Pastoral Psychol (2010) 59:179–189
DOI 10.1007/s11089-009-0228-4

The Clergy, the Clinician, and the Narrative of Violent Death

Edward K. Rynearson

Published online: 11 June 2009

Abstract When death of a loved one occurs, humans use stories as a way of processing their grief and releasing their emotional attachment. In the case of traumatic and violent death, the story telling process is distorted, and focuses intensely and sometimes obsessively, on a often fantasized reenactment of the dying. Violent dying grief is often complicated further by the public and legal processes that surround violent death. The bereaved who get stuck in this dynamic may constitute a new psychiatric diagnosis called "prolonged grief disorder" and the author describes the criteria for this disorder. Clergy can play a key role in stabilizing and meditating the effects of trauma by inviting the bereaved to refocus their story telling, to a story of the loved one's life. In a case the author illustrates many of the techniques used in this process of working with a prolonged grief disorder.

Keywords Violent death · Grief · Trauma · Therapy · Pastors

Introduction

Humans process and share emotive experiences through stories and story telling. The structuring of a story orders a series of events within a matrix of time, space and action—and that ordering first engenders coherence, then understanding, and finally meaning, as in timeless myths and religious parables when the story ends by celebrating a shared social or cultural value.

Stories of our personal, day to day living, while not so formal are nonetheless highly valued. We are most likely to construct enduring, personal stories around events with figures with whom we are emotionally attached who evoke intense feelings of fear or love. Unspoken or shared, the story of our attachment to these emotionally valued figures organizes the relationship on a template of time, space and action as a formative model—a

E. K. Rynearson (✉)
Clinical Professor of Psychiatry, University of Washington Department of Psychiatry,
Separation & Loss Service, Virginia Mason Medical Center, Seattle, WA 98105, USA
e-mail: edward@rynearson.com

relatively fixed narrative of relational security with caring figures and caring enactments. Recurring stories of attachment projected on every day living are challenged by themes of frustration, rejection and loss, but the stories of important attachment relationships of primary and extended family members help in maintaining psychological stability, marking continuity and durability in past and present and serve as predictive stories of future relational fulfillment.

Attachment stories continually unfold, but when dying and death occur as a reality rather than a fearful fantasy the attachment story is challenged by a narrative dilemma—the dying and death of a loved one introduces an anti-narrative, an aberrant story empty of relational fulfillment (Neimeyer and Levitt 2000). Further, the inevitable death of someone intrinsic to one's private self—a parent, sibling, spouse, child, an intimate, a best friend, even a pet—invariably triggers two disparate narratives of the deceased; the alluring remembrance of their living and the traumatic recounting of their dying and death. It is not just the narrative remembrance of the living with the deceased that is absorbing—the narrative of their dying, separable from the narrative of their living, may be even more so. The timing, setting and manner of dying shape and shade the narrative dying remembrance:

- When a loved one dies from a disease, or some "natural" cause, there is time and opportunity to share a dying narrative enactment with proximity, caring, respect and finally relinquishment. There is a place for loved ones in the unfolding dying narrative, painful but meaningful because natural dying is an anticipated ending to our own life narrative.
- If that same loved one is strangled to death after being raped and sodomized, those bereaved are traumatized and outraged. The narrative reenactment of violent dying is a solitary enactment of horror and helplessness isolated from the care, respect and protection of loved ones. This narrative is retold as an alienated event, a surreal story that loved ones cannot "own" because they played no role in its unfolding and is rendered meaningless because it never should have happened.

The narratives of natural and violent dying

With *natural* dying the deceased was not alone while dying. There was a care-giving role in the dying narrative for loved ones, offering restorative themes—remembered interactions within a time and space for "being there"—for caring and enactments of respect and relinquishment. Fragments of a natural dying may be recalled as traumatic, but the dying narrative provides a role for the bereaved to counterbalance the nihilism of death with a lasting remembrance of valued caring, actual participation in the dying enactment allowing ownership of a reality based reenactment narrative that can be retold from a caring perspective.

When the dying is natural but *sudden* (cardio-vascular calamity in adults or sudden infant death in children) the narrative reenactment of the dying is complicated by a dying that is instantaneous. The abruptness leaves little or no time or space for care-giving or relinquishing. And the dying remembrance may be dramatic and frightening—calling 911, attempting cardio-pulmonary resuscitation before the EMT team declares death or following the ambulance to the hospital where further resuscitative attempts result in death. These are traumatic narrative fragments that may appear as unbidden, intrusive, flashbacks or nightmares of the dying reenactment.

