years after the IPF \((M = 2.84\) years, \(SD = 1.62\) years).

Procedure

We used interviews with caregivers to explore how perceptions and resources shaped post-IPF experiences and the adjustment of caregivers and children at the time of the interview. Interviews consisted of 20 open-ended questions covering the IPF and other stressful events in the children’s lives; child and caregiver well-being before and after IPF; child and caregiver coping strategies; and the use of formal and informal services. Although informants were asked to identify one index child, they were free to discuss the other children in the family—and all did.

Data Analysis

Data were analyzed qualitatively using framework analysis (Lacey & Luff, 2001; Ritchie & Spencer, 1994). First, we familiarized ourselves with
Table 1
Characteristics of the Sample

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>n</th>
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<tbody>
<tr>
<td>Race/ethnicity</td>
<td></td>
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<tr>
<td>African American</td>
<td>6</td>
</tr>
<tr>
<td>White</td>
<td>3</td>
</tr>
<tr>
<td>Mixed (White/Latino)</td>
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</tr>
<tr>
<td>All children ( n = 31 )</td>
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<tr>
<td>No. in household at time of IPF(^a)</td>
<td>( M = 3.1 )</td>
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<tr>
<td>Age at time of IPF (years)(^b)</td>
<td>( M = 9.4 )</td>
</tr>
<tr>
<td>Male</td>
<td>17</td>
</tr>
<tr>
<td>Index children ( n = 10 )</td>
<td></td>
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<tr>
<td>Male</td>
<td>5</td>
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<tr>
<td>Age at time of IPF (years)(^c)</td>
<td>( M = 11.3 )</td>
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<tr>
<td>Relationship of victim to index child(^d)</td>
<td></td>
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<tr>
<td>Mother</td>
<td>7</td>
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<tr>
<td>Aunt</td>
<td>2</td>
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<tr>
<td>Sister</td>
<td>1</td>
</tr>
<tr>
<td>Relationship of perpetrator to index child</td>
<td></td>
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<tr>
<td>Father</td>
<td>4</td>
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<tr>
<td>Stepfather</td>
<td>1</td>
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<tr>
<td>Brother-in-law</td>
<td>1</td>
</tr>
<tr>
<td>Unrelated</td>
<td>4</td>
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<tr>
<td>Relationship of perpetrator to victim(^e)</td>
<td></td>
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<tr>
<td>Husband</td>
<td>6</td>
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<tr>
<td>Boyfriend</td>
<td>3</td>
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<tr>
<td>Ex-boyfriend</td>
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<tr>
<td>Status of perpetrator</td>
<td></td>
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<tr>
<td>Prison</td>
<td>8</td>
</tr>
<tr>
<td>Deceased (murder–suicide)</td>
<td>2</td>
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<tr>
<td>Primary caregiver after IPF</td>
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<tr>
<td>Victim’s parents</td>
<td>6</td>
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<tr>
<td>Perpetrator’s parents</td>
<td>2</td>
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<tr>
<td>Biological father(^f)</td>
<td>1</td>
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<tr>
<td>Adult sibling</td>
<td>1</td>
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Note: IPF = intimate partner femicide.

\( a. \ SD = 1.1; \ \text{range} = 1-4. \)
\( b. \ SD = 5.3; \ \text{range} = 11 \text{ months} \ to 18 \text{ years}. \)
\( c. \ SD = 4.1; \ \text{range} = 4-17. \)
\( d. \ \text{All children were living with and being cared for by the victim at the time of the murder.} \)
\( e. \ \text{Five of the nine women in current relationships were in the process of leaving when killed.} \)
\( f. \ \text{This biological father was not the perpetrator.} \)
the data by reading each transcript as a whole. Second, we developed a thematic framework using a priori categories based on family stress theory. The categories were pre-event stressors, stressor event factors, perceptions of the event and the family’s ability to recover, resources and coping strategies, and health adjustment and concerns. We used these categories for conceptual and organizational purposes as we analyzed the data. The process of indexing followed, in which we coded the data using emergent codes and then placed the codes within the categories derived from family stress theory. For example, the emergent code separation anxiety was placed under the a priori category of health adjustment and concerns. We then developed a case chart for each family that displayed the coded data across the categories of the thematic framework. Case charts provided a visual of how the coded data for each transcript mapped onto the categories derived from family stress theory. In the final stage, mapping and interpretation, we used case charts to explore the range and nature of the experiences before and after IPF; the patterns in child and caregiver responses; the associations between factors (e.g., proximity to the event and reported health concerns); and the processes (e.g., how children and caregivers coped).

