Grief following homicidal loss
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Chapter 7

Summary and General Discussion
Summary

Homicidally bereaved individuals have to deal with the notion that their loved one is deliberately taken from them: the death is caused by the premeditated action of another individual, most often unexpected. While the psychological consequences for the people left behind are assumed to be great, few studies systematically examined psychopathology following homicidal bereavement. The aim of this dissertation was threefold. First of all, adaptation to homicidal loss was examined, predominantly in terms of CG symptoms and PTSD symptoms (Chapter 2 and 3). The second key aim was to look closely at revenge following homicidal loss; first by examining the association between dispositional and situational revenge on the one hand and CG, PTSD and positive functioning on the other hand (Chapter 4), and second, by examining the association between negative cognitions and avoidance on the one hand and CG, PTSD, anger and revenge on the other hand (Chapter 5). The third point of this dissertation was to evaluate a combined treatment of EMDR and CBT for homicidally bereaved individuals (Chapter 6). This final chapter will provide a summary of the findings, thereby answering the research questions underlying this study. The summary will be followed by a discussion of the main findings, along with description of the limitations and several suggestions for future research.

A systematic review of psychopathology among homicidally bereaved individuals

The systematic review regarding psychopathology following homicidal loss included eight studies, in which PTSD, depression, CG and substance abuse were assessed (Chapter 2). Prevalence of lifetime homicide-related PTSD varied widely, from 19.1% to 71% across studies. Current PTSD varied between 5.2% and 6%. A comparison of the nature and prevalence of psychopathology between studies was complicated by unequal sample sizes and type, recruitment strategy, study design and time since loss. Based on the findings, it cannot be stated what kind of psychopathology is most experienced by homicidally bereaved individuals. Included studies suggest that PTSD is most frequent. Yet, this conclusion may represent an overestimation since PTSD was measured in all eight studies, whilst depression, CG, and substance abuse were measured in only four, two and one study, respectively. To answer the question which disorder is most prevalent following homicidal loss, studies should include assessments of multiple disorders. The reviewed literature is inconclusive about the severity of psychopathology among the homicidally bereaved individuals when compared to individuals bereaved by suicide, accident or vehicular homicide and victims of interpersonal violence.

Prevalence of CG and PTSD after homicidal loss

Prevalence rates and correlates of self-reported PTSD and CG were examined among 312 individuals confronted with homicidal loss (Chapter 3). A prevalence rate of PTSD of 33.3%, and a prevalence rate of CG of 81.9% was found. Participants were
recruited by two means, via case managers of Victim support (Slachtofferhulp) and by support groups. The time since loss differed significantly between the so-called “case manager group” (three years), and the “support group” (nine years). Because of this difference, the results for both groups were reported separately. The prevalence rate of PTSD was 30.9% for the support group and 37.5% for the case manager group. The prevalence rate of CG was 82.7% for the support group and 80.6% for the case manager group. Closeness of the relationship between the participant and the victim was associated with symptom severity: spouses and parents experienced higher levels of CG symptoms than non-immediate family members. Parents also experienced higher levels of PTSD than non-immediate family members (support group), or than children and friends (case manager group). PTSD and CG levels were lower for participants for which the loss occurred longer ago. Females reported significantly higher PTSD scores (both case manager and support group) and CG scores (only case manager group) than males. PTSD and CG levels did not differ according to whether the perpetrator was known versus unknown, or an intra- or extra-familiar individual of the participant. The conviction of the perpetrator was correlated with heightened symptom levels. Specifically, when the legal process was still on-going, participants reported higher PTSD and CG scores than when the perpetrator was convicted (case manager group). This finding was probably related to time since loss, which was shorter in the casemanger group. In the first years post loss, it is more likely that the legal process is still on-going, than when the loss happened longer ago.

Revenge following homicidal loss

Among 331 homicidally bereaved individuals, the relation was examined between two types of revenge, namely dispositional and situational revenge, and adaptation to homicidal loss (Chapter 4). Situational revenge, directed at a specific perpetrator in response to a specific incident, and dispositional revenge, someone’s general attitude toward revenge, were both positively associated with PTSD and CG, and negatively associated with positive functioning. A multivariate regression model with dispositional revenge and situational revenge as independent variables and CG, PTSD and positive functioning as dependent variables yielded an explained variance of 18% of CG, PTSD and positive functioning. Dispositional revenge and situational revenge explained 17% of the variance in CG, and 7% of the variance in PTSD and positive functioning. Both types of revenge explained CG, whereas only situational revenge explained a significant amount of variance in PTSD and positive functioning. Homicidally bereaved individuals did not differ significantly from a comparison group of students exposed to minor transgressions, such as being cut off in traffic, in terms of dispositional revenge. Homicidally bereaved individuals did report higher levels of situational revenge than a sample of students who experienced for example betrayal in a close relationship. This indicates that homicidally bereaved individuals are not more vengeful in general. They are however more vengeful toward the perpetrator who murdered their loved one than students are towards the person who harmed them.
Revenge, anger, negative cognitions and avoidance behavior following homicidal loss

Among 331 homicidally bereaved individuals, the association was examined between CG, PTSD, anger, and revenge on the one hand, and four types of negative cognitions and two types of avoidance behavior on the other hand (Chapter 5). Results showed that negative cognitions about the self, catastrophic misinterpretations of grief reactions, and depressive avoidance were uniquely associated with variance in symptom levels of CG and PTSD. Negative cognitions about the self was the only cognitive behavioral variable that had a unique association with anger. Revenge thoughts and feelings were uniquely associated with anxious avoidance and with negative cognitions about the future. Among other things, these findings suggest that it could be beneficial to address negative cognitions and avoidance behavior in the treatment of emotional distress following homicidal loss.