When the dying is *sudden and violent* (accident, suicide, homicide, terrorism) the narrative reenactment of dying is not only instantaneous, but alienated and abhorrent. Violent dying and death almost always occurs in a space and time apart from the bereaved and is announced by another. Violent dying, an external event involving human action, is

not from an impersonal, internal disease. It may also be mutilating and transgressive—and the last moments of the dying end in terror and helplessness for the victim.

Caused by human negligence (accident) or intent (suicide or homicide or terrorism), someone is potentially at fault for violent dying. This is a dying that should not have happened and the surrounding community insists on widespread alarm, investigation and mandated apprehension, retribution and punishment of whoever was responsible. The narrative of reenactment after sudden/violent dying "belongs" to the surrounding community and agencies of the police and court. Respect for the narrative privacy of the bereaved may be disregarded in the voyeuristic demand of the surrounding community for the public spectacle of reenactment and punishment.

The private story of sudden/violent dying is surreal, brutal and nonverbal; surreal because the bereaved was absent during the dying (only 5% of violent deaths are witnessed by loved ones), brutal because the dying is projected as a spotlighted, visual reenactment of the dying action, a procession of progressively frightening visual images constructed from reports from the police, the media, the detectives, the courts—and reinforced by an imaginary reenactment of what the victim was thinking, feeling and doing while dying. The fantasized replay of the dying drama roughly corresponds to a fear instilled childhood story of attachment and death run amok; when violent dying was merely threatened in fantasy, now violent dying is magnified not only by its reality but by its imaginary elaboration in nonverbal imagery because words could not be shared during the dying drama. There is no role or perspective of caring for the bereaved in this stark narrative, nothing save role of spectator, helplessly witnessing an imaginary spectacle of sudden/violent dying.

In the early days and weeks, trauma distress associated with remembrance of the dying is common. Flashbacks of the drama of the dying, avoidance of reminders of the dying and autonomic hyper-arousal spontaneously diminish in the ensuing months though may continue to be triggered by reminders. The experiential elements of the dying remembrance are aversive and incoherent, very different than elements of the attachment remembrance that are consoling and meaningful. Fortunately, there is a spontaneous diminishment of this traumatic syndrome within weeks of the dying, but a significant minority (20%) remains traumatized for many months or years (Rynearson 1984).

A prospective, community-based study has documented prolonged responses of trauma distress with reenactment flashbacks and avoidance in parents of children following sudden/violent dying. Nearly one third of bereaved mothers remain significantly traumatized and over half find no meaning in the tragedy 5 years after the dying. This enduring traumatic aftermath of sudden/violent dying is apparently a normative response (Murphy et al. 2002).

Trauma distress to the horrific dying and separation distress to the death are concurrent responses to violent dying (Rynearson 2001). While the thoughts, feelings and behaviors of trauma and separation distress are not specific, they are roughly separable into two syndromes (Table 1):

Prolonged grief associated with violent dying contains concurrent narratives of terror and interrupted attachment associated with intrusive thoughts, images and stories of the intersecting memories of the deceased, the dying and the self:

(1) *Dysfunctional images of the deceased contain their terror and helplessness as they were dying.*
(2) *Dysfunctional images of the dying recur as an involuntary witnessing of a disintegratory drama that cannot be controlled.*
(3) *Dysfunctional images of the self persist as being remorseful, retaliatory, rescuer, or ultimate protector for remaining friends and family members.*

Table 1

	Trauma distress	Separation distress
Thoughts	Reenactment	Reunion
Feelings	Fear	Longing
Behavior	Avoidance	Searching

The role of clergy and counselor

The existential impasse of death cannot permit the direct sharing of an "after life" narrative of attachment; however, this narrative irresolution may be counterbalanced by spiritual and faith inspired themes of spiritual release and reunion which are common to religious belief systems (Lord et al. 2008). The enormously comforting and plausible belief—that the spirit of the deceased not only exists but is enduringly transformed after dying—has been timelessly and ubiquitously celebrated and retold following death from any cause. The thematic triad of attachment, death and spirit may be essential ingredients in any bereavement narrative and belief in spiritual release and transformation is particularly restorative when the dying is violent.