Results and Discussion

We begin by discussing children’s adjustment after IPF, based on caregiver’s perceptions. We then place their adjustment within a larger context of factors that, according to family stress theory, are important to how well individuals and families adjust to stressful events.

Caregiver’s Perceptions of Children’s Adjustment

Caregivers reported overlapping mental, physical, behavioral, and academic adjustment problems among the children after IPF, as illustrated by one woman who was caring for her 7-year-old grandson:

Since the incident, he has been treated for [attention deficit hyperactivity disorder] and hyperactivity, which was diagnosed before but not treated. . . . He has displayed signs of [posttraumatic stress disorder] and recently been diagnosed as “emotionally disturbed.” . . . He is loud . . . destructive, impulsive, . . . and fights kids at school. . . . Immediately after [the IPF], he was full of anger and rage. He . . . had nightmares almost every night. If the hall light was not on, he screamed until I got up and turned it on. . . . He is in a Level 4 program at school, needs one-on-one with all subjects.
Mental health concerns were reported by seven caregivers and included depression, anxiety, prolonged grief, and posttraumatic stress symptoms. Importantly, a child had become suicidal after the event in two of the families. A boy who at age 14 witnessed the aftermath of his sister’s murder had become suicidal three times in the 4 years since her death, with one attempted drug overdose; he recently admitted himself to a crisis center because of suicidal thoughts. A 13-year-old girl attempted suicide three times in the 1st year after her father killed her mother. Half of the caregivers reported concerns about separation anxiety and sleep disturbances, which were most intense in the months immediately after the IPF. One caregiver explained that her 11-year-old granddaughter

will not go anywhere by herself. She does not want to be alone. We can’t close any doors in the house. She wants to sleep with me. She doesn’t want to close the bathroom door or the shower curtain. She’s just afraid of being left alone.

In addition to not wanting to sleep alone, children had sleep problems that stemmed from constant nightmares, waking up in the night, wanting to sleep in different places (e.g., the car), and fear of the dark.

Physical health concerns were reported by six caregivers and included somatic complaints, weight and appetite changes, and asthma symptoms. In one family, in which the interview took place just over a month after the event, the caregiver received a call every day from the school nurse reporting that her 11-year-old granddaughter was complaining of a stomachache or headache. In general, caregivers expressed that they were more concerned about the children’s mental health than their physical health, even when they reported both mental and physical health problems. Perhaps, caregivers were more likely to associate mental versus physical health problems with exposure to trauma and thus worried more about the children’s mental health. Caregivers also may have felt more adept in addressing children’s physical symptoms (e.g., stomachache) than their emotional needs and thus identified mental health concerns as being more problematic. Onyskiw (2002) notes that researchers have tended to focus more on mental health effects than physical, despite evidence linking both to violence exposure (Campbell & Lewandowski, 1997).

Caregivers reported concerns about children’s behavioral \((n = 6)\) and academic adjustment \((n = 5)\). Behavioral changes varied widely and included general rebellion, destructive and impulsive behaviors (e.g., throwing things), peer-related problems (e.g., physically fighting with peers, associating with negative peers, unplanned pregnancies), and illegal
activity (e.g., stealing, using drugs). Behavioral problems were mentioned in conjunction with mental health concerns. Academic performance issues were the least reported (e.g., poor grades, placement in special classrooms for emotional and learning difficulties, dropping out of school). Any variations in the number or type of reported problems based on time since event were not apparent.

**Contextual Influences**

IPF tends to occur among a myriad of other risk factors and problems, such as exposure to prior domestic violence and other traumatic experiences (Lewandowski et al., 2004), which makes it important to consider children’s adjustment after IPF within its larger context. Specifically, family stress theory posits that adjustment is shaped by contextual factors that include pre-IPF stressors, the nature of the stressor event (IPF) and its associated strains and hardships, family resources and coping strategies, and family and individual perceptions of the situation. We discuss each of these factors as well as their relationships to variations in children’s adjustment as reported by their caregivers.

