

**AFRICAN AMERICAN HOMICIDE BEREAVEMENT:
ASPECTS OF SOCIAL SUPPORT THAT PREDICT
COMPLICATED GRIEF, PTSD, AND DEPRESSION**

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ABSTRACT

Psychological adaptation following homicide loss is challenged not only by the violent nature of the death itself but also by the bereaved's relationships with would-be supporters. Recruiting a sample of 54 African-American homicidally bereaved individuals, we examined perceived and actual support, the size of the support network, family- versus non-family support, and number of negative relationships to gauge the role of social support in bereavement outcomes such as complicated grief, PTSD, and depression. Results of quantitative assessments revealed that size of available network, quantity of negative relationships, and levels of grief-specific support were correlated with bereavement outcome. Clinical implications and suggestions for future research on the role of social support in adaptation of African Americans to traumatic loss are discussed.

Equally as devastating as the loss of life through homicide is the heart-wrenching grief that the survivors of homicide victims must endure. Worse still, when grievors must brave bereavement alone or with less than adequate social support,

their pain may be multiplied. Although grief is a highly individualized experience, the pathway through bereavement almost always includes others (Hagman, 2001). In part, the grief response is an attempt to convey to others the meaning of the lost relationship (Neimeyer, 2005); therefore, bereavement becomes problematic when supporters fail to embrace the grief process alongside the bereaved (Hagman, 2001). As Neimeyer and Jordan (2002) explained, even when others are naturally swept along with us in our grief, still “facets of our individual experience will inevitably go unrecognized, unarticulated, and unvalued” (p. 95), especially when the loss is non-normative. This suggests that social interaction does not always equal social support (Knight, Elfenbein, & Messina-Soares, 1998); rather, as Fiore, Becker, and Coppel (1983) aptly stated, social interaction can engender stress as easily as it can support.

As well as socially constructed aspects of grief, of particular interest to this study are the ways in which bereavement is experienced by African Americans. Recent studies indicate that the grief experience of African Americans may differ from their Caucasian counterparts in a number of important ways, and that their social interactions in bereavement might also differ (Laurie & Neimeyer, 2008; Rosenblatt & Wallace, 2005). Unfortunately, few studies offer insight into social support in relation to African American grief, and even fewer attempt to explore bereavement outcome of African American survivors of homicide loss. Paradoxically, however, national statistics show that African Americans experience a disproportionately high incidence of homicide—death by homicide is currently ten times more likely for Blacks than for Whites (Kochanek, Murphy, Anderson, & Scott, 2004). Figures from Laurie and Neimeyer’s (2008) bereavement study reflect this discrepancy, in the rate of Black versus White college students reporting loss of a loved one to homicide within the last 2 years (11.6% and 2.4% respectively). Mode of death also appears to be an important factor affecting bereavement outcome, with unexpected and violent losses producing substantially greater bereavement complications than anticipated and non-violent losses (Currier, Holland, Coleman, & Neimeyer, 2007). Therefore, because death from homicide stands apart as a particularly distressing type of loss (Bonanno & Kaltman, 2000), and because African Americans are disproportionately affected by homicidal death, research is urgently needed on their adaptation to this form of traumatic loss.

Furthermore, our guiding assumption is that differential grief experiences in African Americans can be explained in part by studying their social support systems. This understanding draws upon studies showing that African-American communities have distinctive social support characteristics (e.g., large network size: Rosenblatt & Wallace, 2005; socially constructed mourning rituals: Barrett, 1998), many of which have not been examined empirically. Lack of understanding about how African Americans cope following homicide loss and what role, if any, social support plays in adjustment to loss forms the basis of our inquiry. Therefore, we will explore whether certain aspects of social support act as predictors of grief

(Stroebe, Stroebe, Abakoumkin, & Schut, 1996), PTSD (Murphy, Johnson, Chung, & Beaton, 2003), and depression (Vanderwerker & Prigerson, 2004) in this population as they appear to do in others.

Finally, poor bereavement outcomes often surface in the form of serious psychological disorders, including complicated grief (CG), an elongated, debilitating, and sometimes life-threatening grief response affecting approximately 10-15% of the bereaved population (Prigerson, Frank, Kasl, Reynolds, Anderson, Zubenko et al., 1995; also known as prolonged grief disorder, PGD; Boelen & Prigerson, 2007). In addition, bereavement-related stress can manifest in posttraumatic stress disorder (PTSD; Bonnano & Mancini, 2006), which affects nearly 8% of Americans (Kessler, Sonnega, Bromet, Hughes, Nelson, C. B. et al., 1995), and major depressive disorder (MDD; Bonnano & Mancini, 2006), which has a national lifetime prevalence rate of 17% (Blazer, Kessler, McGonagle, & Swartz, 1994). However, to date little is known regarding the rate at which bereaved African Americans struggle with these types of distress symptoms in response to bereavement; hence, the need for a closer examination of factors that might predispose them to loss-related psychopathology, especially following egregious deaths such as homicide.