Officiating through supportive prayer at the time of notification, and later through invocation, sacrament and ritual during the funeral and memorial ceremony places the clergy in a life affirming confluence—an intermediary figure between the bereaved survivor, the spirit of the deceased and the divine transcendence of violent dying and death. In planning the ceremony with the family, the clergy can direct a retelling that not only celebrates the living narrative of the deceased and ritualizes lament, but reframes the vitality of the deceased within a narrative that transcends mortal time, space, death and even the horror of violent dying. The spirit of the deceased is no longer trapped in the narrative of terror and helplessness. However, the utter meaninglessness of violent death and the resulting rage and disillusionment may pose a severe challenge to belief in a coherent order of any kind, including divine order.

The salient importance of spiritual and religious support after violent death has been documented in a longitudinal study of parents bereaved by the violent death of their child (Murphy et al. 1996; Murphy et al. 2003). In this rigorously designed survey (a large community-based sample of 261 parents serially assessed for 5 years) the most frequently reported resources of support were personal prayer (70%), church attendance (50%), pastoral counseling (30%) and peer led support groups (20%). The authors of the study offered a time limited support group randomly assigned to half of the sample which was enthusiastically endorsed, but there was no independent consultation with a mental health clinician cited. This finding is not surprising. Early clinical evaluation and/or intervention by mental health professionals for bereavement is not associated with better outcome and someone newly bereaved appropriately resists the stigma of seeking clinical counseling for a bereavement related distress that is predictable and self limited.

Because traumatically bereaved parents seek spiritual support before clinical consultation it is important that clergy be aware of the specific psychological effects and challenges of violent dying on bereavement—and recognize the clinical criteria of prolonged and dysfunctional grief (Table 2).

These familiar criteria of grief related signs and symptoms (primarily gathered from populations of adults after spousal death) now have sufficient empirical support to warrant the submission of "Prolonged Grief Disorder" to the DSMV committee of the American Psychiatric Association for consideration as a separate diagnostic entity. However, these same researchers note that a minority (10–20%) of bereaved subjects develop prolonged grief lasting longer than 6 months following death from any cause (Prigerson et al. 2008).

Table 2 Consensus criteria for prolonged grief disorder

A. Event criterion	Bereavement (loss of a significant other)
B. Separation distress	The bereaved person experiences at least one of the three following symptoms which must be experienced daily or to a distressing or disruptive degree: 1. Intrusive thoughts related to the lost relationship 2. Intense feelings or emotional pain, sorrow, or pangs or grief related to the lost relationship 3. Yearning for the lost person
C. Cognitive, emotional and behavioral symptoms	The bereaved person must have 5 (or more) of the following symptoms experienced daily or to a distressing or disruptive degree: 1. Confusion about one's identity (e.g., role in life or diminished sense of self, feeling that a part of oneself has died) 2. Difficulty accepting the loss 3. Avoidance of reminders of the reality of the loss 4. Inability to trust others since the loss 5. Bitterness or anger related to the loss 6. Difficulty moving on with life (e.g., making new friends, pursuing interests) 7. Numbness (absence of emotion) since the loss 8. Feeling that life is unfulfilling, empty and meaningless since the loss 9. Feeling stunned, dazed or shocked by the loss
D. Duration	Duration at least 6 months from the onset of separation distress
E. Impairment	The above symptomatic disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (e.g., domestic responsibilities)
F. Relation to other mental disorders	Not better accounted for by Major Depressive Disorder, Generalized Anxiety Disorder, or Post Traumatic Stress Disorder

In this model of prolonged grief the disorder is conceptualized as reactive, secondary to intense separation distress associated with the irreversible absence of a crucial attachment figure, and occurs in susceptible individuals who share an antecedent, bio-psychological attachment vulnerability, i.e. with permanent loss of the attachment figure the vulnerable survivor experiences an enduring sense of self-devastation which acts as the proximate cause of the prolonged grief syndrome (Jacobs 1999).