**Pre-Event Stressors**

All 10 index children were exposed to domestic violence against their mothers or female caretakers before the homicide. Prior studies indicate a 30%-60% overlap of woman abuse and child maltreatment in families (Edleson, 1999). In the current sample, exposure to violence frequently accompanied other stressful or traumatic experiences. For example, two cases involved prior allegations of physical or sexual abuse of children committed by the perpetrator before the murder; one of the cases was reported to the police 9 months before the murder. Children were also exposed to violence against other family members, and in two families, children were exposed to parental substance abuse. Children in two families lived on and off with other relatives as their mothers or female caretakers tried to shield them from the violence in the home. Clearly, children experienced multiple stressors before the trauma of IPF.

Given the multiple stressors experienced by children, one would expect reports of mental and physical health problems before the homicide event. However, only three caregivers indicated such. The children in one family were previously diagnosed with mood disorders and had received therapy. The index child in this family also had asthma and allergies. In another family, the informant believed that the index child had untreated attention deficit hyperactivity
disorder, and a child in another family suffered from a chronic health condition since birth. The children in the remaining families were described as physically and mentally healthy before the homicide event. These reports are surprising given the large body of research documenting the negative effects on children of exposure to domestic violence (Onyskiw, 2002). It is possible that caregivers were less knowledgeable of the children’s health before the IPF than at present or that difficulties faced before the event now paled in comparison to dealing with the trauma of parental homicide. Without prior knowledge of the children’s health and without a comparison group, it is difficult to say the extent to which IPF affected children above and beyond exposure to domestic violence or other traumatic events before the murder. However, the unique pileup of stressors and hardships (e.g., grief, disruption) resulting from the death likely compounded children’s vulnerabilities.

**IPF and Its Related Stressors and Hardships**

**Proximity and involvement.** Children’s proximity to and involvement in the IPF varied. All of the children were living with and being cared for by the victims of IPF. Victims died as a result of gunshot, stabbing, or strangulation, and most died before medical personnel arrived. In three families, the children were not present at the time of the IPF and did not witness the murder or the aftermath. In two families, the children were present but did not see or hear the murder; however, in one case, the children found their mother’s body. In the remaining five families, the children witnessed the murder. Thus, in 6 out of 10 cases, a child either witnessed the murder or was the first to find the body. Three out of the five cases in which children were witnesses included multiple victims: Two were murder–suicides (one in which the perpetrator was the children’s father; the other was unrelated to the children), and in the third case, the perpetrator killed the victim and her sister. In three cases in which children were witnesses, they were threatened by the perpetrator (e.g., one attempted to shoot the child after killing the mother, but the gun misfired). In the following description given by a woman caring for her four grandchildren, it is clear that children who witness IPF experience not only the trauma related to the death but also the high threat and sensory inputs (e.g., sights, sounds) during the incident (Lewandowski et al., 2004):

[The children] knew that they were not to let [the perpetrator] in the house, but [the oldest daughter] opened the door. . . . He went to the kitchen and got a knife and went downstairs. . . . He first went for [the victim’s sister] and stabbed her twice. [The victim] jumped on his back to stop him, but he shook her off and stabbed her multiple times. All the kids saw it. [The oldest daughter] ran
upstairs to call for help and [the perpetrator] went after her. She heard him coming and hid in the closet while he searched for her . . . then he fled.

Physical health problems appeared related to the child’s proximity to the event. When children were not otherwise exposed to the event and told later what happened, their caregivers reported no physical health problems for the children. All children who were exposed to the murder to some extent, whether it was finding the body or hearing or seeing the event, suffered physical health problems postevent. Furthermore, in the three cases involving multiple victims (two murder–suicides, one double homicide), all children suffered physical health problems. These children witnessed the murders, which may have compounded the trauma and their risk for adverse health effects. Furthermore, sleep disturbances were more common with greater proximity to the event.