Bereavement in African Americans

Despite its importance, the grief experience for African Americans has largely been ignored by bereavement researchers. An exception is Laurie and Neimeyer's (2008) study of 1670 recently bereaved college students, 641 of whom were African American, which investigated ethnic differences and other factors such as time spent talking about the loss and social support. They found a statistically significant main effect of ethnicity such that African Americans reported greater bereavement complication, even after controlling for all other predictors. Correspondingly, in one of the only other known studies examining CG in African Americans, Goldsmith, Morrison, Vanderwerker, and Prigerson (2008) found that African Americans seem to have a higher prevalence of CG than their Caucasian counterparts—22% and 12% respectively. In their combined sample comprised of African Americans ($n = 66$, 12%) and Caucasians ($n = 472$; 88%), they considered a number of potential predictors of CG including perceived social support. Goldsmith et al.'s findings indicated that Blacks and those bereaved by sudden death have a 2.5 times greater risk of developing CG than do Whites, even when all other factors are controlled. Conversely, when Cruz et al. (2007) evaluated ethnic differences between 19 African Americans and 19 Caucasians undergoing complicated grief treatment (CGT; Shear, Frank, Houck, & Reynolds, 2005) they found no difference between the two groups in any aspect of their functioning at baseline or post-treatment. This suggests that CG, when diagnosed, may present similarly regardless of ethnicity. Whether differential prevalence of CG is

observed as a function of ethnicity or not, predictors of poor bereavement outcome in African Americans affected by homicide bereavement is still a clear priority.

Violent Loss and Social Support in African American Bereavement

A number of grief-related factors have been examined in samples that include African Americans, as in research by Currier and his colleagues (2007) on the role of violent death in bereavement outcome among young adults. Of their 1723 participants, 671 (39%) were African American, with 6% of the total population ($n = 100$) having experienced loss of a loved one to homicide. They found that type of loss predicted how well individuals coped, with violent deaths producing substantially more complicated grief symptomatology than non-violent deaths, and death by homicide producing the most problematic bereavement outcome of all. By extension, our study tested the relationship between various aspects of social support and grief outcome in a comparatively older group of Black individuals, all of whom are homicidally bereaved.

In particular, we anticipated that available and actual social support would be important factors affecting the bereaved's ability to cope. Laurie and Neimeyer's (2008) study showed no statistically significant difference between Whites and Blacks in perceived social support following death, yet an interaction effect between the amount of time the individual spoke to others about his or her loss and ethnicity was significant. Specifically, self-report questionnaires revealed that African-American participants consistently spent fewer hours talking with others about the death than did Caucasians. Narratives of one participant in a study of 26 African American grievers illustrated this reluctance to talk about loss: "Black people, we don't sit down and talk about stuff. We just assume . . . unless you let me know you need something, you're okay with it" (Rosenblatt & Wallace, 2005, p. 147). However, what is missing in the literature is research examining how factors such as ethnicity, aspects of social support, and mode of death might interact to predict bereavement outcome. Accordingly, in considering aspects of African-American social networks, it is important to ask the question: of whom are they comprised? Therefore a larger, quantitative project targeting specific aspects of social networks (i.e., available and actual supporters, family vs. non-family) in African Americans was warranted, especially to highlight those instances when the grief response goes awry, as was expected in the objectively traumatic losses that were the focus of this study.

The Role of Social Support in Bereavement Outcome

Much of what is known about social support in bereavement comes from studies of Caucasians. Nevertheless, these studies offer a basis for comparison to examine differences between races, if they exist. Shumaker and Brownell (1984) defined

social support as “an exchange of resources between at least two individuals perceived by the provider or the recipient to be intended to enhance the well-being of the recipient” (p. 13). Our specific interest lay in how the receipt of different dimensions of social support served to help or hinder the grief process of homicidally bereaved African Americans.

Of course, not all bereaved people have a network of supporters, but for those who do, supporters are often the “inner circle” chosen by the griever, many of whom occupy that position through relationships established as a result of the loss (Dyregrov, 2006, p. 356). Whether the inner circle is mostly comprised of family members, non-family members, or a combination of both, there appears to be a clear delineation between what characterizes family and non-family support. Taylor, Hardison, and Chatters (1996), found in their sample of 1322 Black individuals facing serious physical and emotional life stressors that non-family members were particularly beneficial in providing emotional and interpersonal support. Conversely, even though family members may feel more obliged than non-family to offer long-term help to their own who are in crisis by offering physical (e.g., caregiving) or material (e.g., financial) support, family interactions are also likely to cause greater stress, perhaps because family members themselves are affected by the same stressors and losses. In fact, although perhaps assumed otherwise, Coyne, Wortman, and Lehman (1986) found that family members were among the worst supporters. Thus, in terms of support, friendships are generally seen as positive and helpful, whereas family relationships are generally seen as both positive and negative, helpful and unhelpful (Crohan & Antonucci, 1989).

In their meta-analysis of both cross-sectional and longitudinal studies on the influence of social support as a buffer against a difficult and protracted response to loss, Stroebe, Zech, Stroebe, and Abakoumkin (2005) determined that social support does not positively influence recovery speed or the overall grief trajectory of the bereaved (see also Wilsey & Shear, 2007). At best, prior research (Okabayashi, Sugisawa, Yatomu, Nakatani, Takanashi, Fukaya et al., 1997) suggests a recovery effect, as the positive effects of perceived support are only evident when post-loss social support is assessed, and then only for a small subset of the sample whose loss occurred relatively recently. Stroebe and his colleagues therefore concluded that social support is not a definitive factor for those exhibiting a normative reaction to grief.

In contrast, Vanderwerker and Prigerson (2004) studied 293 elderly bereaved individuals to see if social support acted as a mediator between technological connectedness (Internet, email, and cell phone use) and CG, PTSD, and MDD. They found perceived social support to be protective against PTSD, depression, and CG at baseline ($M = 5.9$ months postloss), and against depression and CG at follow-up ($M = 10.6$ months postloss). Likewise, van der Houwen et al. (in press) found in their sample of 195 “significantly distressed,” bereaved individuals that lower levels of perceived social support predicted higher levels of grief and depressive mood (p. 7). However, these findings cannot be generalized to all populations as most of

the studies reviewed were of elderly, female, conjugally bereaved Caucasians whose loved one's death was anticipated, leaving open the question of the role of social support in African Americans bereaved by homicide. The rare research bearing on social processes in accommodating losses that are sudden, unexpected, and often unspeakably shocking reinforces this conclusion.