A specific time limited treatment (Complicated Grief Treatment) for prolonged grief has been developed and a recent study (Shear et al. 2005) with a randomly assigned series of patients has demonstrated its comparative efficacy over an alternative, time limited therapy (Interpersonal Therapy). Proponents of this model and intervention acknowledge the independent "traumatic" effects of violent dying on bereavement, but ascribe it to trauma distress as a separate disorder, PTSD. However, the traumatic effects of violent dying are not completely described by the PTSD criteria. Intrusive reenactment imagery of the dying, avoidance of reminders of the dying, physiologic hyper-arousal and persistent dysfunction may describe some of the reactive signs and symptoms, but there are specific effects of violent dying not included in the criteria for PTSD:

Specific phenomena of violent dying grief

- Violent dying is followed by a socially proscribed inquiry to determine who is "responsible" for the dying act. The intense inquest by the police, the medical examiner,

the media and the court (when the dying is considered criminal), reinforces the personal demand for retaliation and retribution. Natural dying is rarely followed by such a public inquiry, and it is not normative for grief following natural dying to include persistent thoughts, feelings or behaviors of retaliation, retribution or dread of recurrence in surviving loved ones.

- Since violent dying is the most common cause of death before age 40, a disproportionate number of younger parents and children are forced to accommodate to the violent dying of an attachment figure. Young mothers and children presenting for treatment are over represented in every study after violent dying (usually representing over half of the study sample), presumably because of the intensity of their intense attachment bonding with the victim.
- Parents have served as the primary attachment provider for their child (different than the bonding dynamic in spousal or sibling attachment) and because of their parental obligation of protection mothers more than fathers present with inordinate remorse for the dying act.

While there is not enough evidence to designate violent death grief as categorically distinct from prolonged grief or PTSD, these clinical phenomena and dynamics associated with violent dying deserve consideration in supportive and intervention guidelines:

- The immediate investigative aftermath of violent dying demands an intensive engagement of the family with community agencies of the media, police and possibly the courts if a perpetrator is apprehended. Support during this public inquiry should include active advocacy and education.
- Because mothers and young children are particularly vulnerable to prolonged grief after violent dying, support for their delayed adjustment should include proactive outreach and follow up for 18–24 months.
- Since prolonged grief after violent dying is associated with a syndrome of obsessive thoughts of dying reenactment, remorse, retaliation and dread of recurrence, a specific intervention that moderates distress, reinforces resilience and modifies the obsessive syndrome through imaginal re-exposure should be considered.

Specific interventions for violent dying grief

Individual and group interventions recognizing and targeting these clinical particularities for grief associated with violent dying have been developed for children (Cohen et al. 2006), adolescents (Salloum et al. 2001, 2008; Pynoos 1992) and adults (Rynearson et al. 2006). Published manuals of the interventions are available that formalize the staging, focus and timing of relatively specific techniques to modify concurrent trauma and separation distress. Preliminary pilot outcome studies document significant clinical improvement associated with these interventions, but there have been no randomized, controlled studies validating their long term or comparative effectiveness.

In clinical practice, trauma distress takes neuropsychological precedence over separation distress in patients presenting with prolonged grief after violent dying. Since the dysfunctional images and stories are primarily related to the trauma of the violent dying, supportive strategies to deal with trauma distress are the initial goals of any intervention before the clinical management of separation distress.

Viewed collectively these various interventions have a common staging and focus (Frank and Frank 1991). Time-limited trauma and grief agendas focus on the memory and

effects of an external stressor (violent dying and death) and the limitation of time proscribes the application and staging of at least two non-specific techniques:

(1) The moderation of distress (through a confiding relationship, a safe setting and stress reduction strategies—including medication).
(2) Exposure and "*Reconstructive*" processing of the stressor (through a rational scheme that explains symptoms and an active procedure of "reliving" the stressor that restores health and meaningful re-engagement).

Perhaps it is the counterbalancing of stress moderation and reconstructive exposure that forms the therapeutic ingredient of "whatever" trauma or grief treatment.

The therapeutic setting and techniques of stress moderation are not specific, but reconstructive exposure to the comforting attachment imagery and the intrusive reenactment imagery of violent dying is accomplished through explicit narrative procedures. The narration of the attachment and dying stories of the deceased through oral retelling, drawing and journaling is introduced as a creative narrative reprocessing—to promote subjective mastery of the violent dying story, to diminish its dominance, disorganization and dissociation. This narrative procedure is limited and focused to a specific revision of the imagery of attachment and violent dying reenactment rather than the more expansive revision goals of narrative psychotherapy.

Case illustration

Helen, a 48 year old woman, was referred for evaluation by her minister who had known this woman and her family as members of his church for many years. To his knowledge there wasn't any history of major emotional difficulty prior to the death of Maggie, the woman's daughter, 2 years before.