*Family deaths and illnesses.* Following the event, negative health and adjustment problems for children were exacerbated by ongoing stressors and related hardships. The most commonly reported stressor following the homicide involved health problems among caregivers, including those interviewed and their spouses. Within 7 months of the IPF, two caregivers suffered heart attacks, two underwent major surgeries, and one was hospitalized with a heart condition. The children in one family lost a loved one within 6 months of the homicide, and the children in another family lost both maternal grandparents within 2 years of the IPF. Other deaths affecting children included those of extended family members, friends, and pets. According to caregivers, postevent illnesses and deaths of loved ones heightened feelings of insecurity among children. For example, a 6-year-old boy whose grandfather died worried that his grandmother’s death would soon follow. He also worried that his father would get out of prison and kill his grandmother.

*Financial strain.* Post-IPF financial strains were common and were exacerbated by illnesses and deaths. In two families, the maternal grandfathers died, leaving maternal grandmothers as sole providers for the children. One caregiver exclaimed, “I’m a single elder of four children [ages 6 to 13]. I get assistance and food stamps, but life is very difficult.” One caregiver’s husband and the children in their care turned to drugs to cope, which resulted in the family’s filing for bankruptcy. A caregiver of four children (ages 1 to 10) suffered multiple financial strains. After finding a new place to live with the children, she returned to the house where the murder took place to retrieve the children’s belongings only to find that
everything had been stolen. She also fought with her insurance company for 15 months after the IPF to be able to switch to a health plan that covered therapy for the children. In the first 2 years following the event, she and the four children lived on $850 a month.

*Child exposure to family conflict and violence.* Exposure to family conflict and, sometimes, violence continued for children in five families. Most commonly, children experienced conflicts between the victim’s and perpetrator’s extended families, usually over where the children would live after the event. For example, one perpetrator’s extended family wanted to divide the children among the relatives, but the maternal grandmother insisted that they live with her so that they could all stay together. One perpetrator’s sister, whose mother is caring for three children (ages 6 to 11), shared a similar experience:

The mother’s side of the family blames the father’s side, and the adults act out in front of the kids. At the time of the deaths [murder–suicide], there was disagreement over where the kids should go. Kids do not need this. Thank goodness for one person who recognized that they should go with [the paternal grandmother] together.

Family conflict also erupted over perpetrators’ efforts to maintain contact with children after the event. In one family, the children resided with their maternal grandmother but were given mail from their father through their paternal grandmother. The caregiver explained,

The abuse continues from prison. He sends the children filth. We all continue to deal with his angry, obscene mail. He abuses them from prison through their [paternal] grandmother. The letters say he is going to come to get the kids and take care of them.

These children witnessed their father murder their mother and lie to police about what had happened. The children testified against their father (this was the only family to experience a trial) and thus felt responsible for his being in prison. Aggressive acting out often followed children’s receipt of letters from their father because they feared that he would come back to hurt them. Eventually, with the help of the district attorney, the caregiver stopped the transfer of letters from the paternal grandmother to the children and reported that the children’s behavior improved as a result.

*Caregiver parenting stress.* One important context for children is the well-being of their primary caregiver. Given the multitude of stressors and significant
losses, all caregivers reported a great deal of parenting stress, which taxed their emotional and physical availability to the children. They talked most about not knowing how to parent children who had experienced such a traumatic event. A particular concern involved understanding the diverse needs and coping strategies of children who were in the same household but were of different ages and stages of development. One caregiver with four grandchildren provides a good example. In the 4 years since the murder, the children’s responses and needs have varied: Her 5-year-old grandson (who was 11 months at the time of the IPF) does not remember his mother and father from before the murder. He has developed a relationship with his father through phone calls and visits to prison. Her 7-year-old granddaughter (3 years old at the time) believes that another man killed her mother, not her father. Her 9-year-old grandson (5 years old at the time), unlike his siblings, refuses to visit his mother’s grave or visit his father in prison. In contrast, her 10-year-old grandson (6 years old at the time) is angry that his father is in prison and believes that he should not have been sentenced to prison.