Whether violently bereaved or otherwise, one way that social processes can have a deleterious impact on bereavement is when interactions with would-be supporters are perceived by the bereaved as unhelpful or negative. In fact, some studies describe extreme forms of negative interactions (i.e., thoughtless and wicked remarks, and imprudent actions; Dyregrov, 2004; or annoying, intrusive, cold, rude, and combative behaviors; Wilsey & Shear, 2007) that are inappropriately doled out to those in an already weakened psychological state such as is common in bereavement. Moreover, Wilsey and Shear posited that dangerously confrontational interactions likely push grievers past the point of effectual grief management, such that negative social support itself might be foundational to the establishment and perpetuation of CG. Similarly, inadequate social support has also been implicated in development of major depression (Falkenstein, 2004) and PTSD (Lepore, Silver, Wortman, & Wayment, 1996).

Aims of this Study

Our hypotheses were based upon prior research indicating that violent loss—homicide loss in particular—heightens the likelihood of a protracted and incapacitating grief response (Currier et al., 2007). In addition, studies have shown that complicated grievers reported less perceived support than did non-complicated grievers (Ott, 2003), and that perceived support does not provide a buffering or recovery effect in normative grievers (Greene & Feld, 1989; Murphy, 1988; Murphy, Chung, & Johnson, 2002; Nolen-Hoeksema & Davis, 1999; Stroebe et al., 1996). Although a few studies found that actual support offered a degree of protection against depression in non-complicated grievers (Krause, 1986; Norris & Murrell, 1990), we know of only one, limited study (Wilsey & Shear, 2007) that examined the role of received or actual social support in individuals traumatized by loss. Finally, because researchers also found that African Americans access a large network of individuals on whom they rely, at least when facing normative losses and life stressors (Rosenblatt & Wallace, 2005), we chose comprehensively to examine these factors in our sample of homicidally bereaved African Americans. To do so, we used a multifaceted approach of looking not only at perceived support, as many prior studies have done, but also at aspects of the bereaved's objective social network, including size, defined in terms of the quantity of actual or potential support figures, as well as negative relationships. Moreover, we further assessed the quality of support perceived by assessing it at general- and grief-specific levels.

Specifically, we predicted that the size of the bereaved's *available and actual support networks*¹ would be correlated with both *general* and *grief-specific support*, and that all four variables would be inversely predictive of bereavement distress in the form of complicated grief, PTSD, and depressive symptomatology. Furthermore, because previous studies show that especially once the funeral has occurred, family members often are not readily available to support the bereaved in meaningful ways (Coyne et al., 1986; Grad, Clark, Dyregrov, & Andriessen, 2004), we hypothesized that the percent of *family* versus *non-family* supporters would be inversely related to levels of *general support* and *grief support*; that is, to the extent that the network nominated by the bereaved consisted primarily of family, they would report correspondingly less support in general and in relation to their grieving specifically. Finally, in keeping with past research with Caucasian complicated grievers (Wilsey & Shear, 2007), we predicted that those in our sample who reported a higher percentage of *anticipated and actual negative relationships* with people in their network would report greater bereavement distress in terms of CG, PTSD, and depressive symptomatology.

METHODS

Participants

For this study, we recruited 54 homicidally bereaved individuals, all of whom were African American, with an age range of 19 to 71 years ($M = 48.61$; $SD = 12.26$) through a faith-based organization that offers victims' assistance to survivors of homicide in a large city in the Mid-South. This study concentrated on African Americans who were within 5 years postloss ($M = 1.75$ years; $SD = 1.23$ years) and at least 18 years of age. Most participants in our sample were women (88.9%; $n = 48$) and parents of the deceased (i.e., mother, father, step-mother, step-father; 61.1%; $n = 33$). Immediate relatives of the deceased, including siblings (13.0%; $n = 7$), adult children (13.0%; $n = 7$), and the deceased's spouse (9.3%; $n = 5$), comprised the remaining participants, with 3.7% ($n = 2$) representing members of the deceased's community. Twenty-six percent ($n = 14$) of participants reported being married, 29.6% ($n = 16$) being single, 26% ($n = 14$) being separated or divorced, and 18.5% ($n = 10$) being widowed. The socioeconomic status of our participants varied a great deal. For example, with regard to levels of education, we found that 9.3% ($n = 5$) of our sample had completed less than a high school education, 29.6% ($n = 16$) had completed high school/GED, 38.9% ($n = 21$) had attended some college, 16.7% ($n = 9$) had completed college, and 5.6% ($n = 3$) had gone beyond college. With regard to income, 19 (35.2%) participants stated that

¹See the *ASSIS*, *MSPSS*, and the *ISS* scales in the Measures section for definitions of italicized variables.

their annual income was less than \$20,000, 25 (46.3%) reported income levels between \$20,000 to \$50,000, and the remaining 10 participants (18.5%) listed their annual income as being greater than \$50,000. Some of our participants shared the loss of the same loved one; thus, the number of survivors differs from the numbers of victims. Descriptively, the homicide victims in our study were 100% ($n = 44$) African American, 65.9% ($n = 29$) male, with an age range of 2 years to 55 years old ($M = 27.41$ years; $SD = 10.47$).

