

# Domains of Social Support That Predict Bereavement Distress Following Homicide Loss: Assessing Need and Satisfaction

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## Abstract

Psychological adaptation following homicide loss can prove more challenging for griever than other types of losses. Although social support can be beneficial in bereavement, research is mixed in terms of identifying whether it serves as a buffer to distress following traumatic loss. In particular, studies have not parsed out specific domains of social support that best predict positive bereavement outcomes. Recruiting a sample of 47 African Americans bereaved by homicide, we examined six types of social support along with the griever's perceived need for or satisfaction with each and analyzed them in relation to depression, anxiety, complicated grief, and posttraumatic stress disorder outcomes. Results of multivariate analyses revealed that the griever's level of satisfaction with physical assistance at the initial assessment best predicted lower levels of depression, anxiety, and posttraumatic stress disorder levels 6 months later, while less need for physical assistance predicted lower complicated grief at follow-up. Clinical implications and suggestions for future research are discussed.

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The loss of a loved one is an unparalleled, profound, and challenging life event for many individuals. Griefers experience a range of symptoms that fall along a continuum. On one end, some individuals respond to their loss in a resilient manner (Bonanno & Kaltman, 2001) with little in the way of psychological distress, while others respond by exhibiting symptoms of acute, but time-limited grieving (Bonanno & Mancini, 2006), and still others suffer with symptoms indicative of clinically significant and persistent depression, anxiety, posttraumatic stress disorder (PTSD), or complicated grief (CG; Maercker, Neimeyer, & Simiola, 2016).

Loss often is magnified when the mode of death is unexpected and violent, particularly following homicide (Burke & Neimeyer, 2014; Currier, Holland, Coleman, & Neimeyer, 2007). Rynearson (1995) posits that homicide can herald a particularly discordant and prolonged bereavement for survivors. However, few people bereaved by a homicide seek professional treatment (Rynearson, 1995), implying that many rely on their respective social support networks to aid them in their grieving. Unfortunately, investigations of social support as a buffer against poor bereavement outcome have yielded mixed results (Stroebe, Zech, Stroebe, & Abakoumkin, 2005), calling for more fine-grained research examining specific domains of support, for instance. Thus, the goal of this article is to explore the role of specific types of social support in ameliorating psychological distress following the loss of a loved one to homicide, specifically in relation to the griever's level of perceived need for and satisfaction with the support received.

The Centers for Disease Control and Prevention (2013) uses a National Violent Death Reporting System to track the incidence of violent deaths and to determine ways to prevent them. The Centers for Disease Control and Prevention defines violent death as “a death that results from the intentional use of physical force or power, threatened or actual, against oneself, another person, or a group or community” (“Injury Prevention and Control,” para. 1). Annually, approximately 56,000 people die violently in the United States. Roughly, 17,000 (30%) of those deaths are a result of murder.

**Bereavement Outcome Following Homicide Loss**

Contemporary research has documented levels of psychological distress in survivors of homicide. And while a handful of studies found no correlation between bereavement outcome and violent death loss (Feigelman, Jordan, &

Gorman, 2009; Prigerson et al., 1997; van der Houwen et al., 2010), a growing body of research indicates the opposite. Comparing CG rates for survivors of natural death loss (i.e., 10%–15%; Prigerson et al., 2009), research documents disproportionately high levels of bereavement distress among violently bereaved adults, with CG rates ranging between 31% and 70% (McDevitt-Murphy, Neimeyer, Burke, & Williams, 2011; Mitchell, Kim, Prigerson, & Mortimer-Stephens, 2004; Momartin, Silove, Manicavasagar, & Steel, 2004; Shear, Jackson, Essock, Donahue, & Felton, 2006). Thus, not surprisingly, violent death has been classified as an established risk factor for CG (Burke & Neimeyer, 2012) based on results from numerous studies (e.g., Currier et al., 2007; Gamino, Sewell, & Easterling, 2000; Keesee, Currier, & Neimeyer, 2008).

Likewise, studies conclude that the traumatic nature of homicide leaves survivors more vulnerable than survivors of other types of losses to a variety of other deleterious psychological outcomes including depression, anxiety, CG, and PTSD (Burke & Neimeyer, 2014; Currier et al., 2007; Murphy, Johnson, Wu, Fan, & Lohan, 2003; Rynearson, 1984; Rynearson & McCreery, 1993), as well as complicated spiritual grief—a crisis of faith following loss (Burke & Neimeyer, 2014). Moreover, these effects often are enduring, as family members continue to experience troubling and severe symptoms several years post loss (e.g., Kessler, Berglund, Demler, Jin, & Walters, 2005; Kessler, Chiu, Demler, & Walters, 2005; McDevitt-Murphy et al., 2011).