Treating CG and PTSD with CBT and EMDR: A randomized controlled trial

The effectiveness of brief, 8-session, treatment encompassing CBT and EMDR to reduce self-rated CG and self-rated PTSD in homicidally bereaved participants was examined by means of a randomized controlled trial (Chapter 6). A total of 85 participants with elevated levels of CG, PTSD, or both were allocated to one of four conditions: (a) an intervention condition with EMDR followed by CBT; (b) an intervention condition with CBT followed by EMDR; (c) a waiting list condition with EMDR followed by CBT, or (d) a waiting list condition with CBT followed by EMDR. All conditions started with two introductory sessions. Participants received three EMDR sessions and three CBT sessions.

Participants who had completed the treatment reported significantly fewer symptoms of PTSD and GR compared to people in the waiting group, with large and very large effect sizes. Average CG and PTSD scores were significantly lower at mid-treatment, when participants completed three sessions of EMDR (without CBT), compared to pre-treatment. The same result was found when participants completed three session of CBT (without EMDR). Participants in both treatment orders (EMDR followed by CBT and CBT followed by EMDR) showed significantly lower CG and PTSD symptoms at post-treatment when compared with pre-treatment. Orders were equally effective in reducing CG and PTSD symptoms. The results found in this study were comparable for CG symptoms and PTSD symptoms, with the only difference that PTSD symptoms remained stable between post-treatment and a six month follow-up, whereas CG symptoms increased significantly between post-treatment and follow-up. Treatment effect on CG and PTSD symptoms did not vary according to participants’ gender and the recruitment strategy (i.e., recruited via support organizations for homicidally bereaved individuals, the governmental organization Victim Support, or the internet).
General discussion

Homicide is, next to love, probably one of the most represented subjects in books and movies. The entertaining element is central to these representations in popular media, while homicidal loss is on a personal level probably one of the worst things someone may experience. In the Netherlands, between 140 and 150 individuals are murdered each year (Centraal Bureau voor de Statistiek, 2016; Leistra, 2015), leaving an estimated amount of 560 to 600 direct loved ones of the victim behind who experience the emotional consequences of homicidal loss. Many newspapers and television programs report about homicidal cases, but there are few scientific studies about the psychological consequences for the people left behind. As noted in the systematic review presented in Chapter 2, the consequences of homicide are sometimes described in scientific literature as dramatic (e.g., “losing a loved one to homicide is a chronic, never-ending trauma” (Thompson, 1996: 3-4)). However, there is limited empirical data on which this is based. The extent of Complicated Grief (CG) and symptoms of Posttraumatic Stress Disorder (PTSD) are unclear in terms of prevalence rates. It is also unclear whether interventions may help to alleviate these symptoms in homicidally bereaved individuals (Rynearson, Schut, & Stroebe, 2013). The studies presented in this dissertation were designed to improve insight in bereavement following homicidal loss. This general discussion provides a reflection on the main findings, a discussion of the limitations and suggestions for future research, and the contribution of this dissertation to the existing body of knowledge.

1. Reflection on findings and directions for future research

1.1 Prevalence of CG and PTSD following homicidal loss

The prevalence study (Chapter 3), showed high prevalence rates of CG (81.9%) and PTSD (33.7%). This study was one of the first to report a prevalence rate of CG following homicidal loss. The majority of the bereavement literature following homicidal loss, or more general following violent loss, has focused largely on PTSD and depression, rather than on CG (for other reviews, see Kristensen, Weisaeth, & Heir, 2012; Rynearson et al., 2013). The prevalence rate of CG following homicidal loss was found to be higher than a variety of other death causes, such as natural loss (10-20%, Prigerson, 2004), violence during military operations (30%, 2.5 years post-loss, Ginzburg, Geron, & Solomon, 2002), war-related violence (38%, seven years post-loss, Morina, Rudari, Bleichhardt, & Prigerson, 2010), suicide (57-78%, Dyregrov, Nordanger, & Dyregrov, 2003), and the tsunami in South-East Asia (12%, six years post-loss, Kristensen, Weisaeth, Hussain, & Heir, 2015) (see also Nakajima, Ito, Shirai, & Konishi (2012) for prevalence rates of CG among bereaved individuals by other violent and non-violent death causes).
1.1.1 Methodological implications: different cut-off scores for CG

To nuance these high prevalence rates following homicidal loss, several methodological considerations have to be taken into account. Consistent with previous research in the context of CG following bereavement, a relatively liberal cut-off score of the 19 items of the Inventory of Complicated Grief (ICG; Prigerson et al., 1995) was used; > 25 on the ICG, ranging from 0 to 76). Based on this liberal cut-off score, a prevalence rate of CG of 81.9% was found. When a more conservative cut-off score of > 90 was used with the 29 items version of the ICG-revised (based on research by Boelen, Van den Bout, De Keijser, & Hoijtink, 2003), a prevalence rate of 49.2% was found in the same sample (see Chapter 5). As can be seen, the different cut-off scores yield a difference of more than 30%. The more conservative cut-off score, determined based on the structured clinical interview Traumatic Grief Evaluation of Response to Loss (TRGR2L), is better validated than the cut-off score of > 25 (Boelen et al., 2003). In this dissertation however, the more liberal cut-off point was used to allow comparison with prevalence rates found in other studies, for example in relatives of missing persons (46.6%, N = 134, Lenferink, 2016), following sudden loss in the intensive care unit (52%, N = 475, Kentish-Barnes et al., 2015), in earthquake survivors in China (71.1%, N = 803, Li, Chow, Shi, & Chan, 2015) and in earthquake survivors in Iran (76%, N = 400, Ghaaffari-Nejad, Ahmadi-Mousavi, Gandomkar, & Reihani-Kermani, 2007). However, by using a too liberal cut-off, the prevalence of CG following homicidal loss may have been overestimated. When other studies take the prevalence rate of 81.9% as a reference, it is important that authors also report the prevalence of 49.2% when the more conservative cut-off of > 90 is used.