Procedures

Participants for this study were recruited from a grassroots victim services organization with an explicitly faith-based orientation, which collaborates with local law enforcement agencies in order to offer services to all families of homicide victims in the metropolitan area. Victims to Victory² (VTV) offers crisis counseling, victims' advocacy, assistance in filing victim compensation claims, and support to families navigating the criminal justice system. Although VTV is not a mental health agency, it does offer a support group for homicide survivors. And, despite VTV's overtly faith-based provision of services, endorsement of faith is not a prerequisite for receipt of services, nor was it an inclusion criterion for this study. Significantly, both the director and staff of the agency, each of whom was African American, reviewed all procedures and measures involved in the study to ensure their cultural sensitivity. All measures were then piloted with several African-American respondents to ensure their clarity and appropriateness prior to initiation of the formal study.

Following approval from the university's Institutional Review Board, participants were introduced to our study by the homicide agency's staff during their ongoing contact or through the researchers' separate mailing and/or phoning. Although all who were recruited had had at least one interaction with VTV in the past (in the form of an introductory letter), not all who participated had taken advantage of VTV's services and many were not actively engaged in VTV's group activities at the time of this study. Interested persons were contacted, given an explanation of the study, and, if interested, scheduled for an interview. Fifty-four participants met with a trained master's or doctoral-level graduate student for a session that, after signing an informed consent form, began with a brief open-ended interview initiated by the statement "I did not have the pleasure of knowing [loved one], would you please tell me something about [him/her]?" This was followed by an invitation for the survivor to share briefly how he or she had coped since the loss. This interview, along with the interviewer-administered ASSIS (Barrera, 1981), were tape-recorded to obtain qualitative data that will be assessed in a future study, followed by the completion of a number of paper and pencil

²The authors would like to express their gratitude to Dr. Katherine Lawson and Yvonne Becton of *Victims to Victory*, which provides education, advocacy, and support to homicide survivors in the Mid-South, and who partnered with us in this research.

scales (see below). Approximately one-third of the participants took advantage of the option to have 1:1 assistance in completing their measures; however, even when participants chose to complete the measures on their own, the interviewer offered additional assistance at fifteen minute intervals. In this way, the interviewer was able to gauge if the participant understood both the measurement questions and the response options, and was available to assist in other ways if needed.³ Although not specifically asked in the interview, some participants shared the nature of the homicide itself, including details regarding the mode of death and their feelings about pending or recently experienced criminal court hearings, among other things. Unsolicited details about the type of murder—from a wife being stabbed and dismembered by her husband to more distally related killings by drive-by shooters—broadened the authors' understanding about the participants' wide range of loss experiences and how these might influence their social support needs.

Measures

Arizona Social Support Interview Schedule (ASSIS; Barrera, 1981)

The ASSIS uses an interviewer-administered format to evaluate four separate indices: available network size, actual network size, support satisfaction, and support need across the following domains: Intimate Interaction, Material Aid, Physical Assistance, Advice, Positive Feedback, Social Participation, and Negative Interactions. During administration of the ASSIS, participants offered specific names of people in response to questions about positive support such as: *If you wanted to talk to someone about things that are very personal and private, who would you talk to?* and *If you got together with others in the past month just to have fun and relax, who were these people?*; and, with regard to negative relationships using questions such as: *Who are the people who you can expect to have some unpleasant disagreements with or people who you can expect to make you angry and upset?* Because this scale was developed in 1979, adjustments were made to four questions to phrase inquiries in terms of contemporary language surrounding diversity, and increase the scale's sensitivity toward grievers.⁴

³Although not analytically included in this study, lengthy interviews producing qualitative data only served to confirm the quantitative findings from these measures, providing a check-and-balance system to help ensure that assessment questions were understood.

⁴Question F2 was adjusted to read: *If you got together with others in the past month to have fun or to relax, who were these people?* In addition, question G1 was changed to read . . . *who you can expect to make you angry or upset?* Question Ha—the relationship section—was changed to a numbered system to incorporate the many types of relationships anticipated in our sample. Lastly, question Hd asks for the race/ethnicity of the network members. The original ASSIS, created in 1979, gave the following race options: Black; non-Hispanic Caucasian; Mexican, Chicano, Latino, Hispanic; American Indian; Asian; Other. This section now reads in accordance with our own demographics form (i.e., White or Caucasian; Hispanic or Latino; Asian; Black or African American; Native Hawaiian or Other Pacific Islander; American Indian or Alaska Native).

The ASSIS, which identifies the total network size through a series of name-eliciting questions, provides a highly reliable index of system size, demonstrating that social support networks can be dependably measured (Barrera, 1980). Barrera's study also showed low to moderate positive correlations between the various support categories, suggestive of 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. We derived a Cronbach's alpha of .79 for the ASSIS in our sample.

