20 Complicated grief after violent death

Identification and intervention

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Introduction

In periods of peace especially, violent deaths account for only a small percentage of total deaths, with, for example, 7% of annual deaths in the United States falling within the category of murder, suicide, and accidents (National Centers for Disease Control, 2009). However, there is considerable clinical evidence to support the premise that violent dying has specific and enduring effects on bereavement and grief (Rando, 1993; Rynearson, 2001). The violent death of a loved one is a traumatizing experience. In research on family members of murder victims, researchers have drawn attention to the likelihood of strongly intrusive and avoidant thoughts combined with hyperarousal, suggesting the presence of posttraumatic stress reactions (Parkes, 1993; Rynearson, 1994). Because of the often unexpected suddenness of violent death, combined with violation, and often intentionality or culpability associated with the death, those attached to the victim are not only vulnerable to levels of distress that are characteristic of reactions to non-violent deaths, but particularly prone to thoughts of remorse, retaliation, and fears of recurrence related to the act of violent dying. Furthermore, following the work of Janoff-Bulman, it has become widely accepted that fundamental assumptions people hold about themselves, the world, and the relation between these two may be shattered following traumatic loss (Janoff-Bulman, 1992; Matthews & Marwit, 2003), although recent evidence suggests that these effects may not be as strong as has been claimed (Mancini, Prati, & Bonanno, 2011).

In addition, complicating features can include having to deal with legal/crime-related matters and the media. The clinical effects of violent dying are, then, substantive and dynamically divergent from those of natural dying and may be associated with prolonged dysfunction, including complicated grief. These patterns of reactions lead to important questions in the context of this book: Do those who experience the loss of a loved one through violent death have a higher likelihood of suffering from complicated forms of grief? If so, what is the nature of difficulties associated with the grieving process among survivors of violent death? Who among this subgroup are the ones most vulnerable to complications? Can intervention help these persons to come to terms with their loss?

Although the clinical effects of violent dying appear indisputable, they are difficult to quantify and are rarely included in standardized measures of grief or noted in empirical studies. However, given the compelling clinical indications,

there is good reason to address the above questions scientifically and to evaluate the body of relevant research, particularly to give directions for future investigation. Unfortunately for current purposes, but not surprisingly given the nature and manifestations associated with violent death, the limited literature on bereavement following this type of death has focused largely on posttraumatic stress symptoms and disorder rather than complicated grief (e.g., Kaltman & Bonanno, 2003; Mancini, Prati, & Black, 2011; Murphy, 2008). However, violent death has typically been understood to trigger two concurrent but distinct syndromes: (1) separation distress as a response to the lost relationship (with feelings of longing, etc.), and (2) traumatic distress in reaction to the manner of dying (with re-enactment thoughts, etc.) (Rynearson & Sinnema, 1999). Following this distinction, the former can be understood as relating to (complicated) grief, the latter to posttraumatic stress (disorder), suggesting the need for scientific understanding of both types of reactions.

Given the focus of the whole book, in this chapter we examine the phenomena and manifestations of *complicated grief* following violent death. We follow the definition of complicated grief provided by Stroebe, Hansson, Schut, and Stroebe, (2008):

> a deviation from the (cultural) norm (i.e., that could be expected to pertain – importantly – according to the extremity of the particular bereavement event) in either (a) the time course or intensity of specific or general symptoms of grief and/or (b) the level of impairment in social, occupational, or other important areas of functioning. (p. 7)

Different forms of complicated grief have been identified in the scientific literature with various labels frequently being attached to them, the main ones being prolonged or chronic, delayed/inhibited, and absent grief (see, for example, Chapter 5 in this volume). It becomes evident that we are talking then of "complicated grief" in terms of a *clinically relevant syndrome*.