To illustrate, in a study with 54 African American homicide survivors, McDevitt-Murphy et al. (2011) discovered that significant numbers screened positive for various forms of bereavement distress: 54% ( $n = 29$ ) for CG, 44% ( $n = 24$ ) for depression, 46% ( $n = 25$ ) for anxiety, and 19% ( $n = 10$ ) for PTSD, with the majority showing comorbidity for these conditions. The high level of psychopathology found in McDevitt-Murphy et al.'s (2011) study calls for follow-up research on factors that could mitigate distress in this vulnerable population.

Williams, Burke, Neimeyer, and McDevitt-Murphy (2012) conducted a longitudinal follow-up assessment of bereavement distress in this same sample. They discovered that bereavement distress was negatively and strongly associated with poor general mental health functioning and emotional well being. In fact, an increase in depressive symptoms across 6 months was associated with a worsening in mental health functioning over time, even after controlling for PTSD and CG. Specifically, they found unique associations related to each form of bereavement distress they measured, such that PTSD was most strongly associated with emotional role limitations, CG with impaired social functioning, and depression with multiple impairments in mental health functioning, including less vitality, social functioning, and overall mental health.

## Social Support and Bereavement Distress

Social support refers to the emotional, economic, and practical help or information provided to the affected individual by significant others (Dyregrov, 2003). Scholars have stressed the important role of social support in alleviating general distress (e.g., Thoits, 2013; Thuen, 1997; Uebelacker et al., 2013), in reducing grief symptomatology (Dyregrov, 2003), and in facilitating psychological adaptation following violent loss (Burke, Neimeyer, & McDevitt-Murphy, 2010). Likewise, clinicians commonly encourage the bereaved to reach out to different kinds of people in their social support system who are “doers” (those who can provide practical assistance), “respite figures” (activity companions), and “listeners” (those who can hear the mourner’s distress without rushing to advise), while avoiding “negative” figures (those who would criticize the bereaved; Doka & Neimeyer, 2012).

Overall, however, findings related to social supports’ buffering effects in relation to distress have been mixed (Stroebe et al., 2005). For instance, some investigations suggest that social support is directly associated with better physical and mental health, routinely acting as a bulwark against the impact of adverse life events (Thoits, 2013; Thuen, 1997), and chronic strain, such as bereavement (Vanderwerker & Prigerson, 2003). In terms of grief, some studies show that perceived social support has no relation with bereavement outcome (Stroebe, Stroebe, Abakoumkin, & Schut, 1996). Specifically, a meta-analysis of the influence of social support as a buffer against problematic and protracted grief found that social support failed to moderate the impact of bereavement on distress levels (Stroebe et al., 2005). Conversely, studies with normative grievers suggest that social support acts as a protective barrier against depression (Norris & Murrell, 1990). Seemingly paradoxically, researchers also have found that intended social support might be experienced as a negative influence during bereavement and, thus, have an effect contrary to its purpose, particularly when it is perceived as intrusive or voyeuristic (Burke et al., 2010).

Instrumental/tangible social support (also referred to as physical assistance<sup>1</sup>) has been defined as assistance with everyday tasks such as providing transportation, running errands, and doing chores (Thoits, 2011). Physical assistance as a form of social support can promote general mental health. For example, in contrast to emotional support, instrumental support served as a buffer between life stressors and depressive symptomatology in a sample of 320 community members (Wilcox, 1981). Similarly, studying 835 elderly individuals, Cook, Pearson, Thompson, Black, and Rabins (2002) found that an absence of instrumental support was correlated with active suicidality. Based on such research, Thoits (2011) theorized that instrumental aid is the most effective form of social support in terms of assuaging the deleterious effects of stress—specifically, by directly lessening the distressed individual’s situational demands and by conveying the message that he or she is valued.

Homicide trauma, along with its accompanying psychological distress and stigma, may impair grievers' efforts to interact socially as they once did, which, compounded by the anxiety or awkwardness of previous network members, can lead to a potential shrinkage of one's support system. Burke et al. (2010) found in a sample of homicidally bereaved adults that both smaller social support networks and higher levels of negative interactions were associated with higher levels of depression, CG, and PTSD among survivors. On the other hand, Bonanno et al. (2002) examined pre- and postloss data from a sample of 205 conjugally bereaved older adults and found that resilient mourners received more instrumental support than chronic grievers, depressed-improved survivors, and chronically depressed participants.

Despite instrumental support's being shown to be the most effective buffer of general stress in nonbereaved samples, with few exceptions (Bonanno et al., 2002), studies on the role of physical assistance in lowering distress following loss are rare in bereavement literature.

### *Need for Social Support Following Loss*

The common advocacy for social support in grief implicitly assumes that bereaved individuals actually desire such assistance and attention. However, this assumption has rarely been examined. Limited existing studies suggest that the need for social support emerges as family members anticipate their loved one's death (Eilertsen, Eilegård, Steineck, Nyberg, & Kreicbergs, 2013) and also extends into bereavement, specifically in relation to such things as instrumental assistance and advice (Somhlaba & Wait, 2008). Practical assistance may be especially important in underresourced communities, when the loss of a loved one also can imply substantial reduction in instrumental support in meeting the demands of daily living, not to mention the additional burdens imposed by bereavement, per se.