Within weeks of beginning her freshman year in college Maggie was brutally murdered—raped, beaten and stabbed by an unknown assailant. Helen called the minister shortly after she was notified of Maggie's death and he saw her repeatedly, initially through supportive visits with the entire family in their home and then for the planning of the memorial and funeral service which he led.

Seven months after the death Helen's husband called the minister, concerned about Helen's persistent flashbacks and nightmares of Maggie's murder, obsessive frustration with the unsuccessful investigation of the murder, and her over-protectiveness of their surviving daughters. Helen admitted that the intrusive images of her daughter's dying interfered with her concentration during the day and she was sleep deprived because of the recurring dream of the murder (a procession of terrifying images of Maggie's terror and screams as she was beaten and stabbed) and she was obsessed with the safety of her surviving daughters, "…because they haven't even caught the murderer."

She had already sought help the month before when she joined a support group for bereaved parents but as the group members began talking about the deaths of their children she had a panic attack and bolted from the group meeting in the middle of the first session.

I invited Helen into my office where she seated herself and nervously pulled a tissue from the table beside her—preparing herself for crying. I reassured her that though I knew about her daughter's death we didn't need to talk about that until she and I had an opportunity to understand what had helped her cope with this tragedy. Delaying exposure of the violent dying narrative is a fundamental skill to establish in someone in whom the narrative of dying and death is intrusive. Guiding the therapeutic focus away from

premature exposure allows the patient and the clinician to join in mutually delaying or "controlling" their narrative immersion. While delaying, however, there is a mutual effort to reinforce internal and external resilience—actively inquiring about resources of psychological "offenses" of calming, safety and transcendence—skills that can be enlisted during the later stage of treatment.

"You obviously have a lot of strength to have prevailed over this death as well as you have and we need to understand that—where does your strength come from?"

Helen visibly relaxed and first listed her spiritual belief that connected her to Maggie's spiritual presence and her faith that they would be reunited when she died. Though she was angry at God she still prayed for strength and guidance. Then she talked of her devotion to her younger daughters and how she needed to remain resilient for them. And her work as a secretary offered a sense of order and purpose that cleared her mind of her reenactment fantasy of Maggie's dying—and her husband needed her too.

I tried to reinforce the value of each of these resources and reminded her that one of the best resources of resilience is "being" resilient for others.

"But we need others to be resilient for us too—who takes care of you?"

She smiled and admitted that she was more of a care "giver" than "receiver."

We then talked briefly about relevant issues of her past history:

- *Have you experienced any other deaths? What had helped you cope?*

Her father died 10 years before and her response was very different because she cared for him while he was dying and his death was a relief from his suffering.

- *Who cared for you as you were growing up—who in your family could you count on?*

Both parents were consistent and supportive and she remained close to her siblings.

- *Have you sought counseling before? What had she learned about herself from the counseling? May I confer with your counselor?*

No previous counseling excepting her minister. She claimed she would never attend another support group "…because I'm not ready for that."

- *Have you been given a psychiatric diagnosis? Was it treated with medication—and what kind?*

Negative—but she reported signs and symptoms of recurring panic attacks at night after the recurring reenactment nightmares.

- *How do you calm yourself? What can you do to relax and stop yourself from thinking too much?*

Personal prayer, playing the piano and exercising—she continued in daily prayer but her music and workouts didn't seem important any more.

The first stage of intervention for this highly distressed woman with intrusive flashbacks and dreams of her daughter's homicide was inventorying her resources of resilience, reinforcing their value and introducing resiliency enhancing exercises of deep breathing, muscle relaxation and guided imagery. Resilience is a psychological function or "reflex" that maintains the level of intense distress within tolerable limits. Without that reflexive

maintenance the accurate processing of traumatic thoughts and feelings deteriorates and so does the capacity for discriminating reflection and autonomy.

At the end of the first evaluation session Helen was urged to practice the relaxation and guided imagery exercises each day and to replace the intrusive imagery of Maggie's dying with imagery of her vitality.

"You need to think less about Maggie's dying and more about her living."

She was given an assignment—to collect pictures, writings, tapes….any memorabilia that would help us celebrate the life of Maggie and present a commemoration of Maggie's life story to me at the next session. We also needed to reestablish her normal sleep cycle which was disturbed by the nightmares and panic attacks and for the next week I prescribed a low dose of a minor tranquilizer at bedtime.