Consideration is first given to the concept of violent death in the context of bereavement. Then, in the main part of the chapter, empirical literature on complicated grief following violent death is critically assessed. The focus is on well-designed, quantitative studies.[1] The review covers bereavement following different types of violent death, including studies of homicide, suicide, accident, and natural death. It assesses what we know about complicated grief across these violent and non-violent types of loss in terms of its prevalence and distinctive features, risk factors, models/techniques for assessment, and intervention efficacy. More general concerns about the state of research knowledge are also addressed. Finally, we draw general conclusions and set a research agenda for the future.

On the definition of violent death

In the scientific literature, violent deaths have been defined as those resulting from accidents, suicide, or homicide (e.g., Cleiren, 1991; Mancini, Prati, & Bonanno, 2011), and in many international classification systems these three alternative

causes are listed alongside a fourth category, "natural death," featuring illnesses. The category of "fatal accident" includes vehicle crash, drowning, and natural disaster (Currier, Holland, & Neimeyer, 2006). Grouping deaths due to these three causes into the violent death category is usual in the trauma literature (e.g., Kaltman & Bonanno, 2003; Norris, 1992), although it must be noted that some deaths in these categories may not be violent in the sense that they may not be an expression of physical force against other persons (e.g., death from suicide through overdose of sleeping pills, hospital accidents with anesthetics). Traumatic loss is defined mainly in objective terms as a sudden and violent mode of death, characterized by one of the above-mentioned three causes. Violent death is thus more specific than another frequently used categorization including sudden, unexpected, and traumatic death (e.g., Fujisawa et al., 2010). Further to the former categorization, Rynearson's "3 V's" – violent, violation (transgression), and volition (intentional or freely chosen on part of perpetrator or victim) – may pinpoint useful defining properties of these types of death. Not all of the 3 V features may be equally applicable to the different types of violent deaths (e.g., volition does not seem to fit accidents as much as homicide).

Does such a definition into the above three types of violent death suffice? In contemporary society one might consider further specification of the violent categories in terms of military attack, including genocide, and terrorism. However, these massive types of loss are beyond the scope of this chapter, although from a certain perspective these would fall under homicide.[2] Furthermore, euthanasia may merit separate consideration in the context of impact on bereavement, for this too is a non-natural cause of death (though related to natural causes such as cancer), associated with unique bereavement reactions. Like suicide deaths, those following euthanasia take place with the agreement of the "victim." However, regardless of one's opinion on euthanasia, such a death is difficult to include under violent deaths.

A further note of caution is in order when drawing a simple distinction between violent and non-violent (or "natural") deaths. The words of Barry, Kasl, and Prigerson (2002) express the point in relationship to bereavement:

> Researchers commonly classify deaths as violent or non-violent according to how the death occurred. Importantly, deaths perceived to be violent by bereaved individuals may not be classified as violent according to the manner in which earlier studies have defined violent deaths. Such may be the case for a natural death that is accompanied by much pain and physical illness. A death such as this may be perceived as violent by the surviving family member. (p. 454)

Categorization may thus be inaccurate not only because of a failure to specify subcategories of violent death, as mentioned above, but also because deaths may be perceived differently from the formal cause by bereaved survivors. We need to keep this in mind but at the same time we need to be aware of the risk that what are generally regarded as rather clear concepts – such as violent and non-violent causes of death – run the risk of becoming fuzzy, following such reasoning.

Violent death and complicated grief: assessment of the scientific literature

Although there are promising directions in research on this topic, there are also limitations in availability of sound empirical research on bereavement following violent death. It will become evident in our review of the literature, which follows, that there are even fewer studies that stringently examine complicated grief following violent death. Nevertheless, in our view, it is important to assess what is known so far, so that future research can build on the available empirical literature. Furthermore, with this interest in mind too, and in contrast with some other reviewers and researchers conducting empirical research (e.g., Currier, Holland, Coleman, & Neimeyer, 2008; Vessier-Batchem & Douglas, 2006) we made the decision to follow very stringent criteria for complicated grief, in line with the scope of this volume.