### *Satisfaction With Social Support Following Loss*

Beyond the provision of support, some studies have investigated mourners' satisfaction with the assistance they have received. For instance, in Grad, Clark, Dyregrov, and Andriessen's (2004) study of 187 suicide survivors, bereaved individuals were prompted to list the most desirable type of help they had been given. Mourners expressed satisfaction with receiving details about the nature of suicide, psychoeducation about bereavement, and specific facts about their loved one's death. Beyond that, they endorsed appreciation for being respected and given permission to mourn in their own time frame. In comparison, the 16 bereaved parents studied by Toller (2011) indicated that satisfactory social support involved willingness to engage in conversations about their deceased child, indicating that supporters respected the ongoing

bond the parents maintained with the child. Similarly, the 94 bereaved spouses and parents studied by Davis, Lehman, Silver, Wortman, and Ellard (1996) expressed satisfaction in being allowed to fully express their grief, to talk about their deceased loved one, and with receiving encouragement to move through the bereavement process and participate in social events. Simply being present and concerned, and providing concrete support likewise was endorsed as helpful. Additionally, Nolen-Hoeksema and Davis' (1999) investigation of 106 family members of hospice patients documented satisfaction with supporters allowing grievors to openly discuss their loss, and helping the griever to feel that he or she was an integral part of their social network. Conversely, when supporters have not experienced a similar loss, grievors consider their support to be less satisfactory (Barlow & Coleman, 2003). In fact, when 63 survivors of suicide in McMenemy, Jordan, and Mitchell's (2008) study were asked to determine the most satisfactory means of social interaction with supporters, 83% of them ranked highest having 1:1 conversations with another person bereaved by suicide.

Satisfaction with social support has important bereavement outcome implications, as well. For example, siblings bereaved by cancer ( $n=174$ ) who endorsed low social support satisfaction had nearly four times the level of anxiety as did responders who were more satisfied (Eilertsen et al., 2013). Villaceros, Serrano, Bermejo, Magaña, and Carabias (2014) examined satisfaction with available social support in a sample of 130 middle-aged grievors. They found that high levels of satisfaction with available social support predicted low levels of CG. Finally, another study of 156 suddenly bereaved family members (Sherkat & Reed, 1992) found an association between satisfaction with support received on the one hand and lowered depressive symptomatology and increased self-esteem on the other.

The lack of consensus in the literature regarding social support as a buffer to bereavement distress as well the need to assess the generalizability of findings to minority populations calls for further investigation. Moreover, because death from homicide stands apart as a particularly distressing type of loss, research is needed on adaptation to this form of trauma and the role of specific domains of social support during the mourning period.

## Study Aims

Research on the role of social support following traumatic death is limited, as are studies investigating whether social support affects bereavement outcome. Those that do exist are often contradictory. Burke et al. (2010) found that high levels of available support were associated with low levels of CG and depression. However, they did not investigate distinct domains of social support (e.g., physical assistance, positive feedback) or the griever's perceived need for or satisfaction with support, both of which could help predict subsequent grief reactions.

This study's aim is to build upon previous findings showing that aspects of social support protect against problematic grief in homicide survivors (Burke et al., 2010) and to analyze specific domains of social support that best shield survivors from negative grief outcomes. Because physical assistance has been shown to decrease distress, generally, and bereavement distress, specifically, we hypothesize that at entry into the study (referred to as Time 1; T1) (a) social support, specifically in the form of physical assistance (as measured by the Arizona Social Support Interview Schedule; ASSIS; Barrera, 1981), will be inversely related to bereavement scores measuring depression, anxiety, CG, and PTSD at the 6-month follow-up assessment (Time 2; T2). Moreover, because studies with grievors frequently cite forms of physical assistance as being satisfying, and given that research with a variety of samples shows that satisfaction with social support received was associated with lower bereavement symptomatology, we predict that (b) satisfaction with physical assistance at Time 1 will emerge as the most robust predictor of bereavement outcome scores at Time 2 across all outcomes (i.e., depression, anxiety, CG, and PTSD) in this sample.

## **Method**

### *Participants*

Participants were 47 African American adults bereaved by the homicide of a loved one, who were recruited through Victims to Victory (VTV), a faith-based organization that collaborates with local law enforcement agencies to offer crisis counseling, victims' advocacy, and other services to all survivors of homicide in a large city in the mid-South. Demographic and loss-related descriptions of the sample appear in Table 1.

### *Procedure*

Participants for this study were recruited from VTV, a grassroots victim services organization with an explicitly faith-based orientation; however, endorsement of faith was not a prerequisite for receipt of services, nor was it an inclusion criterion for this study. Following the university's institutional review board's approval, several recruitment strategies were employed, including phone contacts, mailings, word of mouth, and distribution of brochures at VTV's biweekly support group meetings.