1.1.2 A multiplicity of terms to refer to CG

The fact that different cut-off scores, which are all used to assess CG, are reported in the literature seems symptomatic for the scientific study of CG. Not merely cut-off points, but also the duration of symptoms before one can speak of CG, in- or exclusion of the disorder in the DSM, and the terminology regarding the psychopathology, and the type of loss, all lack consensus and are subject of an ongoing debate between scientists. For example, the duration of CG symptoms required for the diagnosis has hypothetically been established at two months and six months (Boelen, 2005), and now, in the DSM-5 (where CG is termed Persistent Complex Bereavement Disorder), at 12 months (APA, 2013). Also, there are multiple synonyms used in the literature to refer to CG and to the loss itself. Complicated Grief is also referred to as prolonged grief disorder, complicated grief disorder, pathological grief, traumatic grief, and Persistent Complex Bereavement Disorder (PCBD). Homicidal loss falls in the category of traumatic loss, (Smid et al., 2015), traumatic death (Rando, 1996) and sudden and violent loss (Currier, Irish, Neimeyer, & Foster, 2015; Kristensen et al., 2012).

The lack of consensus about the duration of symptoms and the cut-off scores, together with the multiplicity of synonyms used to refer to CG and to the type of loss, make it difficult to find relevant studies and to compare results across studies. In agreement with Currier, Holland, and Neimeyer (2006), it would be proposed to
use one terminology to denote the objective mode of death (for example homicidal loss) and another terminology for the subjective experience of the loss (Currier et al., 2006; Kristensen et al., 2012). This may avoid different interpretations, facilitate comparison of results across studies and facilitate the allocation of relevant articles. The position of grief in the different versions of the DSM (from an exclusion criterion for major depressive disorder in the DSM-III (1980), with a V-code in the DSM-IV, included in the section ‘Conditions for further study’ in the DSM-5 (APA, 2013)), might contribute to more uniformity in the study of CG.

1.1.3 High prevalence rates of CG and PTSD among members of support groups

The high prevalence rate of CG reported in this dissertation could be due to a selection bias. As described previously, participants were recruited via the governmental organization Victim support, support groups for homicidally bereaved individuals, and a website. This may have caused selection bias. The group of bereaved individuals who were not covered by these recruitment strategies, is possibly the largest group. Because of privacy reasons, it was not possible to obtain the names of these individuals from the police or other governmental institutes. Thereby, these individuals could not be included in the study as participants. It seems probable that the prevalence rates presented in Chapter 3 give an overestimation when compared to the general population of people bereaved by homicide. The participants included in the study received some type of help (Victim support or help by a support group), or sought information about help by their own means (on the internet), which might implicate that they already suffered from some symptoms, while people who did not receive any type of help were underrepresented in the study. Together, this may implicate that the prevalence rate of CG and PTSD in the general population of homicidally bereaved individuals is likely to be lower than reported in this dissertation.

1.1.3.1 Membership of support groups for homicidally bereaved individuals: its function

In Chapter 3, prevalence rates of CG and PTSD were presented for participants recruited via Victim support (hereafter called non-members (Chapter 3) and for members of support groups (hereafter called members). The governmental organization Victim support advices homicidally bereaved individuals on practical and legal matters (i.e. arranging the funeral; dealing with the media). The support groups on the other hand have a supportive character: they organize casual meetings in which individuals can share their experiences with other members who also lost someone due to homicide. As reported in Chapter 3, the time since loss was longer for members (nine years) than for non-members (three years). CG and PTSD scores were found to be significantly lower with the passing of time. Based on that finding, it was expected that participants for whom the loss happened longer ago (c.q. members) reported lower CG and PTSD than for more recently bereaved individuals (c.q. non-members). Interestingly, that was not the case; members did not significantly differ in terms of reported CG and PTSD scores from non-members. This finding questions the
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common assumption that support groups are beneficial for bereavement outcomes (Levy, Derby, & Martinkowski, 1993). Members of support groups, as well as the general community, typically assume that support groups have beneficial effects. However, earlier studies found contradictory results. Some studies about (non-homicidal) bereavement found positive or no effect of membership on bereavement symptoms (Pistrang, Barker, & Humphreys, 2008); following conjugal bereavement, attendance at a larger number of meetings was found to be associated with smaller reductions in anger and medication usage (Levy et al., 1993); following suicidal loss, mutual contact (c.q. contact with a person who also experienced suicidal loss and was unknown prior to the loss), was associated with increased complicated grief (De Groot & Knollen, 2013). In sum, positive as well as negative effects of membership are found in the literature. Comparison of the results between studies is difficult because studies operationalize support groups differently and do not always report number of meetings attended, organization structure and program. Also, it is difficult to unravel what these results imply about the effectiveness of support groups, since cause and effect cannot be established in cross sectional research.

One way to look at the relation between membership of support groups and adjustment to loss is from the function of membership. The three support groups from which participants were recruited seemed to have at least two functions: aid in the sense of sharing experiences between members (the support function), and aid in the sense of lobbying for expansion and strengthening of legal rights for victims and bereaved individuals (the societal function). The support- and societal function of support groups may be based on different assumptions. The support function lies in the offering of support by means of sharing experiences, recognition, and finding understanding between members. With regard to this function, ‘success’ is achieved when members drop out of the support group, because they have achieved the benefit they sought from the group (Levy et al., 1993; Parkes, 1987). The societal function of support groups is fulfilled by speaking to victim organizations, politics and judges about extension of legal rights for victims of crimes and bereaved individuals. Examples are information about placement of the perpetrator, monetary gains for suffered damages, and the right to speak at the trial about the (emotional) consequences of the loss, known as the Victim Impact Statement. The societal function can be exerted by the virtue of a problem, such as the emotional burden of homicidal loss and the limited rights of bereaved individuals. Promoting better rights for homicidally bereaved individuals and revisions of laws may take many years. This strengthens a persistent focus on the manner of death, the perpetrator and experienced injustice, and as such requires membership at great length. This may contribute to the persistence of symptoms: the societal function of a support group may make bereaved individuals inclined to focus on their victim role and to events that occurred in the past (i.e., the homicide). This may prohibit a focus on the future and on adjustment to a life without the deceased. A forward orientation is associated with more positive coping and adjustment and seems more beneficial for bereaved individuals than a past orientation (Baumeister, Exline, & Sommer, 1998). Future studies may provide further insight in the different functions of support groups in
relation to adjustment following homicidal loss.