For this study, the following variables derived from this scale were operationally defined as follows: The *available support network* (those one might expect to receive support from if needed) consists of people nominated by the bereaved who fit into the immediate family (hereafter referred to as *family*) and non-immediate family (hereafter referred to as *non-family*) categories. Accordingly, 23 of the 61 participant-generated relationship types⁵ met our criteria for the *family* category, representing the bereaved's nuclear family and intimate partners. The *non-family* category consisted of 24 types of extended family members including fictive kin⁶ (e.g., "play" sister, God-niece), six types of *professionals* (e.g., clergy, doctors, teachers), and seven *other community members* (non-professional members of the bereaved's support network, including friends, neighbors, and co-workers). Because several participants listed God as a social support figure, a separate category was created for this purpose. Conversely, the *actual support network* represented those people who provided support during the past month in one or more of the six support domains. Lastly, *anticipated and*

⁵Originally, the ASSIS offered the following relationship options: mother, father, brother, sister, wife, husband, and friend. In allowing our participants to expand that list to an indefinite number of relationship types that they deemed important, we could not have anticipated the final number or relationship types that would be found in our sample. In retrospect, we might have sought assistance from the participants themselves in how best to delineate relationships into categories, especially those involving family. Still, a considerable amount of deliberation went into the formation of these categories, including the frequent consultation and feedback of Dr. Lawson. An example of items for her consideration were questions about whether non-spousal intimate partners should be categorized as immediate- or non-immediate family, an issue that varies across cultures. Nevertheless, those replicating this study using the ASSIS will have their own participant-generated relationship list that differs from those in our sample.

⁶*Fictive kin*, commonly found in African American communities, can be characterized as non-related yet family-like relationships that share the level of commitment and care commonly seen in families related by birth or marriage (Rosenblatt & Wallace, 2005). Crucial to an understanding of how fictive kin was factored into this study's analysis is through its categorization as *non-immediate family*—reflective of a non-blood or non-marital yet close relationship. In our sample, fictive kinships surfaced prominently as social support figures, with the following as examples of common monikers: play-sister, -daughter, -son, -mother, -father, -granddaughter, -grandson, and -grandmother; God-mother, -father, -sister, -brother, -daughter, -son, -niece, and -nephew; as well as non-blood relatives such as the participant's grandchild's mother, -stepfather, etc. We observed that these relationships were as vital as immediate family relationships yet meaningfully distinct at the same time.

actual negative relationships were represented by the number of people who might make or actually made the bereaved angry or upset during the previous month.

Multidimensional Scale of Perceived Social Support (MSPSS; Zimet, Dahlem, Zimet, & Farley, 1988)

The MSPSS is a 12-item questionnaire that uses a 7-point Likert scale from 1 = very strongly disagree to 7 = very strongly agree to assess the subjective presence and level of general support from family, friends, and significant others. Examples include: *My family is willing to help me make decisions*; and *I can talk about my problems with my friends*. Reliability, validity, and factor structure has been established for the MSPSS across a number of samples, including urban African Americans. In addition to having strong external validity, the MSPSS has also shown a high level of internal reliability (Cronbach's coefficient alpha = .93; Cauty-Mitchell & Zimet, 2000). In this study, the MSPSS was used as a measurement of *available general support*, which is general social support perceived by the bereaved to be accessible if needed. Internal consistency for this measure in our study was high ($\alpha = .95$).

Inventory of Social Support (ISS; Hogan & Schmidt, 2002)

The ISS is a 5-item, self-report questionnaire that uses a 5-point Likert-type scale ranging from 1 = *does not describe me at all* to 5 = *describes me very well* to measure *available grief support*, defined as subjective social support in bereavement. A representative question is: *I can get help for my grieving when I need it*. Cronbach's alpha for this scale was .76 in a sample of bereft parents, and test-retest reliability correlated over a 14-day period was .86. Criterion validity was assessed through negative correlations of the ISS with a psychometrically established scale of trauma avoidance and depression. An exploratory factor analysis using principal axis factoring revealed one factor, with 52% of the variance explained. Cronbach's alpha for the ISS in this study was .77.

To compare and contrast the instruments we used to measure distinct aspects of social support: the ASSIS measures network size of an unlimited number of relationship types across six domains of positive support, as well as quantity of negative relationships; the MSPSS measures available general support, and the ISS measures available grief support.

Inventory of Complicated Grief-Revised (ICG-R; Prigerson & Jacobs, 2001)

The ICG-R was developed to assess a distinct cluster of symptoms that have been found to predict long-term dysfunction in bereavement. This 34-question measure uses a 5-point Likert scale to evaluate severity of symptomatology on such items as *I feel stunned, dazed, or shocked over _____'s death*. Exploratory factor analysis indicated that the ICG measured a single underlying construct

of complicated grief (Prigerson et al., 1995), although recent research provides evidence that this is a dimensional construct ranging from low-level normative grief symptomatology to severe and prolonged grief disorder (Holland, Neimeyer, Boelen, & Prigerson, 2009). High internal consistency (Cronbach's $\alpha = .95$) was found in Keesee, Currier, and Neimeyer's (2008) study of bereaved parents, and Laurie and Neimeyer (2008) derived high reliability ($\alpha = .95$) in their study, which included African American grievers and the homicidally bereft. Likewise, our study also showed high internal consistency for this measure ($\alpha = .95$).

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, & Hayden, 2006). Likewise, high internal consistency was derived for this scale in the present sample ($\alpha = .92$).

PTSD Checklist-Civilian Version (PCL-C; Weathers, Litz, Herman, Huska, & Keane, 1993)

The PCL-C consists of 17, 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*. Bonanno et al. (2007) used the PCL-C with survivors of 9/11 victims, and Ramchand, Marshall, Schell, and Jaycox (2008) used it with individuals subjected to community violence, with both finding it to have strong psychometrics. In this study, the PCL showed high reliability, with a Cronbach's alpha of .93.