In terms of data collection, participants met with a trained master's or doctoral-level graduate student for the first assessment (T1), which consisted of signing an informed consent, participating in a brief audio-taped, semistructured, open-ended interview and completing a number of paper and pencil measures (see Measures section). The interviews were incorporated simply to build

rapport, through the use of two questions: (a) “I did not have the pleasure of knowing [loved one], could you tell me a little about [him/her]?” and (2) “How have you been doing since [his/her] death?” No aspect of the interviews was analyzed as a part of this study. This was followed by a second assessment session approximately 6 months later (T2). The total length of the sessions was approximately 1 to 3 hours at T1 and 2 to 4 hours at T2.

## Measures

*Arizona Social Support Interview Schedule (ASSIS; Barrera, 1981)*. The ASSIS uses an interview-administered format to evaluate perceived need for and satisfaction with support across the following domains: Intimate Interaction (e.g., the ability to speak to someone about private and personal matters), Material Aid (e.g., loaning something of value), Physical Assistance (e.g., help with transportation, errands, domestic chores), Advice, Positive Feedback (e.g., receiving praise), and Social Participation (e.g., gathering with people to have fun and relax). For example, the need statement for the advice domain reads: “During the past month, how much you think you needed to get advice?” whereas the satisfaction statement for the physical assistance domain reads: “During the past month, how satisfied or dissatisfied were you with the help you received in doing these things that you needed to do?” Participants rated their level of satisfaction with support received on a 7-point Likert scale ranging from *very dissatisfied* to *very satisfied*. Barrera’s (1980) study showed low to moderate positive correlations between the various support categories, suggesting the orthogonal nature of the different aspects of social support that the measure assesses, as well as coefficient alphas of .78 and .74 for available and actual support respectively across the six positive support categories. The ASSIS had a Cronbach’s alpha of .79 for T1 and .81 for T2, respectively, in our sample.

*Beck Depression Inventory II (BDI-II; Beck, Steer, & Brown, 1996)*. The BDI-II is a depression screening measure whose 21 items assess the degree of agreement on 4-point scales with items such as “I have lost most of my interest in other people or things.” Studies of traumatized adults showed high internal reliability for the BDI-II ( $\alpha = .92$ ; Scarpa, Hurley, Shumate, & Haden, 2006). Likewise, high internal consistency was found in the present sample (T1,  $\alpha = .92$ ; T2,  $\alpha = .95$ ).

*Beck Anxiety Inventory (BAI; Beck, Brown, Epstein, & Steer, 1988)*. The BAI is an anxiety measure consisting of 21 items, with scores on a 4-point scale assessing severity of such symptoms as numbness or tingling, feelings of choking, difficulty breathing, and so forth. Chapman and Woodruff-Borden (2009) found that the BAI had strong internal consistency in both an African American sample ( $\alpha = .88$ ) and a European American sample ( $\alpha = .86$ ). Our analyses reflected a Cronbach’s alpha of .92 and .95 for T1 and T2, respectively.

*Inventory of Complicated Grief-Revised (ICG-R; Prigerson & Jacobs, 2001)*. The ICG-R assesses grief symptoms indicative of long-term dysfunction in bereavement, using 34 items rated on a 5-point Likert scale. The ICG-R evaluates severity of grief symptomatology on items such as “I think about \_\_\_\_\_ so much that it can be hard for me to do the things I normally do.” High internal consistency (Cronbach’s  $\alpha = .95$ ) has been reported for the ICG-R in samples of both normative and traumatic, premature loss (Keesee et al., 2008). In the present sample, the ICG-R also showed high internal consistency (T1,  $\alpha = .94$ ; T2,  $\alpha = .95$ ).

*PTSD Checklist-Civilian (PCL-C; Weathers, Litz, Herman, Huska, & Keane, 1993)*. The PCL-C consists of 17 items, with 5-point Likert scales ranging from 1 = not at all to 5 = extremely, on which respondents indicate how bothered they have been by certain psychological disturbances, such as “Feeling very upset when something reminded you of a stressful experience from the past.” The PCL-C has shown high reliability in previous samples of bereaved individuals (Bonanno et al., 2007) and also in our study at T1 ( $\alpha = .92$ ) and T2 ( $\alpha = .96$ ).

## Data Analysis Plan

The goal of the present study was to examine discrete domains of social support at T1 that best predict bereavement symptomatology at T2 in a sample of homicide survivors. Pearson’s correlations were conducted to determine the direction and strength of associations between social support variables at T1 and outcome measures at T2. All social support variables that were significantly correlated with outcome variables at T2 were then included in a series of regression analyses.

Four hierarchical regression models were evaluated, each analyzing a distinct bereavement outcome (i.e., depression, anxiety, CG, and PTSD). In each of these models correlated T1 social support domains (predictors) and aspects of social support (i.e., satisfaction or need) from the ASSIS were analyzed for their predictive power in relation to specific bereavement outcomes at T2 while controlling for T1 distress. In each case, preliminary analyses were conducted to rule out violations of the assumptions of linearity, normality, multicollinearity, and homoscedasticity.