Similarly, conflicting emotions and loyalties resulted in diverse grief reactions among children and caregivers. Children grieved the loss of their mother or mother figure or, in the case of very young children, the mother whom they never knew, and some grieved the loss of their father. At the same time, some felt angry at their father, which complicated their feelings of love and loyalty to both parents. Caregivers grieved the loss of their child and loved one and their lives before the IPF. Parents of the perpetrator grieved the loss of their son to prison or suicide, which conflicted with children who blamed their fathers and with the victim’s extended family. The diverse responses to IPF among the children reflect their developmental levels and their cognitive abilities to comprehend and make sense of traumatic events (Eth & Pynoos, 1994). For caregivers suddenly parenting children with such varied and conflicting responses, however, the task may be overwhelming, with the potential to negatively affect caregivers’ health.

**Resources and Coping Strategies**

*Resources.* According to family stress theory, access to and use of formal and informal resources as well as positive coping strategies are essential for the health and adjustment of individuals and families when in crisis. In the immediate aftermath of IPF, all caregivers and family members in the current sample received support and referrals to services, and nine took advantage of these opportunities. Immediate support came in the form of counseling, money, food, and help with funeral arrangements. Police officers and health care providers referred families to bereavement services, and five families received support for their children through school counseling.
programs, which involved home visits for two families. Neighbors, relatives, friends, and local community organizations (e.g., churches, health centers) provided monetary and other types of support (e.g., food, cards, prayers, phone calls, emotional support, lodging for children, advice).

However, caring for children exposed to IPF extends beyond the traumatic event and immediate aftercare. For half of the families, offers of and access to support dwindled quickly. As one caregiver put it, “lots of people came to the funeral . . . then nothing.” Caregivers reported that bereavement services were helpful but too short-term or that therapists were helpful but children could not see them often enough because of financial constraints. Intensive, comprehensive services were desired but not available, or, if available, caregivers were not able to access them or did not know how.

Furthermore, the children in most families \( (n = 9) \) moved to new homes and communities after the homicide; thus, they were removed from their support networks and the familiarity of their friends and schools. Given that additional major stressors (e.g., death of a grandparent) occurred soon after moving, children may not have had time to develop adequate support networks in their new environments. One 11-year-old boy and his mother (who was murdered) were close friends with their neighbor. Before the IPF, the child saw the neighbor daily; after the event, their visits decreased, and the distance was hard for both the child and the neighbor.

Caregivers were specifically asked how helpful they thought it would have been to get a phone call or a home visit from a nurse or mental health provider to see how things were going or to answer questions. Six caregivers were confident that a home visit would have been very helpful in identifying problems early on and providing them with the opportunity to talk and grieve. One caregiver did not believe that a home visit would have helped unless the provider took the time to develop a trusting relationship with the children. Six caregivers indicated that a phone call would have been very helpful if it gave them the opportunity to talk about their problems. Two caregivers preferred a home visit to a phone call, and another caregiver thought a phone call would have helped if the provider talked with the children. Four caregivers emphasized the need for more support and services of any kind.

The lack of support and services reported by the current sample is consistent with others’ findings that families affected by IPF receive limited health services (Freeman et al., 1996; Lewandowski et al., 2004). The reported decrease in services after the initial crisis period is consistent with Horne’s (2003) findings. Horne hypothesized that co-victims of intrafamilial
homicide, when compared to those of interfamilial homicide, may be most receptive to external services in the initial crisis period but may abruptly withdraw from outside intervention after the initial intense period passes. Our findings suggest that financial barriers and the lack (or perceived lack) of availability or knowledge of long-term services play a major role in decreased service use over time.

**Coping strategies.** The coping strategies commonly used by children and their caregivers and family members included connecting with supportive others, enacting family rituals, and staying busy. Several caregivers described the important role that caring adults played in helping children cope over time. For example, a 12-year-old child reached out to a neighborhood family and formed a close attachment with its members. The supportive relationship continued for 3 years after the murder. Other children sought support from within their families, most often from siblings and aunts and from the victim’s support network (e.g., friends or former partners of the victim). A caregiver of a 4-year-old boy described the important role of a homicide detective: “The detective took special interest in him and helped tremendously. He picked us up for hearings and meetings at the attorney’s office. He was very supportive, a wonderful person. He took [the child] under his wing.”