RESULTS

Table 1 presents the mean scores for all social support and distress measures used in the study. Consideration of the latter indicate that the present group of African Americans bereaved by homicide experienced much higher levels of CG, when compared to Goldsmith et al.'s (2008) sample which included African-American grievers ($M = 69$; $SD = 13$), and higher levels of depression, when compared to Scarpa et al.'s (2006) sample of adults exposed to community violence ($M = 9.40$; $SD = 8.45$). Additionally, our sample had PTSD scores comparable to Bonanno et al.'s (2007) study of violently bereaved individuals ($M = 37.3$; $SD = 12.9$). African Americans in our study reported social support networks that ranged from 4 to 32 supporters, with a mean of 12.7, yielding a slightly larger network size than Barrera's (1981) Caucasian college student sample ($M = 10.6$).

Table 1. Descriptive Statistics for Social Support and Bereavement Outcome Variables for African American Adults Bereaved by Homicide ($n = 54$)

Variables	<i>M</i>	<i>SD</i>
Available Support	12.65	(5.17)
Actual Support	9.04	(4.70)
% Family/Non-Family	1.45	(2.71)
# Anticipated Negative Relationships	2.81	(2.02)
# Actual Negative Relationships	1.87	(1.54)
General Support	65.30	(18.46)
Grief Support	20.13	(4.27)
Complicated Grief	79.61	(24.46)
PTSD	36.59	(15.33)
Depression	15.43	(11.27)

Our participants also had slightly higher scores on the general support scale than Caucasian motor vehicle accident victims ($M = 62.52$; $SD = 15.24$; Clapp & Beck, 2009), and on the grief-support measure than a sample of Caucasian, female caregivers ($M = 18.17$; $SD = 4.27$; Ott, Sanders, & Kelber, 2007). In addition, our participants' average number of actual negative relationships was lower than the mean in other samples ($M = 2.55$; Barrera, 1981), suggesting that African American homicide survivors might suffer less relational tension in spite of immense stressors. Although few in number, these comparisons tell a consistent story: African Americans in our study scored higher than Caucasians in other studies on all three social support instruments used, despite their very high levels of psychological distress.

Available and Actual Support Network Size

Table 2 presents Pearson correlation coefficients between scales assessing size of social networks, type of support, negative relationships, and bereavement outcome. As predicted, the sizes of available and actual support networks were positively correlated to perceived general support; those persons with quantitatively larger social networks also experienced qualitatively superior support of a general kind from others in their social world. Contrary to predictions, however, network size was not significantly related to *bereavement-specific* support, such that those persons with larger systems were no more likely to feel supported in their grieving

Table 2. Intercorrelations of Aspects of Social Support and Bereavement Outcome for African American Adults Bereaved by Homicide ($n = 54$)

Variables	1	2	3	4	5	6	7	8	9	10
1 Available Support	—	.78**	-.01	-.28*	-.34*	.38*	.03	-.28*	.17	-.24 ⁺
2 Actual Support		—	.02	-.24 ⁺	-.32*	.30*	.14	.06	-.07	-.17
3 % Family/Non-Family			—	.09	.11	.06	-.08	-.01	.10	.20
4 % Anticipated Negative Relationships				—	.80**	-.24 ⁺	-.08	.21	.22	.28*
5 % Actual Negative Relationships					—	-.17	.03	.28*	.28*	.24 ⁺
6 General Support						—	.28*	.01	-.07	-.02
7 Grief Support							—	-.17	-.23 ⁺	-.27*
8 Complicated Grief								—	.74**	.67**
9 PTSD									—	.76*
10 Depression										—

Note: Pearson's r ($n = 54$). ⁺ $p < .10$. * $p < .05$. ** $p < .01$ (2-tailed).

than those with fewer support figures at hand. Available and actual network sizes were also negatively correlated with the percent totals of anticipated and actual negative relationships: larger networks tended to include a smaller absolute number of non-supportive figures.

As hypothesized, the size of the available support system was negatively related to complicated grief and to a lesser degree to depression. However, available support was unrelated to PTSD symptomatology, and the size of the bereaved's actual support network likewise was not associated with any measurement of bereavement distress.

Family Versus Non-Family Support

Because previous studies had suggested the limits of family as opposed to non-family support in the context of stressful events, we had predicted that participants who designated a higher percentage of their support systems as family members would report lower overall and grief-specific support than those whose support systems were comprised of a higher percentage of non-family. Contrary to this reasoning, Table 2 reports no relation between the percentage of the support system designated as family and either measure of perceived support, or any of the three bereavement distress measures.⁷

Negative Relationships and Bereavement Outcome

In keeping with our hypotheses, Table 2 demonstrates that the greater the percentage of actual negative relationships in the bereaved person's social system, the higher the level of both complicated grief and PTSD, with a trend toward greater depressive symptomatology as well. Anticipated negative relationships were also significantly associated with depression, though not with CG or PTSD, reinforcing a trend in the published literature that associates conflicted relationships with worse bereavement outcome.

General and Grief-Specific Support

Table 2 also depicts correlations between the two measures of perceived social support, the MSPSS and ISS, as well as between these variables and bereavement-related symptomatology. As predicted, the measures of general and grief-specific support were significantly correlated, although the modest level of association between them suggests that they are substantially different constructs, at least as operationalized. Of the two, grief-specific support, as assessed by the ISS, was more closely associated with reduced PTSD and depression for the present group of homicide survivors, whereas general support was unrelated to bereavement

⁷Variations in relationship-type categorizations (e.g., re-categorizing fictive kin as *family*) did not produce statistically significant variations in these results.

outcome on any of the measures used in this study. Interestingly, however, even perceived *grief* support was unrelated to levels of complicated grief, a finding whose clinical implications will be discussed below.

Measures of Bereavement Distress

Finally, correlations reported in Table 2 underscore the strong relationships between the various measurements of bereavement-related PTSD, depression, and complicated grief symptomatology in this sample of traumatized grievers.