## Results

Table 1 presents the descriptive background statistics for the sample, as well as the means and standard deviations of the bereavement outcome measures used in this study. Table 2 shows statistically significant associations between the major variables explored.

**Table 1.** Descriptive Statistics for Background Variables and Bereavement Outcome for African American Adults Bereaved by Homicide ( $n = 47$ ).

| Outcome measures                 | Range     | M (SD)           | % (n)     | Time 1<br>M (SD)       | Time 2<br>M (SD)       |
|----------------------------------|-----------|------------------|-----------|------------------------|------------------------|
| Depression                       |           |                  |           | 15.1 (11.2)            | 12.6 (12.1)            |
| Anxiety                          |           |                  |           | 11.7 (11.2)            | 10.1 (12.2)            |
| Complicated grief                |           |                  |           | 80.4 (24.4)            | 71.0 (25.1)            |
| Posttraumatic<br>stress disorder |           |                  |           | 36.5 (15.2)            | 34.7 (16)              |
| Demographic variables            |           |                  |           |                        |                        |
| Months since loss                | 1.1–58.3  |                  |           | 1.66 yrs<br>(1.20 yrs) | 2.16 yrs<br>(1.70 yrs) |
| Age                              | 19–71 yrs | 49.65<br>(11.91) |           |                        |                        |
| Race                             |           |                  |           |                        |                        |
| African American                 |           |                  | 100 (47)  |                        |                        |
| Sex                              |           |                  |           |                        |                        |
| Female                           |           |                  | 89.4 (42) |                        |                        |
| Male                             |           |                  | 10.6 (5)  |                        |                        |
| Kinship                          |           |                  |           |                        |                        |
| Spouses                          |           |                  | 10.6 (5)  |                        |                        |
| Mothers                          |           |                  | 57.4 (27) |                        |                        |
| Fathers                          |           |                  | 2.1 (1)   |                        |                        |
| Step-fathers                     |           |                  | 4.3 (2)   |                        |                        |
| Sisters                          |           |                  | 8.5 (4)   |                        |                        |
| Extended family                  |           |                  | 14.9 (7)  |                        |                        |
| Other                            |           |                  | 2.1 (1)   |                        |                        |
| Marital status                   |           |                  |           |                        |                        |
| Married                          |           |                  | 25.5 (12) |                        |                        |
| Single                           |           |                  | 27.7 (13) |                        |                        |
| Separated/Divorced               |           |                  | 29.8 (14) |                        |                        |
| Widowed                          |           |                  | 17.0 (8)  |                        |                        |
| Education                        |           |                  |           |                        |                        |
| <High school                     |           |                  | 10.7 (5)  |                        |                        |
| High school/GED                  |           |                  | 25.5 (12) |                        |                        |
| Some college                     |           |                  | 38.3 (18) |                        |                        |
| College                          |           |                  | 19.1 (9)  |                        |                        |
| >College                         |           |                  | 6.4 (3)   |                        |                        |
| Income                           |           |                  |           |                        |                        |
| <\$20,000                        |           |                  | 36.1 (17) |                        |                        |
| \$20,000–50,000                  |           |                  | 46.8 (22) |                        |                        |
| >\$50,000                        |           |                  | 17.1 (8)  |                        |                        |

**Table 2.** Intercorrelations of Social Support Domains and Bereavement Outcome for Adults Bereaved by Homicide.

|                                      | 1      | 2      | 3     | 4      | 5     | 6     | 7     | 8      | 9     | 10   | 11    | 12   | 13 |
|--------------------------------------|--------|--------|-------|--------|-------|-------|-------|--------|-------|------|-------|------|----|
| 1 BDI-II T1                          | —      |        |       |        |       |       |       |        |       |      |       |      |    |
| 2 BDI-II T2                          | .73**  | —      |       |        |       |       |       |        |       |      |       |      |    |
| 3 BAI T1                             | .59**  | .57**  | —     |        |       |       |       |        |       |      |       |      |    |
| 4 BAI T2                             | .58**  | .72**  | .82** | —      |       |       |       |        |       |      |       |      |    |
| 5 ICG-R T1                           | .64**  | .60**  | .50** | .59**  | —     |       |       |        |       |      |       |      |    |
| 6 ICG-R T2                           | .62**  | .80**  | .58** | .65**  | .81** | —     |       |        |       |      |       |      |    |
| 7 PCL T1                             | .78**  | .82**  | .67** | .75**  | .76** | .78** | —     |        |       |      |       |      |    |
| 8 PCL T2                             | .67**  | .86**  | .68** | .81**  | .68** | .80** | .85** | —      |       |      |       |      |    |
| 9 Advice Need                        | .34*   | .31*   | .56** | .45**  | .41** | .40** | .43** | .40**  | —     |      |       |      |    |
| 10 Physical Assistance Satisfaction  | -.32*  | -.42** | -.35* | -.54** | -.25  | -.31* | -.28* | -.41** | -.05  | —    |       |      |    |
| 11 Physical Assistance Need          | .33*   | .38**  | .38** | .29    | .20   | .38** | .38** | .42**  | .56** | -.12 | —     |      |    |
| 12 Intimate Interaction Satisfaction | -.50** | -.23   | -.23  | -.20   | -.36* | -.33* | -.36* | -.28   | -.18  | -.03 | -.01  | —    |    |
| 13 Positive Feedback Need            | .18    | .24    | .32*  | .27    | .23   | .35*  | .26   | .27    | .58** | .05  | .52** | -.04 | —  |