1.1.3.2 The Victim Impact Statement

Based on the previous outline, it cannot be easily answered whether or not attendance of support groups is beneficial for bereaved individuals. The same seems true for other developments that are currently emerging for victims of crimes and bereaved individuals. One example is mediation; direct or indirect contact between victim or bereaved individual and the perpetrator. Another example is the Victim Impact Statement (VIS); the right to deliver a written or oral statement during the judicial process. The goals of the VIS are informing the judge, confronting the perpetrator with the (financial, social, psychological and physical) harm of the offense and making the victim more visible (Lens, Pemberton, & Groenhuijsen, 2010; Lens et al., 2015).

Studies find contradictory results regarding the influence of such procedures on PTSD symptoms, anger, anxiety and revenge in victims and bereaved individuals (see for example Frazier, 2003; Lens et al., 2015; Rimé, 2009; Van Stokkom, 2012). Procedures such as the VIS likely have both positive and negative effects for bereaved individuals. These effects may be seen from the shattered assumptions theory of Janoff-Bulmann (1992), as shortly described in the general introduction of this thesis. According to the shattered assumptions theory, people have fundamental assumptions about themselves and the world, such as the belief in a benevolent, safe, and predictable world. Individuals are believed to be worthy and competent (Edmondson et al., 2011; Janoff-Bulman, 1992). Extreme life events, such as life-threatening illnesses and criminal assaults such as homicide, are likely to shatter these fundamental assumptions because they are extreme and unexpected in the normal course of life (Janoff-Bulman, 1992). Changed worldviews as a consequence of traumatic events are related to traumatic distress and psychopathology (Edmondson et al., 2011). Recovery would then require integration of the traumatic experience in the victim’s assumptive world (Janoff-Bulman, 1992).

What may be negative effects of the VIS, and how can use of the VIS by homicidally bereaved individuals violate their assumptions? By using the VIS, bereaved individuals attend the courtroom and become confronted with the perpetrator. An indifferent or unashamed attitude of the perpetrator, together with horrific details about the violence committed against the victim, may even further violate the assumption of the bereaved individual that the world is just and safe, and that individuals are trustworthy. Using observations of eighteen sentencing hearings of homicide offenders, it was examined whether offenders took responsibility for their crime, showed remorse and expressed an apology (Booth, 2013). None of the offenders took responsibility of the crime; they mitigated their culpability because of mental illness or intoxication at the time of the killing, blamed the co-accused or even shifted some of the blame on to the deceased on the basis of provocation or self-defense. Only four offenders expressed remorse or regret to the family of the victim. In general, the majority of the offenders did not respond to the VIS at all and remained impassive (Booth, 2013), a result consistent with another study regarding offenders
attitudes during the VIS (Rock, 2010). Based on these findings, it seems unlikely that assumptions of bereaved individuals will be repaired by use of the VIS, at least not by the attitude of the perpetrator. The relation between the behavior of the perpetrator during use of the VIS and the wellbeing or assumptions of the user of the VIS have, as far as known, not yet been studied. If the perpetrator displays behavior that does not fit, or even further undermine, the assumptions of the bereaved individual, will that be associated with a negative effect of the VIS for the bereaved individual? Although the behavior of the perpetrator is not controllable, it might still be useful to know more about this association; expectations of bereaved individuals about offender behavior can be tempered and they can use this information to make a considered choice whether or not to use the VIS.

On the other hand, the VIS may be used to repair violated assumptions. In rebuilding assumptions, it is important to positively construe aspects of the traumatic experience, to find meaning in the suffering, and to regain a sense of self-worth and control (Janoff-Bulman, 1992). Following homicidal loss, bereaved individuals are confronted with an array of uncontrollable events. Informing the judge and confronting the perpetrator about the harm of the offense are opportunities to regain a sense of control. Even the fact that bereaved individuals have a choice whether or not to use the VIS, may contribute to their sense of control and self-worth. In a study about the effectiveness of the VIS on the emotional recovery among victims of severe violence, users of the written VIS (writers), users of the spoken VIS (speakers) and non-users were compared with each other. Results showed that victims who used the VIS (writers and speakers) experienced lower initial levels of control over their recovery process than non-users. However, by using the VIS, writers and speakers reported significantly more control over their recovery process than non-users (Lens et al., 2010). This is an important finding, since experienced control over the recovery process among victims and higher levels of procedural justice are associated with decreased levels of anger and anxiety (Lens et al., 2015) and distress (Frazier, 2003). Following victimization, people might experience a newly found awareness of one’s own strengths and possibilities, despite the new recognition that the world is more dangerous than previously held (Janoff-Bulman, 1992). Facing and confronting the perpetrator with their pain may contribute to this awareness of strength.

Altogether, the increasing possibilities for bereaved individuals in the juridical process, such as mediation and the VIS, may be beneficial because they give bereaved individuals a regained sense of control and a chance to rebuild shattered assumptions. Some open questions that remain are: What is the association between gaining a sense of control during the juridical trial and psychopathology following homicidal loss, such as CG and PTSD? And how does the behavior of the offender during the VIS influence the wellbeing of homicidally bereaved individuals who make use of the VIS?

1.2 Revenge following homicidal loss

Another topic that warrants further attention is the role of revenge following homicidal loss. In the studies about revenge (Chapter 4 and 5), the term ‘revenge
thoughts and feelings’ was used. Since revenge is already conceptualized in many ways (see for example Grobbink, Derksen & van Marle, 2015), it is important to avoid any misinterpretations. In hindsight, it would have been better to use the terms dispositional and situational revenge.