Another coping strategy involved family ritual, which is a form of symbolic communication that fosters family cohesion and belongingness during times of transition (Fiese et al., 2002). Healing rituals in particular can be used to mark profound loss, help survivors grieve, and facilitate ongoing life following loss (Imber-Black, 1999). Only two caregivers in the current sample talked about using ritual as a way to cope. One woman who was caring for her son’s (the perpetrator’s) four children (aged 11 months to 6 years at the time of the homicide) takes the children to their mother’s grave regularly to pray, although the 5-year-old (now 9) chooses to remain in the car during these visits. The same caregiver also takes the children to visit their father twice a year. Another family comes together with the children to pray on the anniversary of their mother’s death. For these families, ritual was used to keep the memory of the victims alive and to heal. In contrast, two caregivers tried their best to keep the children’s minds off of the traumatic loss by keeping them busy with activities and friends. Interestingly, caregivers who reported keeping children busy as a way of coping were the families in which the murders had occurred most recently (5 weeks and 3 months post-IPF). Perhaps this strategy is common in the immediate aftermath but used less over time as the complexities of children’s responses and needs are realized.
Caregiver Perceptions of the Situation

In addition to resources and coping strategies, caregivers’ perceptions of the situation are important for understanding how they cope with IPF and its associated stressors and how they care for children in the aftermath. In making sense of their experiences, caregivers wrestled with their awareness of the dangerousness of the situation before the murder, as reflected in their quotes:

“I knew he was going to kill her.”
“I tried to warn her. He shot at her 2 weeks prior but missed.”
“She told me that I should not be surprised if she was killed because there is no protection for abused women. She told me that the day before she was shot.”
“I worried about him having a gun in the home and got onto them all the time about it.”

None mentioned feelings of self-blame, but all clearly struggled with having sensed the risk but not having done (or being able to do) anything to prevent the murder. Similarly, caregivers struggled with the perception that their loved ones had almost escaped death. When asked what the most difficult part of the experience was, their responses included the following:

“She didn’t want to go to the house that night.”
“She said she didn’t want to have anything to do with him, which triggered [the murder].”
“The worst part was that my daughter was ready to get on with her life. She had asked for a divorce.”
“The hardest part is knowing she was leaving him. The killing was so senseless.”

Caregivers knew that the situation was dangerous; but making sense of a senseless murder is difficult, and they questioned whether it could have been prevented considering how close the victims were to escaping.

Nonetheless, several caregivers were able to identify positive outcomes of their tragic experiences. One caregiver explained that her family became more involved in church and “closer to God” as a result of the void left in their lives after the children’s mother died. Another caregiver reflected on the challenges over the years and concluded that it made her stronger. She believed that there were no other options—she had to be strong for the children. In some ways, the children gave her purpose and kept her from falling apart. She now wants to reach out to other abused women. A third caregiver felt that despite her and the children’s ongoing struggles, the children were better off now than they were before.
Those caregivers who were able to see positive outcomes seemed to perceive more control over their situations or a greater sense of agency in caring for the children. For example, one caregiver moved to the country with her four grandchildren, ages 1-10, because the county school system provided more opportunities for support: “The county school system is wonderful. They have after-school programs, athletics, supportive teachers, and administrators—excellent support. Moving to the country was the best thing we’ve done.” This caregiver seemed to perceive her situation as one that she could manage and had to. She had to seek out the resources and support systems necessary to help her children. She made decisions with the children’s care in mind despite serious financial limitations. In contrast, another caregiver described her perception of the situation in the following way: “We lost our only daughter. The family fell apart. The entire family is torn apart. It destroyed the whole family.” To her, recovering from the loss of her daughter 5 years ago still seemed impossible for her and her family.

Although a caregiver’s adjustment to crisis likely influences how well children cope, the caregivers in the current study talked minimally about their personal health and coping. One caregiver discussed her struggles with depression and how she slept to avoid dealing with the loss. She felt emotionally unavailable to the children. Her doctor prescribed medication, but she did not follow through with referrals for counseling. Four years after the murder, she remained depressed. Three caregivers regularly saw counselors, and two of them continued therapy for 3 to 5 years post-IPF. One caregiver with grandchildren ranging from 6 to 13 years old sought help specifically about parenting: “The counselor taught me how to talk and relate to the kids.”