Prevalence of complicated grief

With considerable consistency, studies have shown higher intensities of grief following violent than non-violent causes (e.g., Currier et al., 2008; Dyregrov, Nordanger, & Dyregrov, 2003; Mancini, Prati, & Black, 2011), but these do not inform us about *complicated* grief (as a clinically relevant condition). As Hardison, Neimeyer, and Lichstein (2005) commented: "Higher scores [on their complicated grief scale] represent greater impairment . . . [providing] a continuous measure of intensity of grief-related symptomatology *rather than a classificatory diagnosis of complicated grief disorder*" (pp. 103–4; italics added).

When cut-off points on questionnaires have been used as indicators of complicated grief (i.e., also not diagnostic categorization), those bereaved from violent causes seem to have excessive rates compared with norms for the bereaved in general. Although one must be cautious about inferring prevalences of complicated grief from such sources (further application of diagnostic criteria and professional clinical assessment is needed), some indication may be derived. For example, Ghaffari-Nejad, Ahmadi-Mousavi, Gandomkar, and Reihani-Kermani (2006) examined the prevalence of complicated grief (intensity) following the Bam earthquake in Iran, which killed thousands. Scores over the established cut-off point for complicated grief were present among 76% of their large sample of respondents. Dyregrov et al. (2003) reported that 78% of parents following the violent loss of their child (suicide or accident) scored above the cut-off levels for complicated grief reactions 1.5 years post loss. The above prevalences are in excess of rates found for complicated grief irrespective of mode of death (which is typically within the range of 5–33%; see Forstmeier & Maercker, 2006). However, the data are not totally conclusive, since some studies do not find higher prevalence of complicated grief after violent death, although this may be because population samples include only small numbers of people bereaved by violent death (e.g., Kersting, Brähler, Glaesmer & Wagner, 2011).

Some researchers have drawn conclusions about the comparative impact of the different modes of violent death (e.g., Cleiren, 1991; Currier et al., 2008;

Dyregrov et al., 2003). For example, in terms of highest ICG scores, Currier et al. (2008) reported homicide to be the most perturbing cause of death, followed by suicide, accidents, natural sudden, and natural anticipated deaths. Dyregrov et al. (2003) found similar differences in high levels of grief among bereaved parents following the death of their child as a result of suicide or accident. Some studies have focused on intensity of symptoms following loss from specific types of violent death compared with non-violent death, for example for suicide (Bailley, Kral, & Dunham, 1999), providing insights into differential types of reactions, but so far not comparing prevalences of complicated grief across types of death.

Distinctive features of complicated grief

Just as there are no scientifically stringent studies comparing the prevalence of complicated grief reactions following violent as compared with non-violent causes of death, so is there little sound investigation of distinctive features across these modes of death. The literature on bereavement following homicide is a case in point. There is frequent reference to the excruciating, long-lasting, and extremely complex reactions following this type of loss (e.g., Horne, 2003; Pynoos & Nader, 1990). Causal statements (e.g., about mechanisms contributing to resilience) are often made on the basis of small-scale qualitative studies of the homicide bereaved (e.g., Burke, Neimeyer, & McDevitt-Murphy, 2010; Johnson, 2010). Although these studies provide fine-grained descriptive accounts of what these persons are encountering, it remains unclear to what extent the identified reactions are characteristic of bereavement in general, or specific to homicide bereavement in particular. Clearly, for this purpose, one needs to compare homicide bereaved with other bereaved groups.

Are there any studies of complicated grief that have included control groups of bereaved from non-violent death causes, to take us a step further toward discerning unique bereavement reactions following the different types of loss? To our knowledge, only one study comes near to reaching the necessary criteria. McClatchey, Vonk, and Palardy (2009) investigated the prevalence of "childhood traumatic grief" (CTG) among bereaved children, using a cut-off score indicating "clinically-significant frequency" (p. 312). Children who had lost a parent through violent/sudden or through expected death were compared. Rather in contrast to what one would expect from studies reviewed so far, the incidence of CTG did not differ between these groups. However, it must be noted that this study did not completely follow our definition for violent death: This category included sudden non-violent deaths (heart attacks). This may partly explain why no differences were found between the groups.