The results confirmed the association between revenge and psychopathology: bereaved individuals with higher levels of dispositional and situational revenge also experience higher levels of CG and PTSD (see Chapter 4). However, the association between both types of revenge and psychopathology was less strong than expected. Situational revenge was a stronger predictor of CG and PTSD than dispositional revenge. Cross-sectionally, it was found that both types of revenge together were weak predictors of CG (17%) and PTSD (7%). This may indicate that homicidally bereaved individuals do have thoughts and feelings about revenge, but that vengeful thoughts and feelings have little impact on the psychological processes underlying CG or PTSD. It should be noted that the instrument that was used to assess dispositional revenge was designed to measure attitudes toward personal vengeful responses to perceived wrongdoing (Stuckless & Goranson, 1992). There may be an incongruity between, on the one hand, someone’s attitude about the appropriateness to take revenge and, on the other hand, (intrusive) thoughts and feelings about revenge, or the felt need to actually take revenge in terms of action. A positive attitude towards revenge in general (i.e., “I think it is fair to take revenge after a transgression”), does not automatically imply actual vengeful behavior. In a similar vein, it has been shown that suicidal thoughts not necessarily also translates in actual attempt to commit suicide (suicide ideation versus suicide attempt) (Nock et al., 2008). In other words, a positive attitude about the appropriateness to take revenge is not necessarily informative about the degree to which a person suffers from vengeful thoughts. One way to operationalize revenge may be the degree to which somebody ruminates about the offender (i.e. what should I do when I meet the offender? How can I hurt him? How can I make him suffer?). Rumination has been found to be associated with maintenance of psychopathology, such as anxiety, depression and CG (Aldao, Nolen-Hoeksema, & Schweizer, 2010; Eisma et al., 2015). Such an operationalization might be more useful to examine whether homicidally bereaved individuals suffer from revenge thoughts and feelings and whether or not that complicates adjustment following homicidal loss.

1.2.1 Revenge and anger

Another common reaction to loss, next to revenge, is anger (Frijda, 1988). Anger, a strong feeling of annoyance, displeasure or hostility, may be a reaction to a situation in which someone has been deliberately and improperly mistreated, and where someone was to blame for (Averill, 1982; Frijda, 1988; Wyer, & Srull, 1993). In this case, it exhibits some similarities with revenge, since vengeful feelings are also elicited following intentional harm and perceived wrongdoing (Stuckless & Goranson, 1992). The trigger for anger and revenge may be similar, but the continuation is different. Taking revenge leads to an aggressive action against the offender (McCullough, Bellah, Kilpatrick, & Johnson, 2001), while anger might be communicated but without
the need to cause him harm. Following this line of reasoning, it seems likely that revenge is accompanied by anger, but not always vice versa, i.e., vengeful individuals are also angry at the offender, but angry individuals are not necessarily vengeful. This is slightly reminiscent of the view of McCullough, Kurzban, and Tabak (2013), who states that “anger is the motivational system that brings about revenge” (p. 8).

Based on the results in this dissertation, it seems that anger may be of more importance following homicidal loss than revenge. The correlations of anger with CG, PTSD, four types of negative cognitions and two types of avoidance behavior were higher than the correlations of revenge with all these variables (Chapter 5). This seems to indicate that, for instance, when looking at CG, bereaved individuals with CG are more angry than they are vengeful. Bereaved individuals may be angry at the perpetrator but may not feel the need to cause him harm, for example, because they consider vengeful behavior as amoral and unlawful, or because they do not want to compare themselves with the behavior of the perpetrator.

While this result may provide some support for the importance of anger above revenge, the scale that was used have to be taken into account. To assess anger, the Hostility subscale of the Symptom CheckList-90 was used, a self-report measure to assess psychopathology (SCL, Derogatis, 1983; Dutch version by Arrindell & Ettema, 2003). The scale assesses thoughts, feelings, and actions which reflect the affect state of anger. Items included are “Feeling easily annoyed or irritated,” and “Temper outbursts that you could not control”. However, the hostility subscale of the SCL-90 is a limited operationalization of anger. It does not measure trait anger and does not differentiate between anger directed at others (in case of homicidal loss for example the perpetrator and the legal system (e.g., lawyers, judges)), and self-anger.

1.2.2 Blame
Yet another reaction related to anger is blame, which has been thought to be an important factor in distinguishing maladaptive from adaptive forms of grief (Field, Bonanno, Williams, & Horowitz, 2000). Following conjugal (non-homicidal) bereavement, Field et al. (2000) examined the effects of blame, directed at the deceased and at the self, on symptomatology. Results showed that blame at the deceased was associated with anger toward the deceased, while self-blame was associated with guilt. Blaming others was found to be associated with greater psychological distress (Field et al., 2000; Tennen & Affleck, 1990), whereas self-blame was associated with heightened levels of grief symptoms, and less decline in grief symptoms over time (Stroebe et al., 2014). The association between anger, blame, mental health and quality of life was also examined by Stuckless (1996) in a study where several death causes were compared. In participants who believed that authorities rightly held someone responsible for the death (culpability group) and in participants who believed that the death could not be attributed to someone (non-culpability group), anger was significantly associated with a lower quality of life. However, the relationship between anger and lower quality of life was stronger in the culpability group (Stuckless, 1996). Together, these results suggest that both anger and blame, directed at others or at oneself, are associated with distress following
bereavement. Blaming others is likely to be present following homicidal loss, directed either at the perpetrator or the judicial system. To understand and treat dysfunctional coping following homicidal loss, it may be important for researchers, clinicians and bereaved individuals to look at the function of particular thoughts and feelings, such as blame, anger or revenge.

1.2.3 The function of revenge and anger following homicidal loss

Both anger and revenge may be defensive and function as avoidance of loss. Since death is irrevocable, grief is related to helplessness and passivity, while anger and revenge give the impression that a situation could be changed, which gives bereaved individuals a sense of action and hope (Frijda, 1988). The illusion of change may make someone not forced to helpless misery or resignation (Frijda, 1988). Consequently, it may be easier for bereaved individuals to experience anger or revenge than grief. In the words of Frijda (1988): “Sadness, having to accept an unpleasant situation that cannot be undone, is one of the most difficult states to endure, a situation which one tries to avoid using all possible escape manoeuvres”(p. 449). The assumption that revenge may serve as an avoidance mechanism was supported by the findings presented in Chapter 5. Revenge thoughts and feelings were associated with anxious avoidance of loss-related stimuli. This indicates that individuals who are preoccupied with thoughts about revenge directed at the perpetrator are more likely to avoid situations, places, people or objects who remind them about the victim and that may elicit feelings or thoughts about the loss (Boelen, Van den Hout, & Van den Bout, 2006).