Note.  $n = 47$ ; BDI-II = Beck Depression Inventory-II; BAI = Beck Anxiety Inventory; ICG-R = Inventory of Complicated Grief-Revised; PCL = PTSD Check List; T1 = Time 1; T2 = Time 2.

Pearson's  $r$  \* $p < .05$ . \*\* $p < .01$ .

### *Depression*

To evaluate if aspects of social support at T1 predicted levels of depression at T2, a hierarchical regression analysis was conducted (see Table 3). To control for levels of baseline depression, T1 depression scores were entered in Step 1. Next, T1 correlated social support variables (i.e., need for advice and physical assistance, and satisfaction with physical assistance) were entered in Step 2. After controlling for T1 depression scores, the total variance in depression at T2 explained by the model as a whole was 59%,  $F(4, 42) = 15.18$ ,  $p < .001$ . Of all correlated T1 social support variables entered in Step 2, satisfaction with physical assistance most closely approached significance in predicting T2 depression scores ( $p < .06$ ,  $\beta = -.20$ ).

### *Anxiety*

To explore the aspects of social support at T1 that predicted anxiety scores at T2, a second hierarchical regression analysis was conducted (see Table 3). T1 anxiety scores were entered in Step 1. In Step 2, T1 correlated social support variables (i.e., need for advice and physical assistance, and satisfaction with physical assistance) were entered. In relation to anxiety at T2, after controlling for T1 anxiety scores, the total variance explained by the model, with all correlated social support variables entered, was 74%,  $F(4, 42) = 30.25$ ,  $p < .01$ . When all correlated T1 social support variables were entered in Step 2, satisfaction with physical assistance emerged as the most robust predictor of anxiety scores at T2 ( $p < .001$ ,  $\beta = -.30$ ).

### *Complicated Grief*

To investigate whether T1 social support predicted T2 CG, we ran a third hierarchical regression analysis (see Table 3). We controlled for levels of baseline CG in Step 1. In Step 2, T1 correlated social support variables (i.e., need for advice, physical assistance, and positive feedback, and satisfaction with physical assistance, and intimate interactions) were included in the analysis. In relation to CG at T2, after controlling for T1 CG, the total model variance was 73%,  $F(6, 40) = 18.59$ ,  $p < .06$ . After all correlated T1 social support variables were entered in Step 2, only the need for physical assistance significantly predicted CG scores at T2,  $p < .05$ ,  $\beta = .20$ , such that high need for physical assistance from others tended to complicate the bereavement process for mourners in our sample.

### *Posttraumatic Stress Disorder*

Finally, to examine the role of initial social support in prospectively predicting PTSD, a final hierarchical regression was completed (see Table 3). T1 PTSD

**Table 3.** HierarchicalRegression Analyses for Variables Predicting T2 Bereavement Outcomes in Adults Bereaved by Homicide.

| T2 Outcome           | Step 1       |                      |                 |        | Step 2                           |                      |                  |                   | Overall F |
|----------------------|--------------|----------------------|-----------------|--------|----------------------------------|----------------------|------------------|-------------------|-----------|
|                      | T1 Predictor | Total R <sup>2</sup> | ΔR <sup>2</sup> | β      | T1 Predictor                     | Total R <sup>2</sup> | ΔR <sup>2</sup>  | β                 |           |
| T2 Depression        | T1 BDI       | .53***               | .53***          | .73*** | T1 BDI                           | .59                  | .06              | .62***            | 15.18***  |
|                      |              |                      |                 |        | Advice Need                      |                      |                  | .01               |           |
|                      |              |                      |                 |        | Physical Assistance Need         |                      |                  | .15               |           |
| T2 Anxiety           | Step 1       | .67***               | .67***          |        | Physical Assistance Satisfaction |                      |                  | -.20 <sup>†</sup> | 30.25***  |
|                      | T1 BAI       |                      |                 | .83*** | Step 2                           | .74                  | .07**            | .69***            |           |
|                      |              |                      |                 |        | T1 BAI                           |                      |                  | .08               |           |
| T2 Complicated Grief | Step 1       | .66***               | .66***          |        | Physical Assistance Need         |                      |                  | -.06              | 18.59***  |
|                      | T1 ICG-R     |                      |                 | .77*** | Physical Assistance Satisfaction |                      |                  | -.30***           |           |
|                      |              |                      |                 |        | Step 2                           | .74                  | .08 <sup>†</sup> | .73***            |           |
|                      |              |                      |                 |        | Advice Need                      |                      |                  | -.12              |           |