Risk factors

Not surprisingly, given the state of knowledge described above, no information is available about risk (or protective) factors that may make some individuals more (or less) vulnerable to complicated grief following a death through murder,

suicide, or accident. Future research needs to cover a broad range of risk/protective factors. So far, leads have been provided by researchers examining the relationship between intensity of grief and sense making or meaning making and found these factors to be particularly problematic following violent (compared with non-violent) death circumstances (e.g., Currier et al., 2006, 2008). Likewise, based on previous research (e.g., Wickie & Marwit, 2000), there are good reasons to assume that the shattering of world assumptions should be systematically and differentially related to mode of death. Furthermore, in a recent study by Mancini, Prati, and Black (2011) self-worth was found to mediate the effects of violent loss on posttraumatic stress symptoms and depression, but not on levels of grief. However, extension beyond meaning making and world assumptions to other intra- and interpersonal risk and protective factors is essential.

Conclusions

Our review of the empirical literature has revealed that there is remarkably little sound empirical research on complicated grief following violent compared with non-violent death. Such comparisons are essential to establish the unique consequences of violent types of death. Quite consistently, studies have shown higher intensities of grief following violent than non-violent causes, but these do not inform us about *complicated* grief. Likewise, those bereaved from violent causes seem to have highly excessive rates compared with norms for the bereaved in general, but evidence is weak: We could not find a single well-controlled study that compared complicated grief rates following violent versus non-violent death. A research design to overcome these gaps in the literature would comprise a (preferably) longitudinal comparison across violent and non-violent modes of death of the prevalence and manifestations of complicated grief assessed by means of clinical interviews. The ideal study would be large-scale, use a prospective design, assess violence incrementally, not use cause of death and violence interchangeably, and consider the circumstances of the bereaved. A research agenda for the future should include examination of risk/protective factors, map different patterns of complications following different causes of violent death, and go beyond diagnosis based on total symptom score, to consider complicated grief due to some particular, idiosyncratic feature. Furthermore, we need to test the models and strategies of psychotherapeutic intervention; examining the effectiveness of these programs is critically important.

Even with such guidelines, the challenge remains for researchers and clinicians to decide who among the bereaved should be included in the complicated grief category in future investigation of bereavement following violent death. As stated earlier, our interest is in complicated grief as a clinically relevant syndrome. Simply using a continuous measure of intensity of grief symptoms that indicates increasing impairment is not – in this context – informative (it simply shows the intensity of grief-related symptomatology). Using a validated cut-off point to ascertain the likelihood of complicated grief is at least a first step toward establishing the presence of complicated grief. However, this by itself is not

sufficient when we are striving to investigate complicated grief as a clinically relevant syndrome. Thus, as indicated above, in our view, it is necessary for trained professionals to conduct clinical interviews to establish "complicated grief." The criteria they use for determining this are also not set in stone, but are currently likely to include use of a cut-off point on a validated grief questionnaire for initial screening, making use of criteria proposed for the future DSM category system, and further information from the bereaved person in the clinical interview(s).

Violent death and complicated grief: conceptual issues

We have already considered the definition of *complicated grief* in some detail. However, other conceptual issues arise from our review. In particular, when suggesting new directions for research, it is important to step back and consider whether extension of current directions is sufficient, or whether we should be extending the scope of our investigation. Although far from comprehensive, the following two issues illustrate the sorts of extensions that we think deserve attention.

Different causes, different complications?