When talking about their health, caregivers more frequently expressed worries about physical problems, such as heart troubles (although not necessarily relating them to the IPF or to recent changes), compared to mental health concerns. This was in contrast to their tendency to emphasize mental versus physical health problems among the children. There are several possible reasons for this discrepancy. Caregivers may have found it easier to talk about their physical health than their emotions, or they may have denied their own mental health needs. The extent to which caregivers may have focused on the children’s and other family members’ needs at the expense of their own is unknown; however, feminist researchers have documented the influence of the social expectation that women, especially mothers, will devote themselves to the care of others (Arendell, 2000). Only one caregiver expressed frustration with what she perceived to be an overfocus on her needs: “I wish [professionals] had made it easier to get help for the kids.
They bugged me to get therapy for myself. I’m fine. I wanted to be strong for the kids and stay focused on them.” In contrast, one informant, who was not the primary caregiver of the children but a neighbor and close friend of the family, discussed in detail her struggle with recovery. On the night of the murder, one of the children fled to her house to call 911:

I feel so very bad for [the victim]. She was breathing when I got to her. Her face was swollen. He had beaten her. He claimed self-defense. Everyone thinks about immediate family effects. I mean the last 2 years have been hell for me. I’ve had nightmares. I suffered so much. I could not eat or sleep. My family did not understand. I feared for my own life. I thought he would come back and kill me. I moved out in 2 weeks. I went to the trial. I testified. I had my boyfriend go to the trial with me every day. I was afraid his family would kill me. I was so afraid.

Perhaps being thrust into the role of parenting severely traumatized children forced primary caregivers into a survivor mode, in which their own needs became secondary to the children’s. This neighbor, although close to the children, may have been able to recognize her needs in the aftermath more so than those who were managing the daily care of the children.

Overall, the results indicate that children and their caregivers manage numerous health and adjustment challenges after IPF in the context of ongoing hardships, resource-poor environments, and continued efforts to come to terms with the loss of their loved ones and its effects on their families. According to Garmezy (1981), resilience refers to successful adaptation despite exposure to significant risk, with successful adaptation being the restoration of balance between family capabilities and demands after crisis (Patterson, 1988). Although caregivers and children in the current sample were able to draw from internal sources of strength (e.g., close family relationships), their struggle to successfully adapt continued as they managed chronic stress. According to family stress theory, the ability to be resilient extends beyond internal relationship processes to include opportunities in the larger social system (Patterson, 2002). However, these families lacked ongoing external support. Thus, in drawing from the perceptions of those who care for children after IPF, we now present recommendations for future directions that center on formal services to families that strengthen their capacity for resilient outcomes.

**Future Directions**

Because the results are based on cross-sectional data from a small sample, they should be viewed as suggestive and not representative of all caregivers’
and children’s experiences. Nonetheless, because the existing literature on families and IPF is limited, the current study provides valuable preliminary information for future research and practice. According to Horne (2003), the state of crisis following IPF may differ from other crisis situations in that it tends to be prolonged and chronic because of the pileup of other stressors that complicate recovery (e.g., changing schools, trauma reactions). Given the multitude of challenges faced by the families in the current sample, it is problematic how little long-term support they received. Although immediate support was available, formal services that extended beyond initial crisis management were limited, and the perceived availability of formal and informal support decreased over time. These findings are consistent with other studies that report limited services to families affected by IPF (Burman & Allen-Meares, 1994). Furthermore, the decrease in service usage over time, whether by choice or because of a decrease in available services, is consistent with Horne’s (2003) research with co-victims of intrafamilial homicide.

Longitudinal research using larger samples is needed to better understand why some families choose not to continue services beyond the initial crisis period. Our results suggest several important factors to consider further, including lack of awareness of services and how to access them, financial constraints, and caregivers’ tendency to focus on children’s needs before their own, which may deter caregivers from seeking services for themselves. Furthermore, Horne (2003) points to the emotional issues unique to co-victims of intrafamilial homicide that may prevent families from seeking help after the initial crisis period passes. More research is needed to identify current gaps in the availability of long-term services and to evaluate the effectiveness of services currently provided to families after IPF.

