



# COMPLICATED GRIEF: ASSESSMENT AND INTERVENTION

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Since the suicide of her husband, John, nearly 2 years ago, Mary, age 62, has been suffering greatly. Even though John's condition had deteriorated over the course of many months and several unsuccessful attempts to treat his incapacitating depression, she felt "totally unprepared" for the loss of "the man who had been everything to me"—her best friend, her lover, her helpmate, her companion. Most of all, Mary felt that with John's death she had lost her "anchor" in the world, and described her ongoing grief as "soul-shattering." She found herself sadly preoccupied with memories of him and traumatic images of his death by gunshot, and she had been unable to sleep in the bedroom in which she discovered his body. Struggling to make sense of his dying, Mary continually ran aground of seemingly unanswerable questions about why John took his own life, coupled with a deep anger at him for leaving her. Just as often, she found herself consumed by guilt about not having been able to save him from the painful condition that finally claimed his life. Since John's death, Mary never missed a day visiting his graveside, even in forbidding winter weather.

Looking back, Mary described John as a perfect partner for most of their long marriage—devoted, good-humored, a responsible father, an excellent provider, and her "buffer" from a harsh world. After his death, she felt a keen sense of abandonment by the man who promised he would always be there at a time of need. As a consequence, she felt vulnerable and alone, a feeling that was heightened by the sense that other people in her family and social world just don't understand the complexity of her loss.

The feeling that people were pulling away, as well as the general pressure she felt "to get over it already," left her embittered and distrustful of the intentions of others. She also confessed that the quality of her work as a sales person has deteriorated, as her negativity, sleeplessness, and loss of self-confidence had taken their toll, and she found herself lacking motivation to connect with other people.

Mary only experienced any respite from her grief when she felt John's "presence." Her desperate yearning for contact with him was reflected in her overexcited attempt to climb into John's open casket at the funeral, and her still frequent calls to his answering machine to hear his voice. The most sustained sense of contact came during one of her daily visits to his grave, when she felt surrounded by signs of his heavenly existence in the sunset, a flock of birds, and the whispering of his voice on the wind. Mary confessed that such moments accentuate the loss when she "awakens" to the reality of John's death. Mostly, however, she reported living in a kind of detached dream-like state, simply going through the motions in a joyless, mechanical way. Accordingly, she ruminated frequently about death as a release from pain and about the heavenly reunion it could bring, but had no clear plans to end her life.

Mary went on to say that she felt so encased in grief that she did not know who she was anymore. She felt enraged that "God would leave me here without any purpose for being left behind." Nothing about her present life seemed to have meaning for her—"the quality of my life is gone, and it's like I

<http://dx.doi.org/10.1037/0000020-016>

APA Handbook of Trauma Psychology: Vol. 2. Trauma Practice, S. N. Gold (Editor-in-Chief)  
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have lost my future as well as my past.” In her own words, she can’t accept that John is gone, and was left “in shock after losing the foundation John provided.” Although it has been 2 years since John’s death, in many ways, Mary felt much like she did in those early weeks.

Building on the companion piece (see Volume 1, Chapter 11, this handbook), this chapter discusses several approaches to assessment and intervention of traumatic or complicated grief (CG), and their accumulating evidence base. It illustrates clinical strategies with brief case examples, and gives precedence to cases that target grief and depression in the aftermath of tragic loss.

## CONTEMPORARY THEORIES OF BEREAVEMENT

Although older models of bereavement rooted in “decathexis,” or withdrawal of emotional energy from the deceased (Freud, 1917/1957), or stages of adaptation to loss (Kübler-Ross, 1969) remain rooted in the professional and public imagination, they have lost much of their authority in light of recent theoretical advances and empirical studies of grieving (Holland & Neimeyer, 2010; Maciejewski, Zhang, Block, & Prigerson, 2007; Neimeyer, 2013). Five contemporary models of grief that are attracting research and clinical attention are introduced following, each of which carries implications for grief therapy.