Finer-grained quantitative examinations of comparative *patterns* of complication associated with the different types of violent death are completely lacking. Studies that have provided qualitative or descriptive accounts of bereavement following the different modes of death can be drawn on for identification of variables for inclusion in future studies (see, for example, Armour, 2006, for comparison of experiences among those bereaved following accidents, suicide, and homicide). It is noteworthy that there are more qualitative studies focusing on homicide (e.g., Asaro, 2001a, 2001b; Burke et al., 2010; Clements & Burgess, 2002; Goodrum, 2005) and suicide (e.g., for reviews, see Jordan, 2008; Jordan & McIntosh, 2010; Sveen & Walby, 2007) than on accidents. A notable exception is the study of traffic accident survivors by Lehman, Wortman, and Williams (1987), although, again, the focus is not on complicated grief but on other consequences such as depression and general psychiatric symptoms. Thus, more studies specifically on (complicated) grief reactions following accidental death circumstances are needed too.

A few studies have looked in general (i.e., not cause of death specifically) at the comorbidity of complicated grief with posttraumatic stress disorder, depression, or anxiety disorders (e.g., Morina, Rudari, Bleichhardt, & Prigerson, 2010) but, to our knowledge, none have compared patterns of comorbidity following violent versus non-violent causes.

Accumulation of symptoms versus idiosyncratic complications?

Complicated grief may be overlooked if the focus is limited to high accumulated levels of symptoms or even diagnostic assessment, rather than identifying essential and unique bereavement reactions relating to a particular mode of death (violent

and non-violent). In other words, assessment of complicated grief following a violent death which is based on an initial score above a prescribed cut-off point on a questionnaire and/or confirmed by diagnostic investigation may still exclude persons who do suffer complications. Following violent death, complications in the grieving process may have more to do with a specific aspect than elevation of symptoms, or accumulation of symptoms, to reach diagnosis. For example, following suicide, a specific difficulty may have to do with the overwhelming feeling that one should have prevented the death, or with the extreme strain of feeling one has to keep the actual cause of death a secret. These types of thoughts are reported more frequently following suicide than following other types of death (Bailley et al., 1999). In this context, it is important to note that assessment of the level of grief may vary according to whether general grief instruments or mode-of-death-specific instruments are used (see Sveen & Walby, 2007, for suicide bereavement).

Psychotherapeutic intervention following violent death

The review of empirical evidence presented above identifies limited, yet valuable, knowledge about complicated grief following violent death and areas for research in the future. However, as will have become evident from the preceding review, although such lines of investigation are potentially informative, they are unlikely to provide a comprehensive picture, and certainly not one that is sufficient for clinical purposes. They can usefully be complemented – and enriched – through examination of principles of psychotherapeutic intervention and assessment. In our view, there are good reasons to bring research and practice together to address these topics, to provide further insight into complicated grief following violent death, which will also contribute to the forthcoming research agenda.

Effects of psychotherapeutic interventions

Given that few studies have specifically isolated complicated grief reactions following violent deaths, it is not surprising that there is little information available about the efficacy of intervention programs specifically on complicated grief following violent loss. Very few studies have even focused on other consequences of intervention (e.g., on lowering posttraumatic stress symptom levels) for bereaved persons after violent death. Most of the studies that have done so also include people who have encountered other impactful events without lethal consequences (e.g., Brom, Kleber, & Defares, 1989; Layne et al., 2008). These studies do find positive results of the interventions put to the test, but results are not presented for bereaved and other victims of these events separately, and no attention is paid specifically to recovery from complicated grief.

A study conducted by Murphy (Murphy et al., 1998; for a recent overview, see Murphy, 2008), however, specifically focused on parents who have lost a child through suicide, homicide, or accident. In this study, the parents were randomly assigned to a mixed problem- and emotion-focused intervention condition or a non-intervention control group. Results show that mothers with high initial levels

of distress improved more in the intervention condition than did similar mothers in the control condition. By contrast, mothers with relatively low levels of distress at baseline were worse after intervention than the control group. The number of fathers participating in the study was small, but results did not indicate an effect of the intervention for fathers. The impact specifically on complicated grief, however, was not investigated in this study (the grief measure was an unvalidated scale developed by the investigators for this particular study).