Clinically, these results imply that therapists should be aware of the function of feelings and thoughts about revenge and anger. Besides acknowledging vengeful feelings of clients, therapists could make clients aware that they might use revenge as a way to avoid connecting to the harsh reality of the loss itself. Therapy could address strategies and behavior to focus on feelings of loss and how to regain a meaningful life again. Therapists sometimes report to be so impressed by the magnitude of the loss and the vengeful feelings of their clients, that they find it difficult to give bereaved individuals insight in their avoidance behavior. Therefore, therapists need to be trained in effective coping with their aversive reactions, elicited by the emotional stories of their homicidally bereaved clients.

1.2.4 Anger, revenge and psychopathology: what is cause and effect?

Based on the cross-sectional design of the study, it is not possible to draw conclusions about causality: anger and revenge thoughts and feelings might lead to more CG and PTSD (i.e., it might be a vulnerability factor), or vice versa: CG and PTSD symptoms may lead to more anger and revenge thoughts and feelings in homicidally bereaved individuals. Other (non-homicidal) studies might provide some clues about this association. In a prospective study about the association between trait anger and PTSD over time in soldiers, it was found that higher trait anger before deployment was predictive of higher PTSD symptoms 2 month after deployment (Lommen, Engelhard, Van de Schoot, & Van den Hout, 2014). This finding supports
the view that anger is a vulnerability factor in developing PTSD following traumatic events (see for example also Ehlers, Mayou, & Bryant, 2003; Feeny, Zoellner, & Foa, 2000). A longitudinal study among crime victims of sexual and non-sexual assault found evidence for the opposite direction: PTSD levels predicted subsequent levels of anger, but not the other way around (Orth, Cahill, Foa, & Maercker, 2008). Future longitudinal studies may shed light on the causality of anger and PTSD and CG in bereaved individuals following homicidal loss.

1.3 Treatment issues

As reported in Chapter 6, the combination of EMDR and CBT was found to be effective for many participants, showing large effect sizes in reducing symptoms of CG and PTSD. However, not for all participants did their CG and PTSD symptoms decrease to a level below the clinical cut off point. There was no evidence that the treatment effect differed according to participants’ gender, time since loss, the treatment order (EMDR versus CBT or CBT versus EMDR), recruitment style (i.e., via support groups and Victim Support or via self-referral) or the relation between the perpetrator and the bereaved individual (intra-familiar versus extra-familiar).

Research into the variables that are associated with a less profitable treatment outcome following loss are scarce. In two studies, regarding non-homicidal loss, it was found that low educational level, kinship (namely loss of a partner or child) and higher initial levels of CG at pre-treatment were associated with worse treatment outcome (Boelen, De Keijser, Van den Hout, & Van den Bout, 2011; Piper, Ogrodniczuk, Joyce, & Weideman, 2009). Studies about worse treatment outcome following homicidal loss are lacking at all. Measures of educational level were not included in this dissertation, so it is not known if this variable moderates the treatment effect following homicidal loss. There is no clear explanation why kinship and initial levels of CG were associated with worse treatment outcome following non-homicidal loss, but not following homicidal loss. Another difference between these studies, apart from the death cause, was the therapy that was used; the study described in Chapter 6 included EMDR, while in the other studies, CBT (Boelen et al., 2011) and interpretive- and supportive therapy (Piper et al., 2009) was examined. It could be that the effect of EMDR is less strongly associated with background variables. If other studies with homicidally bereaved individuals do find a worse treatment effect due to these variables, then the effectiveness of the intervention with CBT and EMDR may be enhanced. For example by simplifying the workbook for lower-educated participants, and by longer treatment for spouses and parents and participants with initial high levels of CG, such as suggested by Boelen et al. (2011).

1.3.1 Other types of treatment

As reported previously, and in accordance with the cognitive behavioral model of Boelen et al., (2006), reductions in CG symptoms are associated with reductions in negative cognitions and avoidance behavior (Boelen, De Keijser, Van den Hout, & Van den Bout, 2007; Boelen et al., 2011). Measures of negative cognitions and avoidance were not included in the treatment study (Chapter 6). It may be that
individuals who profited less from the intervention were to a lesser extent capable of changing their negative cognitions and avoidance behavior by the 8 session intervention, leading to less improvement in CG and PTSD symptoms. Instead of offering those individuals longer CBT treatments, they may benefit from other types of treatment, for example of so called ‘third generation behavioral therapies’, such as Acceptance and Commitment Therapy (ACT; Hayes, Strosahl & Wilson, 1999) and Compassion Focused Therapy (CFT; Gilbert 2010). Although there are many third generation behavioral therapies (such as Mindfulness Based Cognitive Therapy, Dialectical Behavior Therapy, Metacognitive Therapy, Behavioral Activation and Functional Analytical Therapy), only ACT and CFT are discussed in this paragraph. Key focus of these therapies is changing the relationship someone has with his aversive experience, instead of the experience itself.

Results showed that negative cognitions about oneself (c.q. low self-esteem, shame, and negative self-worth), catastrophic misinterpretations of one’s own grief reaction and depressive avoidance, explained a unique proportion of the variance of symptom levels of CG, PTSD, anger and revenge (Chapter 5). Also, negative cognitions about the self were the only variables which had a unique association with anger. Given the finding that negative self-worth and low self-esteem play an important role in psychopathology following homicidal loss, CFT may be helpful for homicidally bereaved individuals with strong negative judgements. In CFT, the bereaved individual is helped to replace self-blame, condemning and self-criticism with a more compassioned attitude towards his thoughts and feelings (Gilbert, 2009, 2010). In a study among 134 relatives of missing persons, it was found that self-compassion was significantly negatively correlated with depression, PTSD and CG (Lenferink, 2016). This finding also points to the possibility that CFT might have beneficial effects following traumatic loss.