### Attachment Theory

Grounded in the psychodynamic tradition, Bowlby’s (1980) theory of the function of attachment in human relationships and its relevance for the understanding of grief remains one of the most comprehensive and best researched models in the contemporary literature. Central to his argument was the contention that distress, protest, and yearning for a security-enhancing attachment figure is clearly an adaptive response in an evolutionary sense to the threat of separation, characteristically leading to the restoration of connection with a protective figure. Indeed, ethological and laboratory-based research on many species documents the presence of such behavior when individual animals are separated

from their mothers or pair-bonded mates. Likewise, human children display comparable distress and patterns of adaptation in the face of such separation, in the laboratory and in the real world (Shaver & Fraley, 2008). A key insight of attachment theory is that similar psychological mechanisms underlie reactions to such temporary disruptions and to the more permanent separation occasioned by a loved one’s death (Bowlby, 1980).

Bowlby (1980) and his followers (Parkes & Prigerson, 2009) also recognized that in the context of the death of an attachment figure, these normally functional and adaptive responses to loss could become severe and prolonged, differing from normal or healthy grieving quantitatively and qualitatively. More problematic variants of grieving feature intense and unremitting yearning, intrusive preoccupation with the deceased or the circumstances of loss, and an inability to accept its reality. As discussed in Volume 1, Chapter 11, of this handbook, such attachment-based symptoms of CG distinguish the condition from other possible problems that could also be triggered by loss, such as depression or posttraumatic stress disorder (PTSD).

A particularly valuable contribution made by Bowlby (1980) was his recognition that a person’s reaction to separation varies depending on his or her attachment history and how that individual learned to accommodate it. In optimal circumstances, the developing child has been given sufficient care by an attuned parenting figure, and constructed an internal working model of relationships in which the self is viewed as lovable and capable, and in which key attachment figures can be trusted to be safe and available in times of distress. As this *secure attachment style* is consolidated in later intimate relationships, the individual is likely to react to later losses, including bereavement, with initial distress, but with relatively quick or resilient adaptation.

In contrast, children who experience more adverse environments of upbringing marked by parental neglect, loss, abandonment, or even abuse may develop *insecure attachment styles* marked by high anxiety and dependency on one hand (anxious attachment) or by avoidance of intimacy and compulsive self-reliance on the other (avoidant attachment). In the wake of later losses, the grief



responses of individuals with an anxious attachment style are likely to be characterized by prolonged and intense preoccupation with the loss, profound yearning for the lost attachment figure, profuse tears, and disruptive emotion, and difficulty accepting the loss—all key symptoms of CG, as described in Volume 1, Chapter 11, of this handbook. In contrast, those children who adapt to a history of similar abuse or abandonment through an avoidant attachment style may respond to later loss with apparent nonchalance, either having learned to suppress attachment needs or having failed to cultivate intimate bonds to begin with. For Bowlby (1980), then, either extreme of persistent activation of attachment or excessive deactivation of attachment in bereavement can be problematic, as they block natural processes of revising and reorganizing internal working models that are repeatedly triggered in grieving but are invalidated by the loved one's physical inaccessibility. This does not mean, however, that emotional detachment from the deceased is the necessary outcome of such reorganization. Indeed, many people across cultures are able to reconstruct a continuing bond with the deceased that fully recognizes their physical absence, but maintains an emotional, spiritual, or even conversational sense of connection to the loved one in a fashion that is in no sense pathological (Klass, Silverman, & Nickman, 1996; Neimeyer, Klass, & Dennis, 2014).

A good deal of research supports attachment theory formulations of adaptive grief and CG (Parkes & Prigerson, 2009; Shaver & Fraley, 2008; Stroebe & Schut, 2005). For example, in one recent two-part study (Meier, Carr, Currier, & Neimeyer, 2013) researchers investigated the relation between attachment anxiety and avoidance on one hand and CG symptomatology on the other in a heterogeneous cohort of over 650 bereaved adults. They found that an anxious preoccupied style was associated with greater symptoms of complication, but that an avoidant, self-reliant style was not. However, when they focused attention on a subset of 191 bereaved participants who had lost a loved one to violent death (i.e., suicide, homicide, or fatal accident) and compared them to a carefully matched group of nonbereaved controls, attachment avoidance proved to be a salient predictor of mental and physical

health problems for the bereaved group, but not for the nonbereaved controls. Therefore, in keeping with Bowlby's (1980) theory, anxious attachment seems to represent an instigating context for complicated and intense bereavement responses across a variety of losses, whereas avoidant attachment appears to be a fragile defense that may mitigate distress in response to natural death losses, but one that can collapse under the weight of traumatic loss.