A recent review by Szumalis and Kutcher (2011; for a further review, see McDaid, Trowman, Golder, Hawton, & Sowden, 2008) summarized results for the effectiveness specifically for postsuicide intervention programs, including their impact on grief symptoms (though again not specifically on complicated grief). Improvements in grief experiences, both short and long term, were reported.

These results are promising in that they suggest that intervention programs may be effective in reducing distress, but it is evident that more research into the effects of intervention after (specific types of) violent bereavement is needed too, and for subgroups undergoing complications in their grieving.

Turning to specific techniques of assessment: At this time, to the best of our knowledge, there are five manualized, time-limited, focused interventions specifically designed for non-natural dying. Three of these (Cohen et al., 2006; Layne et al., 2008; Salloum, 2008) have been designed for children and adolescent outpatients and two (Rynearson et al., 2006; Murphy, 2008) for adults. Although evidence so far seems to suggest decrease of grief symptoms and trauma distress, further methodologically sound investigations are needed to establish efficacy (only the Murphy study met the necessary criteria for current purposes). Four of the interventions applied combined techniques from CBT and narrative therapy. CBT principles included structured, time-limited agendas (10–12 individual or group sessions), relationship-based collaboration, clarification of connections between thoughts, feelings, and behaviors, affirmative guidance, relaxation exercises, modeling, and teaching techniques of imaginative exposure. We illustrate this by describing next the two adult approaches developed by Murphy and Rynearson.

The support groups designed by Murphy and colleagues (e.g., Murphy, 1996; Murphy, Baugher, Lohan, Schneidermann, & Herrwagen, 1996; Murphy et al., 1998) included problem-focused and emotion-focused support. This program was professionally led, and designed specifically for parents who had lost a child to violent death. Twelve sessions of 2 hours were held, one each week. The first hour in each session (apart from the first and last, which were data-collecting sessions) was dedicated to the problem-focused support dimension of providing information and building coping skills, addressing areas such as managing cognitive and emotional responses; health issues; parental role loss; legal concerns; partner and family relationship concerns; feelings toward others; and expectations for the future. The second hour, of more direct emotion-focused support, assisted parents to share their experiences; obtain feedback to help reframing of aspects to do with the death and its consequences; and receive emotional support.

Narrative therapy (Rynearson, 2010; see also Currier & Neimeyer, 2006, and Currier et al., 2008, for their related meaning making approach) contrasts in some respects with the problem- and emotion-oriented support program of Murphy and colleagues. Strategies based on the narrative approach encourage the retelling of the living and dying story of the deceased with a restorative goal of creating a more plausible and coherent retelling of the narrative imagery, of re-enactment, promoting alternative outcomes and a transcendent perspective. Rynearson (2010) recently described his narrative therapy approach in some detail. According to this perspective, in the case of violent death, storytelling is distorted, focusing intensely, even obsessively, on a re-enactment of the dying (further complicated by the public and legal processes surrounding this type of death). Fundamental to this approach is the understanding that established clinical assessment principles (based on narrative analysis) and associated constructs for guiding therapeutic interventions give insight into complicated grief following violent death. It is understood that, in order to assess the impact of the death on the bereaved person, the clinician needs to listen to and help the client to revise his or her personal account of the loss and its aftermath. This is likely to be necessary for bereavement in general, but it may be even more important after violent death. Characteristic of narratives of bereavement after violent death are themes of horror and helplessness and topics such as remorse, re-enactment, retaliation, and retribution that distort the dying story structure (Currier & Neimeyer, 2006).