(continued)

**Table 3.** Continued

| T2 Outcome | Step 1       |                      |                 | Step 2 |                                   |                      | Overall F |
|------------|--------------|----------------------|-----------------|--------|-----------------------------------|----------------------|-----------|
|            | T1 Predictor | Total R <sup>2</sup> | ΔR <sup>2</sup> | β      | T1 Predictor                      | Total R <sup>2</sup> |           |
| T2 PTSD    |              |                      |                 |        | Positive Feedback Need            |                      | .15       |
|            |              |                      |                 |        | Physical Assistance Need          |                      | .20*      |
|            |              |                      |                 |        | Intimate Interaction Satisfaction |                      | -.08      |
|            |              |                      |                 |        | Physical Assistance Satisfaction  |                      | -.12      |
|            | Step 1       | .71***               | .71***          |        | Step 2                            | .75                  | .04       |
|            | T1 PCL       |                      |                 | .81*** | T1 PCL                            |                      | .75***    |
|            |              |                      |                 |        | Advice Need                       |                      | .01       |
|            |              |                      |                 |        | Physical Assistance Need          |                      | .11       |
|            |              |                      |                 |        | Physical Assistance Satisfaction  |                      | -.18*     |
|            |              |                      |                 |        |                                   |                      |           |

Note. *n* = 47; BDI-II = Beck Depression Inventory-II; BAI = Beck Anxiety Inventory; ICG-R = Inventory of Complicated Grief-Revised; PCL = PTSD Check List; T1 = Time 1; T2 = Time 2.  
 \**p* < .05, \*\**p* < .01, \*\*\**p* < .001; † *p* < .06.

scores were entered in Step 1, and associated T1 social support scores (i.e., need for advice and physical assistance, and satisfaction with physical assistance) were entered in Step 2. In the assessment of T2 PTSD, the total variance explained by the model as a whole after controlling for T1 PTSD scores was 75%,  $F(4, 42) = 32.10$ ,  $p < .09$ . Of the three T1-correlated social support variables entered in Step 2, only satisfaction with physical assistance significantly predicted reductions in PTSD scores at T2,  $p < .03$ ,  $\beta = -.18$ .

## Discussion

Despite its impact, homicide loss is underrepresented in bereavement research, and specifically in relation to how aspects of social support might mitigate the psychological pain that follows sudden, violent death. Our findings were consistent with studies suggesting that social support acts as a protective cushion against mental health sequelae, and inconsistent with previous studies showing no association between perceived social support and bereavement outcome, insofar as several analyses suggested a significant, albeit modest role for physical assistance as a prospective predictor of bereavement outcome.

Consistent with previous studies with bereaved individuals (Burke et al., 2010; Dyregrov, 2003; Vanderwerker & Prigerson, 2003), our results showed that social support was associated with the reduced emotional struggles experienced by grievors in our sample. Likewise, survivors in our study appeared to have a clear idea of which domains of social support were useful to them, and could differentiate between their need for support and their degree of satisfaction with that support, which is consistent with previous studies (e.g., Toller, 2011).

Despite heightened levels of psychological distress following violent loss, individuals in our sample appeared to display resilience to problematic grief outcomes through mechanisms of social support—namely physical assistance—consistent with Bonanno et al.'s (2002) findings. Overall, our analyses showed that receiving tangible assistance from supporters accounted for a small but significant proportion of their T2 distress scores. In terms of depressive symptomatology, our results conceptually replicate earlier studies (Sherkat & Reed, 1992). When grievors in our sample reported being satisfied with the physical assistance they received early in bereavement, they also tended to experience fewer signs of depression later on, even after controlling for their self-reported need for advice and physical assistance.

Parallel to our findings in regard to depression and consistent with our hypothesis, results suggested that when participants were satisfied with the physical help offered them their level of anxiety dropped significantly, confirming and adding specificity to Eilertsen et al.'s (2013) more general examination of social support satisfaction after losing a sibling.

Villacieros et al. (2014) discovered that social support satisfaction in terms of available support from others predicted whether mourners avoided a prolonged,

complicated bereavement trajectory. However, contrary to this precedent and our own hypothesis, no relation between prior social support and subsequent CG was observed in our sample. In this case, we found that satisfaction with support played a lesser role than did need. Our results showed that the griever's initial need for physical assistance predicted ongoing distress in terms of CG. Although just how need for practical help complicated homicide survivors' grieving process deserves further study, it is possible that high neediness among survivors taxed would-be supporters' own limited resources, leading to their exhaustion or withdrawal. This interpretation is compatible with a systematic qualitative case study from this same sample conducted by Piazza-Bonin, Neimeyer, Burke, Young, and McDevitt-Murphy (2014), which documented both the seeming inability of many in the social system to meet the needs of a bereaved mother contending with CG, and the stalwart support of at least one friend in the face of intense and protracted need.