Furthermore, it is imperative that families have access to comprehensive, ongoing services that are relevant to their needs. Toward this end, we posit that interventions with families should involve family-centered, strengths-based, and advocacy components (for an example, see Sullivan, Bybee, & Allen, 2002). A family-centered approach places the family system, rather than individual members, at the center of intervention. This approach assumes that children, caregivers, and other family members are inextricably intertwined; the adjustment or health problems of any one member has consequences for the entire family system. Thus, the provision of family-centered support would target the entire family and its support networks, which is likely to be more effective over time than interventions focused exclusively on the child or the caregiver (Baily, Buysse, Edmondson, & Smith, 1992). Relevant to the current sample, a family-centered approach
would educate caregivers about the importance of addressing their physical and mental health needs as part of fostering children’s healthy adjustment. Promoting caregivers’ parenting competence is another goal that would positively influence outcomes for caregivers (e.g., by fostering their perceptions of agency as parents) and children over time.

Professionals using a family-centered approach may benefit from the existing research on family processes in stepfamilies. Clearly, these populations differ in the acts that precede the structural and boundary shifts that take place, but the underlying processes of adaptation are relevant. As with newly created stepfamilies, families after IPF must re-form family to manage changes in structure (e.g., losing and gaining household members) and dynamics (e.g., a caregiver’s assuming a new parenting role). Other similarities include conflicts of loyalty and attachment, unresolved loss, guilt issues, boundary ambiguity (who is “in” and “out” of the family system), and adult conflicts in front of children. After IPF, families may need transitional and long-term support as they negotiate workable arrangements that consider children’s needs and as they develop ways to reduce blame and conflict and facilitate a supportive family unit (Armour, 2002a). Similar to stepfamilies, some families affected by IPF may benefit from approaches that emphasize working together for the children (e.g., in conflicts between victims’ and perpetrators’ families). Both sides experience tremendous loss, and children suffer when family members blame one another. Part of the focus with stepfamilies involves learning to accept (or normalize) the complexity of family relationships, the varied responses based on developmental levels, conflicting emotions (e.g., missing dad but also blaming him), and dealing with unresolved loss. More research is needed to know if such approaches are transferable to families affected by IPF.

In addition to a family-centered approach, a strengths-based component would focus on families’ existing and potential strengths and resources. Existing studies highlight the numerous risk factors associated with maladaptation following IPF, with little attention to protective factors that promote resilient responses. Family’s use of ritual following IPF may be one way to foster family strengths while creating new family patterns that foster meaning and cohesion. Ritual can be important not only for healing but also for maintaining prior attachments. Research shows that rituals may aid families in making sense of tragic events and the changes that follow, which may be a promising area for integrating a strengths-based focus (Patterson, 2002). Making sense of the experience through ritual may also help to restore a sense of purpose and agency after tragic loss (Armour, 2002a). However, co-victims of homicide may find that normative grieving or healing rituals
are not sufficient for them given the magnitude of IPF (Patterson, 2002). Helping families develop appropriate rituals that embrace continuity of attachments and changes in roles and relationships and that consider the diverse needs of family members may help build on their strengths and foster resilience over time. More research is needed to understand what rituals are useful and how, which would inform intervention efforts that incorporate ritual development.

Finally, an advocacy component would not only connect families with resources but also transfer advocacy skills to families for long-term adjustment (Sullivan et al., 2002). By teaching advocacy skills, professionals extend services beyond the immediate crisis period and so empower families with a greater sense of agency and control over their situations. Such an approach can incorporate support for caregivers who wish to extend advocacy efforts toward helping other families affected by violence, given that this was helpful for some in the current sample.

Conclusion

Our purpose was to explore children’s and their caregivers’ adjustment after IPF in a sample of 10 families. We found that they experienced a unique pileup of stressors and hardships that taxed their ability to adjust, including prior exposure to domestic violence, direct exposure to IPF and its aftermath, other deaths and illnesses in the family, financial strains, and family conflict. Children experienced overlapping physical, mental, behavioral, and academic adjustment problems after IPF, and their caregivers managed the stress of parenting traumatized children and dealing with their own health issues. The complexity of their challenges points to the need for long-term, comprehensive support for these families, which the current sample lacked. Nonetheless, these families persevered by drawing on internal family resources, and they continued their efforts to cope with and make sense of their situations.

References