The procedures of Murphy and Rynearson may overlap, insofar as participants presumably shared their narratives of the living and dying of the deceased spontaneously during the support group of Murphy and colleagues. There are also apparent differences between the Murphy and Rynearson (and other) approaches (the Murphy program has no sessions of direct exposure and retelling of the traumatic dying re-enactment, whereas the Rynearson one does). However, none of the manualized interventions cites a specific corrective mechanism, and that is presumably because the explanation of treatment effects is non-specific. It seems plausible that the various interventions are successful because they are based upon the common principles of stress moderation, reconstructive exposure, and meaningful re-engagement, which are basic to time-limited trauma or grief treatments. Three main goals of such interventions are (see also Rynearson, Correa, Favell, Saindon, & Prigerson, 2006):

1 The moderation of distress (through a confiding relationship, a safe setting, psychoeducation and stress reduction strategies) that fosters mastery of personal safety and autonomy.
2 Exposure and reconstructive processing of the dying and grieving narrative through an active procedure of reliving the narrative fixation (through imaginary verbal and non-verbal retelling). This would foster coherence and motivation for re-engagement by revising the teller's role (identity) within the narrative.

3 Meaningful re-engagement with valued, vital activities and relationships within the family and community in an altered identity that honors the transformation.

Apart from the Murphy investigation (which included examination of grief reduction but not of clinically assessed complicated grief), we know of no studies that have put such approaches to strict scientific test. Nor do we know of any that have compared these assessment techniques in relationship to the effectiveness of an intervention based on their protocol. Specific investigation of their impact on complicated grief for bereaved persons following violent loss is also lacking. These are all matters for future investigation. A useful strategy would be to follow the example of Shear, Frank, Houck, and Reynolds (2005), who conducted a study of the efficacy of intervention for bereaved persons with complications in their grieving, comparing the efficacy of two different scientifically based programs. They assigned their clients either to traditional interpersonal psychotherapy or to a treatment program that followed the principles of a specially derived protocol, based on the dual-process model (see Stroebe & Schut, 1999), called complicated grief treatment, and examined the course of their grief over time (the latter treatment program was associated with faster and better adjustment). Naturally, inclusion of a non-intervention control group to compare the treatment conditions with natural recovery trajectories would be advisable; this was not feasible in the Shear et al. (2005) study. For our current interests, it would be useful to extend such intervention efficacy examination of its impact on those bereaved following the violent death of a loved one, specifically. It is useful to note in this context that Asukai, Tsuruta, and Saito (2011) recently conducted a pilot study using a modified version of Shear and colleagues' complicated grief treatment for a small sample of Japanese women bereaved by violent death. The results were promising, with reporting of a significant reduction of grief symptoms but, as for the Shear et al. study, a non-intervention control condition was not included.

General conclusions

To convince governments and funding agencies of the importance of supporting those dealing with the violent death of a relative, one needs, first, to demonstrate that these survivors encounter greater and/or different extreme difficulties than do other bereaved persons and, second, to show how professional intervention can actually help reduce suffering associated with this type of death. However, our review of scientific evidence on complicated grief following violent death revealed remarkably little sound knowledge to date in terms of recovery from complicated grief through intervention. However, research is moving toward addressing issues surrounding the prevalence of complicated grief and comparing violent and non-violent causes. Although more fine-grained research is needed, results do suggest violent death to be a risk factor for complicated grief. We highlighted new research directions, ranging from prevalence (e.g., good comparative studies of impact, focusing on symptomatology and complicated grief "caseness")

to intervention efficacy studies (to elucidate what works best for whom, following specific types of violent death). As illustrated above, promising research along these lines is already being conducted (e.g., Fujisawa et al., 2010; Kersting et al., 2011). We outlined how different approaches, including the narrative approach to clinical assessment and intervention, can fuel future research, and how such approaches provide guidelines for the treatment of complicated grief experienced by some bereaved persons following the violent death of a loved one. We hope that researchers and practitioners can work together toward building a solid knowledge base, thereby improving the evidence base of care for these bereaved persons.

Notes

1 It is beyond the scope of this chapter to cover qualitative investigations of complicated grief following violent death. In fact, most qualitative studies also highlight posttraumatic stress rather than complicated grief reactions.
2 For an example of empirical research in this category, see Schaal, Jacob, Dusingizemungu, and Elbert (2010). For a review of the consequences of disasters on individuals, families and communities, see Bonanno, Brewin, Kaniasty, and La Greca (2010).

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