Finally, we found that grievers in our sample who endorsed feeling satisfied with their supporters in terms of the physical assistance they offered earlier in bereavement were more likely to also report fewer trauma symptoms 6 months later.

In summary, viewing bereavement outcome as a whole, we found that the grievers' satisfaction with support generally was more important than was how much they perceived themselves as needing the particular type of help. Overall, when assessed across six separate domains of social support, our participants' satisfaction with practical, everyday support in the early months following loss was most predictive of positive bereavement outcome. Specifically, having others pitch in by helping around the house, transporting children to school, running errands, and so forth, may have enabled mourners to devote attention to the process of grieving, which some theorists believe involves intentionally focusing attention alternately on the pain of the loss itself and on creating a new life (Stroebe & Schut, 1999). However, our results showed, with the exception of CG, that the key was experiencing satisfaction with the physical assistance received. In the case of CG, it appears that an intensified need to turn to others to meet one's needs carries with it a cost in terms of exacerbated duration and severity of grief symptoms. In this instance, it is possible that heightened need can be understood as a vulnerability marker for underresourced mourners or families, which other investigators have also found to be at risk of poorer bereavement outcomes (van der Houwen et al., 2010).

Our findings also suggest that, at least in the context of African American bereavement by homicide, emotional support, advice, and so on, seem to be less important than tangible assistance, which carries implications for social services beyond psychotherapy or support groups, *per se*. Laurie and Neimeyer's (2008) study suggests potential factors that might help explain these findings. In their large comparison study ( $n = 1,670$ ) of recently bereaved college students, 641 of whom were African American, they noted that, compared with Caucasians,

African Americans spent fewer hours talking with others about their loss. Likewise, the 26 African American grievors in Rosenblatt and Wallace's (2005a) study endorsed a similar reticence about sharing their feelings with others. Similarly, results from our sample imply that African Americans find tangible expressions of help more significant than words alone following the murder of their loved one.

Recent research also shows that in the face of tragedy, African Americans naturally turn to their community for support, by accessing a large network of family, friends, neighbors, and other informal helpers (Burke et al., 2010; Laurie & Neimeyer, 2008). Thus, Barrett (2001) emphasized that researchers and clinicians working with African Americans should recognize and respect social and cultural-specific factors bearing on the grieving process, such as reduced access to economic and other resources when a loved one dies (Rosenblatt & Wallace, 2005b). Alternatively, perhaps the devastating effects of homicide bereavement make physical assistance more important than might be the case in more benign forms of loss for mourners of any ethnicity. Such alternative explanations call for replication of this study with culturally different samples and exploring different causes of death to assess whether the importance of physical assistance evident in this study generalizes beyond the present participants.

### *Clinical Implications*

This study suggests that mental health professionals who assist grievors, particularly those exposed to violent loss, should encourage clients to foster healthy relationships with others and to seek out positive forms of social support. This may include not only being open to receiving physical assistance when offered but also consciously reaching out to others for such help when needs arise. For example, clinicians can prompt grievors to seek assistance through supportive figures or institutions that they already have in place, such as religious communities, neighbors, and family—which often serve as a good source of tangible aid. However, viewed more broadly, the present results also underscore the limits of psychotherapy or peer support groups to provide sufficient aid in the wake of devastating loss, insofar as these services are rarely configured to provide physical assistance with the practical needs mourners require. Instead, as in “best practice” guidelines recently formulated for suicide loss (<http://actionallianceforsuicideprevention.org/taskforces>), a public health focus may be called for that provides tangible access to concrete services (e.g., child care, financial assistance) on the part of vulnerable mourners and communities.

### *Limitations*

Although the present study is one of the rare investigations of social support in the context of violent death loss, a larger sample might have enabled more

sophisticated statistical analyses, and perhaps yielded further significant associations. Focusing on a unique sample (homicidally bereaved African Americans from the mid-South) also constrains our ability to generalize to grievors with other types of losses, other races, or regions of the world. Nonetheless, one strength was the ability to test genuinely prospective predictions about aspects of social support associated with better long-term bereavement outcome. To our knowledge, no other study has parsed out the role of specific domains of social support with a severely underrepresented population such as homicidally bereaved African Americans.

In summary, we hope this study clarifies what traumatically bereaved individuals want and need from their friends, family, and community as they seek to mourn their losses and reconstruct their lives. We attempted to elucidate the domains and characteristics of social support that ameliorate the deleterious effects of bereavement distress in adult grievors. When family members of murder victims in our sample were satisfied with the tangible support they received from their social network, they tended to fare better in specific realms of emotional wellbeing. Given that social support is one of the few factors amenable to therapeutic change in bereavement, when mental health professionals are armed with this knowledge they should be better able to affect change and facilitate the needs of grievors.

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### **Note**

1. Physical assistance and instrumental/tangible support are used interchangeably in this article as they also are in the literature.

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