DISCUSSION

The norm in bereavement research has been to concentrate on elderly, conjugally bereaved, Caucasian women with an average to high socioeconomic status (SES), who have normative responses to non-violent losses. Conversely, our study focused on African-American homicide survivors, who our data suggested struggled with high levels of psychological distress in several domains. Our sample included both men and women, spanning all age brackets and SES levels, and comprising a large number of highly distressed grievers who reported having a wide variety of relationships to the deceased. Most notably, in addition to assessing perceived social support, our study examined actual, available and anticipated support, the size of the bereaved's social network, and the presence of negative relationships as well as positive ones. To do so, we used three validated social support scales, one of which was specifically designed to measure grief-related support in bereaved individuals. In contrast, all other studies we are aware of used only one social support scale, occasionally using only a single-item, and, with one exception (Ott, Sanders, & Kelber, 2007), used scales intended for use with the general public rather than with the bereaved. Ours is one of the few studies to examine social support in a sample with a high level of complicated grief symptomatology and, equally important, one of the rare studies of under-represented, violently bereaved, African-American grievers. All other studies we are aware of that have examined social support with such groups have considered support as an add-on variable to a study having another primary aim.

This study's overarching goal was to provide a more comprehensive assessment of social support in a sample of traumatically bereaved individuals than was previously available in the literature. Our results add detail to what little is known about bereaved African Americans—namely that these grievers may, in fact, draw on distinctive social support systems that could carry implications for bereavement outcome (Laurie & Neimeyer, 2008; Rosenblatt & Wallace, 2005; Taylor et al., 1996). These features of social support systems described by our participants are discussed below, with an emphasis on their link to bereavement-related distress.

African Americans in our study scored higher in several realms of social support than did their Caucasian counterparts in other studies. Still, replication

and expansion of this study would be necessary for us to state exactly how social support differs between these two races, inasmuch as the present sample differed from comparison groups on numerous variables, of which race was only one. However, our study was not intended to focus on differences between African Americans and Caucasians or other cultural groups, but instead to examine whether higher levels of support in the former group predict better accommodation of unexpected, violent loss.

Many studies have shown that perceived social support does not affect bereavement outcome in either direction (Greene & Feld, 1989; Murphy, 1988; Murphy et al., 2002; Nolen-Hoeksema & Davis, 1999; Stroebe et al., 1996), yet a few studies of actual support in normative grievers suggest that social support acts as a protective buffer against depression (Krause, 1986; Norris & Murrell, 1990). Such ambiguity about the putative benefits of social support warranted further study, especially in regard to actual support received. Our finding that a larger number of available supporters was associated with lower levels of CG (and to a lesser degree depression) is broadly consistent with the latter, more optimistic interpretation. However, the absence of a relation between perceived general support and CG, PTSD, or depression qualifies this possible buffering effect, and implies that availability of potential supporters and perceived support are likely two separate constructs. A further implication of these findings is that it may be more meaningful and psychologically soothing when the griever senses that specific, named people would be supportive if needed than it is to tally the actual number of people who have provided support recently or to consider the general, yet unspecified support that might be available in the future. Still, the cross-sectional nature of the present study limits our ability to conclude that more extensively available support, for example, mitigates bereavement distress, as the alternative conclusion that lessened distress allows the bereaved to consider a broader range of support figures cannot be discounted.

The scarcity of past research on characteristics of supportive networks of African Americans led us to explore whether they are protective against development of CG or make the overall grief experience less difficult. As with perceived support, the number of actual supporters in our sample was unrelated to symptomatic distress. These findings are illuminating because, relative to Caucasian populations studied by other investigators, our sample had higher levels of support in every arena; and yet, with the exception of the size of the available support network, there was little evidence that social support was associated with reduced deleterious effects of homicidal loss in African Americans. Moreover, although some researchers have found that when distressed individuals receive support from family members, it is often lacking in crucial aspects (Coyne et al., 1986), we found that the relative participation of family members versus non-family supporters had no relevance for perceived support or any distress variable.

Our findings corroborate reports by Dyregrov (2004) and Wilsey and Shear (2007) that unkind, hurtful comments and unhelpful, rude behaviors from network

members might actually make the process of mourning more difficult than would be otherwise expected. One participant with a particularly small social network shared, "I just don't have anybody to talk to. My neighbors stay away from me like I committed some kind of a crime. And, if I talk to them . . . well, I went over to my neighbor's twice . . . and my eyes watered up once and she told me, 'Now, don't you cry!' Like I'm some kind of a baby. Well, I don't want to be around her either" (personal communication, February 2008). The findings that depressive symptoms are positively associated with the bereaved's anticipation of negative exchanges and that actual receipt of negative interactions predicts increased levels of CG, PTSD, and depression, signals that greater attention should be paid to the impact of social negativity following homicide, particularly when overall network size is small, potentially magnifying the impact of adverse interactions. These findings carry greater import when considering that compared to positive relationships, a much smaller number of negative relationships was disproportionately predictive of levels of bereavement distress. Here again, however, causal inferences cannot be corroborated by our correlational data, insofar as more intensely or chronically distressed grievers might elicit more negativity from others in their social world, who respond with anger and blame when their attempts to help are rebuffed or ineffectual.