As noted, catastrophic misinterpretations of one’s grief reaction also explained unique proportion of the variance of symptom levels of CG, PTSD, anger and revenge. Bereaved individuals with such catastrophic misinterpretations may interpret their intense emotional reactions as intolerable or insane, and may have the feeling that they will go mad when they allow themselves to mourn. People may avoid the loss and reminders of the deceased because they assume not being capable of handling the grief. They want to protect themselves from discomfort and unpleasant thoughts (Worden, 2009). Individuals with catastrophic misinterpretations and avoidant coping strategies may also profit from ACT. With ACT, a person who is suffering from CG could be helped to increase his psychological flexibility to cope with the loss. This can be done by encouraging him to observe his distress and cognitions non-judgmentally, without trying to change the loss-related content of his thoughts, nor the intensity of the experienced emotional pain. Bereaved individuals are stimulated to refocus their attention on long-term goals (values) and are motivated to take actions toward those values, as those values serve as ultimate reinforces for living a vital life (Hayes et al., 1999). In doing so, ACT may be important for homicidally bereaved individuals that are likely to engage in depressive avoidance, defined as withdrawal from (social) activities which were important to the individual prior to the loss and which could
potentially provide positive reinforcement (Boelen et al., 2006). As ACT is aimed at accepting inevitable experiences and an active refocus on vitality and values, it may help homicidally bereaved individuals to become more inclined to engage in activities which could foster adjustment.

In sum, results showed an association between both negative cognitions and depressive avoidance with CG, PTSD, anger and revenge. That finding might provide a rationale for ACT and CFT when homicidally bereaved individuals may not profit from the initial CBT-based protocol. ACT has proven to be an effective treatment for a variety of psychological disorders (for an extensive review, see A-Tjak et al., 2015), and CFT was found particularly effective for individuals which high levels of self-criticism (for a review, see Leaviss, & Uttley, 2015). To date, no studies are available about the effectiveness of ACT and CFT on CG following natural loss or violent loss, such as homicide. Future studies may examine the effectiveness of these therapies on CG and the quality of life of homicidally bereaved individuals, thereby offering other treatment possibilities to homicidally bereaved individuals who do not benefit from the combined treatment with CBT and EMDR to a clinically significant degree.

2. Limitations of this dissertation

This is one of the first large series of empirical studies in which bereavement following homicidal loss was examined. The results presented in this dissertation have to be interpreted while bearing several limitations in mind.

2.1 Depression not included

In questionnaire research, there is a fine line between what scientists want to examine – mostly as much as possible – and what can be asked from participants, both mentally and time wise. CG and PTSD were the primary outcome measures in the studies included in this dissertation. Depression, also found to be associated with homicidal loss (Burke, Neimeyer, & McDevitt-Murphy, 2010; Freeman, Shaffer, & Smith, 1996; Rheingold, Zinzow, Hawkins, Saunders, & Kilpatrick, 2012), was not included. The main reason for this was to limit the volume of the questionnaire package, based on the idea that too many questionnaires will ask too much of the participant, in terms of possible distress (by filling in multiple questionnaires about severe symptoms) and time wise. In hindsight, when examining the psychological symptoms following homicidal loss, it can be questioned whether this was a good choice. CG and depressive symptoms often co-exist following bereavement. Studies examining non-homicidal bereavement reported that approximately between 50% and 70% of bereaved individuals who suffer from CG symptoms also meet criteria for a major depressive episode (Lotterman, Bonanno, & Galatzer-Levy, 2014). Four of the eight studies reported in the systematic review (Chapter 2), included depression. In two of them, prevalence rates were reported; for at least mild depression (54%, 1.8 years post-loss) and for past six month depression (8%, time since loss was not reported) (McDevitt-Murphy, Neimeyer, Burke, Williams, & Lawson, 2012; Rheingold
et al., 2012). Based on the comorbidity between CG and depression following loss, it is deemed important in future studies to include depression as an outcome measure when studying the impact of homicidal loss.

2.2 Generalizability of the findings

The generalizability of the findings presented in this dissertation is limited in several ways. First, recently bereaved individuals whose loved one died within the previous six months were not included. The participants in the study were Dutch citizens, predominantly of western cultures. It is not known to what extent the results could be generalized to recently bereaved individuals and to other, non-western, cultures. Second, this dissertation was restricted to bereaved individuals who lost someone by intentional death or by intentional and premeditated death (in Dutch doodslag and moord, respectively). People who lost a loved one by means of involuntary manslaughter (in Dutch dood door schuld) were excluded. The main difference between these legal definitions is the intent element, which is absent in involuntary manslaughter. An example is a drunken driver, who is legally held responsible for the death, although he did not intended to kill someone. It is not known to which extent the results found in this dissertation are generalizable to other types of loss in which bereaved individuals feel that another person is to blame for the death, such as accidents and loss due to medical mistakes. Literature about the association between (other) blame and mental distress and grief (Field et al., 2000; Stroebe et al., 2014; Tennen & Affleck, 1990) might support the idea that the results found in this dissertation may be generalizable to situations in which someone was to blame for the death, although the intent element is absent.

Third, this dissertation was restricted to bereaved individuals who lost someone by means of individual violence. Bereaved individuals of violence performed in a collective context, such as war, were excluded. Bereaved individuals of war victims and refugees may have to cope with additional stressors such as multiple loss, torture, and the flee to another unknown country without their acquaintances and belongings. It is unknown whether the results from this dissertation are generalizable to people in these circumstances. However, theoretically there are no reasons to assume that the association between for example negative cognitions and avoidance behavior in combination with CG and PTSD is different following war in a collective context than following individual violence.