She noted improvement during the next week—the reenactment flashbacks were less intense and though she continued to have nightmares, the panic attacks cleared. The assignment to prepare a commemoration presentation had been positive. Gathering the memorabilia evoked a comforting narrative of Maggie's living that had been eclipsed by the obsessive reenactment fantasies and presenting that story to me allowed further reinforcement of her vitality.

Helen continued the relaxation exercises on a daily basis and at my urging began to exercise at the gym and play her piano and after 2 weeks she discontinued the bedtime tranquilizer. We arranged a supportive family session the next week attended by her husband and two daughters to enlist their support in Helen's improvement. The issue of her over protectiveness was discussed and the family agreed to a strategy allowing the daughters to "check in" with Helen periodically by phone when separated instead of Helen compulsively trying to contact them.

Though the intrusive reenactment thoughts and dreams had diminished, they still recurred and we agreed to prepare an intervention for their modification and control.

"We need to help you control the fantasies and nightmares of Maggie's dying. It would help me if I could see and share the story of her dying with you so we could work on it together."

I encouraged her to somehow externalize the reenactment fantasy and not only in conversation with me, but by drawing it or writing about it—and she could complete that assignment on her own or we could work on it together at the beginning of the next session.

Helen arrived with a drawing she had sketched in crayon. An image of her daughter's brutal stabbing—thankfully she had not allowed herself to visualize the rape. There was an outpouring of admixed feelings as she presented this visual reenactment to me—horror at the murder, rage at the assailant, tears for her loss and remorse that she (Helen) should have prevented the dying. I congratulated her for her courage in sharing this reenactment and told her that she was no longer alone in the fantasy—that I was now with her—and I wondered aloud where she would place herself in the fantasy if she allowed herself a role. Initially she wrestled the knife from the assailant and killed him, then saw herself holding Maggie and trying to save her. Finally she wiped the blood from Maggie's wounds and kissed her goodbye as she died.

The completion of this exercise was a significant event in her treatment. Visually and verbally reprocessing the reenactment story was relieving and imagining a role in the reenactment drama brought some "ownership" of the story that now contained and belonged to her instead of her helplessly witnessing it. The intrusive reenactment imagery and dreams, still devoid of meaning, virtually disappeared and she now reported several

dreams in which Maggie appeared as alive and restored. Maggie's imagined vitality compensated for the meaningless act of her dying but nothing could erase that evil narrative, a destructive act that was so extreme, so complete, that no light escaped. Nothing good came of it, or came out of it. It made no sense and left no helpful legacy.

We met for three more supportive weekly sessions during which we reviewed our work together, consolidated our shared insights and prepared for termination. I reviewed her progress with the minister and it was decided by Helen and the minister that he would continue to provide support and I would be available if they requested further consultation.

Summary

Violent deaths from accidents, suicide, homicide or terrorism account for 7% (162,000) of annual US deaths. Extrapolating that each of these deaths affects at least five primary and extended family members, each year 800,000 Americans are forced to adjust to this traumatic form of bereavement.

Unlike natural death, violent dying is followed by a strident alarm from the surrounding community for its announcement, investigation and retributive punishment if a perpetrator is apprehended. This criminal-judicial process is substitute for the more basic but socially unacceptable act of direct retaliation—which though socially prohibited commonly persists. Because violent dying is the number one cause of death before age 40, young mothers and children engaged in an intense attachment relationship with the victim of violent dying are particularly vulnerable to its long term effects.

Clinical surveys of family members challenged by violent death demonstrate normative and persistent responses of intense trauma distress specifically associated with the violent dying act with intrusive reenactment fantasies, avoidance and physiological arousal. The reenactment fantasy of the dying registers as a horrific narrative, a raw recounting of the killing as a chain of visual images. Since only five percent of violent deaths are actually witnessed by family, reenactment narrative imagery usually portrays an imaginary and surreal dying retold by a survivor now in the paradoxical position of being forced witness to the dying rather than caring participant.

The clergy can play a stabilizing role in this traumatic and paradoxical narrative. The bereaved most often seeks their clergy to serve as intermediary between the bereaved and the spiritual transformation of the victim to a space and time of eternal peace. Officiating at the memorial and funeral service the clergy counterbalances the chaotic and meaningless narrative of reenactment with a narrative of enduring spiritual vitality through invocation, sacrament and comforting ritual that emphasizes release rather than the fixation of the spirit as helpless and terrified victim within the reenactment narrative. This transformative spiritual narrative acts as a natural buffer to the traumatic imagery of reenactment, not through denial or repression of the dying narrative but by a selective emphasis of the comforting memories of attachment and encouraging a connection with a continuity of the deceased through a divinely inspired narrative.