The correlation between general- and grief-specific support suggests that the bereaved's sense of being supported in a general way translates into a sense of feeling supported within his or her grief. That more grief-specific support was related to lower depression (and to a lesser degree PTSD) and yet had no bearing on CG, further emphasizes the need to view and measure bereavement outcomes independently (Neimeyer, 2008; Prigerson et al., 1995; van der Houwen, et al., 2009). If substantiated by future research, the lack of a significant relationship between grief-specific support and CG suggests that intense and debilitating grief symptomatology may be beyond the reach of well-intended gestures of supporters, and may instead call for professional intervention (Currier, Neimeyer, & Berman, 2008).

Limitations of this Study

Although the present study provides a more detailed view of the relationship of social support to bereavement distress than previous studies, and does so for a relatively neglected and highly symptomatic group of survivors, design constraints limit the interpretation of the data generated. For example, although to our knowledge no study has conducted a similarly detailed analysis of a significant number of African-American homicide survivors, a larger sample size would have enabled more sophisticated statistical analyses, permitting an assessment of the role of several social network and support variables in predicting or mediating the stress of a loved one's murder. Moreover, the cross-sectional nature of the study

makes it impossible to evaluate genuinely prospective predictions, to consider, for example, whether high levels of early social support predict lessened bereavement symptomatology in the months that follow, or vice versa. Clearly, to accurately analyze the social needs of homicidally bereaved African Americans, we must measure how facets of the bereaved's social support and his or her response to the loss are related over time (van der Houwen et al., in press).

Furthermore, given the dearth of scales for measuring social support among grievers as well as the complexities of measuring social support networks, most bereavement studies resort to using standard instruments that assess only perceived general support. Admittedly, only one of our scales was designed specifically to assess grief support following loss. The development of other general- and grief-specific social support scales designed to assess the unique experiences of grievers is greatly needed in order to advance this arena of bereavement research, as are culturally specific scales for use with minority populations, such as African Americans. Future studies examining negative social relationships or interactions would benefit from the use of scales that measure this variable in greater depth. Finally, because our aim was to examine an understudied population—African Americans traumatized by homicide—we recognize that this study's results cannot be generalized to other populations or even to African Americans who differ in their demography or the character of their loss from the present sample. Moreover, despite lacking concrete data on endorsement of a faith tradition, because our sample was recruited through a faith-based organization this factor may limit our study's generalizability to the larger population. Still, we have succeeded in our attempt to offer a descriptive overview of a large number of social support domains that are commonly experienced by bereaved individuals, carefully examining them in homicidally bereaved individuals. A logical next step would entail the use of a longitudinal design incorporating structured, diagnostic interviews in the evaluation of psychological sequelae of homicide loss, potentially yielding even clearer bereavement outcome markers with which to examine the affects of social support and other factors that could mitigate the impact of violent death bereavement in vulnerable populations.

Clinical Implications

For mental health professionals assisting African American grievers, especially the violently bereaved, the present study can act as a guide to considerations surrounding the bereaved's social support system. However, rather than offering hard and fast rules, our findings may steer the empathic clinician toward an increased sensitivity to what may or may not be available to this population in the way of support following traumatic death. For instance, although grief-related social support was unrelated to complicated grief, our sample's overall general- and grief-specific support, and social network size were somewhat larger than the

Caucasian samples in other studies with which they were compared. These findings are consistent with previous research that shows that, in the face of tragedy, African Americans turn naturally to their community for support, by accessing a larger network of family, friends, neighbors, and other informal helpers (Laurie & Neimeyer, 2008). Yet, along with Barrett (1998), we encourage therapists to be attentive to the varied and numerous sociocultural issues facing both Black grievers and those who are victims of violence (Barrett, 1996). For example, as there is a paucity of research on African-American homicide survivors, this also implies a resultant lack of culturally appropriate interventions designed to meet their needs, potentially increasing their reluctance to seek out treatment. Barrett (2001) specifically emphasized that clinicians should recognize and respect the role of spirituality espoused by many African Americans confronting death and bereavement. Pointing Black homicide survivors toward church- or faith-based counseling and grief support groups would likely affirm aspects of their culture that can aid them in the grieving process. Furthermore, as clinicians gain knowledge about how African-American homicide grievers traverse bereavement, they, in turn, are in a position to share that knowledge with those in the faith community.

Knowledge that the size of the available support network plays a role in bereavement adaptation can encourage the therapist to carefully enumerate and augment with the client specific named members of the social network who could provide support of different kinds, rather than simply consider perceived social support more globally. By the same token, our findings suggest that strategizing with the client how to negotiate adverse or intrusive social interactions or consider how to buffer oneself from their effects could be useful, perhaps providing coaching in communication skills for managing difficult encounters (Burns, 1989). However, enhancing social support is no panacea, insofar as problematic and protracted grief responses exhibited by complicated grievers may be more than what the average lay supporter can accommodate. In such cases, professional intervention may well be called for, as it is precisely when symptomatology is intense and debilitating that grief therapy appears to offer substantial benefits (Currier et al., 2008).

In summary, the present findings suggest that various dimensions of social support, from network size and the number of negative relationships through grief-specific support, play a role in adaptation following the murder of a loved one. We hope that future studies will build on this foundation, examining what specific forms of assistance from what specific caregivers might mitigate the pain of traumatic loss. Likewise, we encourage future investigators to study the probable interplay of social and psychological features in bereavement adaptation, as impoverished support may contribute to the demoralization or self-blame of homicide survivors, just as their intense and prolonged symptomatology could stress naturally occurring support systems, potentially leading to withdrawal of the social field. Designing a study that yields meaningful results by

using social support scales appropriate for grievers is complex. Although there is much more research to do, we hope that our contribution will spur further inquiry into social support in bereavement, and particularly in underserved, marginalized populations.

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