Last, in all studies included in this dissertation, a measure of CG was included. CG has recently been found to be a different diagnostic entity than Prolonged Grief Disorder (PGD) and Persistent Complex Bereavement Disorder (PCBD) (Maciejewski, Maercker, Boelen, & Prigerson, 2016). In a sample of 317 (non-homicidally) bereaved individuals, different prevalence rates were found for CG (30.2%), PGD (11.9%) and PCBD (14.2%) 6 months post-loss. Results showed that the prevalence of CG was significantly higher than those of PGD and PCBD. This result may imply that the prevalence rate reported in Chapter 3 gives an overestimation, and that the prevalence rate is not directly generalizable to studies which measure PGD or PCBD following homicidal loss. Since the criteria for PCBD were not defined yet at the start
of this dissertation, it was not able to correspond with the DSM-5 criteria. Although many items of the tests for PGD and PCBD correspond with items of the Inventory of Complicated Grief, several other items are needed to investigate the different prevalence rates of CG, PGD and PCBD in the sample included in this dissertation (Maciejweski et al., 2016). In line with the current developments and to be consistent with the DSM-5, it is advised that in future research, the criteria for PCBD are used.

2.3 Type of instruments
Another limitation of the studies was the use of self-report questionnaires to assess prevalence rates of PTSD and CG. Self-report measures assumingly give an overrepresentation of psychological symptoms, thereby limiting the possibility of making more precise estimations of the prevalence of disorders (Engelhard, Arntz, & Van den Hout, 2007; Kristensen et al., 2012). As noted in the previous paragraph, the Inventory of Complicated Grief (ICG) was used to assess CG. The ICG is based on criteria from the DSM-IV-TR (APA, 2000), and is not entirely consistent with criteria for Persistent Complex Bereavement Disorder (PCBD) according to the DSM-5 (APA, 2013). Since PTSD was not formally assessed and diagnosed by a structured clinical interview, only probable PTSD or PTSD-related symptoms could be assessed. The Impact of Event Scale (IES) was used to assess PTSD symptoms (Chapter 6), because it is a widely used instrument, thereby allowing comparisons across studies. However, the IES measures only two of the four PTSD symptom clusters, namely avoidance and intrusions. These clusters are also symptomatic of CG. Hyperarousal, one of the symptoms which is characteristic for PTSD, but not for CG, was not assessed. In retrospect, the use of interview-based assessments such as the SCID-I, would be more suitable to draw conclusions about the effectiveness of the treatment for individuals with PTSD. Other limitations of self-report measures were the lack of more objective behavioral measures and the possibility that some individuals from the same family completed the questionnaires together. Because the prevalence rate for PTSD symptoms reported in Chapter 3 was based on a self-report measure, it is not known whether the intervention reported in Chapter 6 is also effective for participants who met formal criteria of PTSD.

2.4 Other limitations
Another limitation was the overrepresentation of women (71%) in the treatment study, limiting generalizations to the male population. A limitation of the studies about revenge, avoidance and negative cognitions (Chapter 4 and 5) was the cross-sectional design. Hence, it was not possible to draw conclusions regarding the direction of the association, i.e., whether homicidal loss is associated with psychological distress (c.q. CG and PTSD) which in turn accelerates feelings of revenge, or vice versa. Revenge, anger, avoidance and negative cognitions were measured at one time point, and were not included in the treatment study. Therefore, it was not possible to examine how these variables develop over time, nor to examine the effectiveness of CBT and EMDR on negative cognitions, avoidance, anger and revenge following homicidal loss. Another limitation of the treatment study (Chapter 6) was the lack of follow-up
data in the non-treatment control group. Since all participants received treatment, it was not possible to assess whether the effect at follow-up was solely due to the treatment or to spontaneous recovery, since there was no control group to compare with over that period of time.

3. What has this dissertation added to the existing body of knowledge?

Notwithstanding these limitations, this dissertation added broadly to the knowledge about homicidal bereavement, both on a scientific and a clinical level. Scientifically, the studies in this dissertation were the first to examine the prevalence of CG and PTSD related symptoms in such a large sample of homicidally bereaved individuals, while other studies used a small sample of homicidally bereaved individuals (McDevitt-Murphy et al., 2012) or grouped different causes of violent loss together (Asukai, Tsuruta, & Saito, 2011; Boelen et al., 2011; Bryant et al., 2014; Rosner, Pföh, Kotoucová, & Hagl, 2014; Wagner, Knaevelsrud, and Maercker, 2006). By means of this dissertation, insight is provided in psychopathology following homicidal loss, the relative importance of revenge, anger, negative cognitions, and avoidance behavior, and in the effectiveness of CBT and EMDR following loss by homicide. The scope of CBT and EMDR may be broadened, from a treatment for trauma and bereavement in following non-violent loss (Boelen et al., 2007; Currier, Holland, & Neimeyer, 2010) to bereaved individuals following homicidal loss.

Clinically, a specialized treatment for people whose loved one was murdered was examined. The short, 8 session treatment protocol, was found effective in reducing CG and PTSD symptoms for homicidally bereaved individuals. In order to make this treatment protocol widely available for therapists in the Netherlands and Belgium, the treatment protocol may be added in the current Dutch guideline for the treatment of CG (Boelen & Van den Bout, 2011). A nationwide network of trained therapists was constructed to treat the bereaved individuals. The creation of this network marked the beginning of an expert group of therapists who are specialized in the treatment of bereaved individuals following violent loss. Since 2016, this network is included in the Nationwide Expertise Network of Traumatic Grief in the Netherlands. Currently, the scope of this network is broadened to bereavement following disappearances (Lenferink, Wessel, De Keijser, & Boelen, 2016) and flight accidents (De Keijser, Boelen, Smid, & Lenferink, 2016). Bereaved individuals, as well as mental health care providers, now have access to a range of therapists with experience in the treatment of psychopathology following homicidal loss. Next to the treatment protocol, a website about bereavement following homicidal loss was developed, together with a workbook for bereaved individuals, which can be used in the treatment. This workbook could be made widely available for bereaved individuals as a tool for psycho-education following homicidal loss. More generally, this dissertation added scientific knowledge, as well as practical implications, about homicidal bereavement;
a situation experienced by a relatively small group of people, but with potentially large emotional consequences.
References


Bryant, R. A., Kenny, L., Joscelyne, A., Rawson, N., MacCallum, F., Cahill, C., . . . Nickerson,


Summary and General Discussion

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grief among Sichuan earthquake survivors. *Journal of Affective Disorders, 175*, 218-223. doi:10.1016/j.jad.2015.01.003