A significant minority (10–20%) of those bereaved by violent dying continue to experience levels of trauma and separation distress 6 months after the dying severe enough to cause social and personal disability. High levels of reenactment imagery, remorse and demands for retaliation and retribution are more specific in the prolonged emotional aftermath after violent dying than natural dying.

There are encouraging reports of specific interventions for prolonged grief following violent death manualized for children and adults. These interventions apply the staging of

familiar, well tested techniques—moderation of distress and psychoeducation followed by imaginal retelling (exposure) and preparation for termination—that can be mastered and replicated by clinicians and counselors. When someone with prolonged grief becomes fixated on intense imagery of violent dying the procedure of therapeutic retelling reestablishes a more coherent nexus of the memories of the deceased's life that now intertwine and soften the memories of their dying. Including a simple, time limited narrative intervention (described in the case illustration) may serve as an ancillary procedure in the spiritual support and restoration of the grief stricken parishioner.

References

Cohen, J. A., Mannarino, A. O., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. New York: Guilford.

Frank, J. D., & Frank, J. B. (1991). *Persuasion and healing*. Baltimore: John Hopkins University Press.

Jacobs, S. C. (1999). *Traumatic grief: diagnosis, treatment and prevention*. Philadelphia: Brunner/Mazel.

Lord, J. H., Hook, M., Alkhateeb, S., & English, S. J. (2008). *Spiritually sensitive care giving*. Burnsville, N. C.: Compassion Press.

Murphy, S. A., Johnson, L. C., & Lohan J. (2002). The aftermath of the violent death of a child: An integration of the assessments of parents' mental distress and PTSD during the first five years of bereavement. *Journal of Loss and Trauma*, *7*, 203–222.

Murphy, S. A., Bauger, R., Lohan, J., Schneideman, J., Herrwagen, J., & Johnson, L. C. (1996). Parents' evaluation of a preventive intervention following the sudden violent deaths of their children. *Death Studies, 20*, 453–468.

Murphy, S. A., Johnson, L. C., Wu, L., Fan, J. J., & Lohan, J. (2003). Bereaved parents' outcomes 4 to 60 months after their children's' deaths by accident, suicide or homicide: A comparative study demonstrating differences. *Death Studies, 27*, 39–61.

Neimeyer, R. A., & Levitt, H. M. (2000). What's narrative got to do with it? Construction and coherence in accounts of loss. In J. H. Harvey & E. D. Miller (Eds.), *Loss and trauma* (pp. 401–412). Philadelphia: Brunner/Mazel.

Prigerson, H. G., Vanderwerker, L. C., & Maciejewski, P. K. (2008). A case for inclusion of prolonged grief disorder in DSM-V. In M. S. Stroebe (Ed.), *Handbook of bereavement research and practice advances in theory and intervention* (pp. 165–186). Washington: American Psychological Association Press.

Pynoos, R. S. (1992). Grief and trauma in children and adolescents. *Bereavement Care, 11*, 2–10.

Rynearson, E. K. (1984). Bereavement after homicide: A descriptive study. *American Journal of Psychiatry, 141*(11), 1452–1454.

Rynearson, E. K. (2001). *Retelling violent death*. New York: Brunner Routledge.

Rynearson, E. K., Correa, F., Favell, J., Saindon, C., & Prigerson, H. (2006). Restorative retelling after violent dying. In E. K. Rynearson (Ed.), *Violent dying: Resilience and intervention beyond the crisis* (pp. 195–216). New York: Taylor and Francis.

Salloum, A., Avery, L., & McClain, R. P. (2001). Group psychotherapy for adolescent survivor of homicide victims: A pilot study. *Journal of the American Academy of Child and Adolescent Psychiatry, 40*, 1261–1267.

Salloum, A. (2008). Group therapy for children experiencing grief and trauma due to homicide and violence: A pilot study. *Research on Social Work Practice, 18*, 198–211.

Shear, M. K., Frank, E., Houck, P., & Reynolds, C. F. (2005). Treatment of complicated grief: A randomized controlled trial. *Journal of the American Medical Association, 293*, 2601–2608.