### Cognitive Behavioral Approaches

Just as bereavement can be complicated by a variety of disorders and disturbances ranging from depression and anxiety symptoms (Bonanno & Mancini, 2006; Burke, Neimeyer, & McDevitt-Murphy, 2010) to disruptions in family systems (Hooghe & Neimeyer, 2012), so too do cognitive-behavioral therapies (CBT) address different maladaptive processes depending on what features of the mourner's response are of central concern. Persistent depression following the death of a loved one can be partly understood in terms of the loss of reinforcement and attendant deactivation of purposive and pleasurable activities that characterized the mourner's earlier life, just as postloss-anxiety states can be conceptualized in terms of encounters with unwelcome reminders of the loss and associated reliance on avoidant coping. Interventions associated with these formulations are reviewed in the treatment section that follows later in this chapter. Here, however, a summary of CBT theories of CG are given as these address features unique to bereavement.

A model of mourning based on rational emotive behavior therapy (Ellis, 1962) has been formulated by Malkinson (2007), who borrowed Ellis's familiar ABC model to distinguish between adaptive and maladaptive forms of grief. Faced with an activating event (A), an individual's beliefs (B) about what has occurred shape the individual's emotional and behavioral consequences (C). In the context of the death of a loved one, the loss can be evaluated in a variety of ways, some of which are rational (e.g., "My life has changed forever," "I'll miss him"), leading to healthy emotional consequences (e.g., uncertainty, sadness), whereas others are irrational (e.g., "My life is worthless," "It's my fault") and trigger dysfunctional grief (e.g., depression, guilt).



Therapy therefore entails assessment of the client's cognitions (e.g., demandingness toward self and others) and associated emotions and behaviors (e.g., rage, low frustration tolerance), psychoeducation in the ABCs of rational responses, and disputation and correction of irrational beliefs (Malkinson, 2012).

A second CBT conceptualization of CG has been put forward by Boelen, van den Hout, and van den Bout (2006). Central to this model is their assumption that CG is sustained by three factors: poor integration of the reality of the loss into the individual's autobiographical memory, negative cognitions, and avoidance coping. The first of these implies that the individual fails to reconcile the fact of the loved one's death with previous schemas of their relationship, resulting in continued disbelief about the loss and associated "searching" behaviors. The second factor, negative cognitions, takes the form of pernicious global beliefs about the self ("I am worthless since she died"), life ("My life has no purpose"), and the future ("My future is empty"). Such beliefs are presumed to promote a ruminative preoccupation with the loss and to interfere with adaptive behaviors that would promote adjustment. The final factor, avoidance coping, involves anxious avoidance of reminders of the death, which block processing of the experience, just as depressive avoidance of healthy behaviors prevents adjustment to a changed life.

A CBT model of CG is supported by evidence that negative cognitions, especially about life and the future, predict contemporaneous and subsequent CG and depression in 97 bereaved adults assessed on three occasions in the first year and a half following the death of a loved one, even after several relevant background variables (e.g., sex, kinship to deceased) were controlled. Evidence for the role of avoidance was more equivocal, however (Boelen, van den Bout, & van den Hout, 2006). Accordingly, challenging and changing catastrophic cognitions play a central role in a CBT approach to treatment (Boelen & van den Bout, 2012).

### Dual Process Model of Coping With Bereavement

With roots in attachment and coping theories, the Dual Process Model (DPM) put forward by Stroebe

and Schut (1999, 2010) proposes that people deal with loss dialectically, oscillating between *loss-oriented coping* and *restoration-oriented coping*. The former process entails engaging and managing the negative emotions triggered by the death, missing and yearning for the lost person, and reorganizing the attachment bond with the deceased. Importantly, coping in this way entails temporarily denying or distracting oneself from the demands of the external world that have been changed by the loss. Restoration-oriented coping, on the other hand, entails attending to the many life changes required to adjust to a world after the loss. These can include learning new household or work-related skills, assuming new roles in the family, engaging changed relationships and forming new ones. Dialectically, this sort of outwardly focused coping involves denying or distancing from the pain of grief to "relearn the world" and embrace necessary change.

A distinctive feature of the DPM is its proposition that individuals normally modulate grief and moderate change by alternately confronting their loss at some times and avoiding associated emotional pain at others. Rather than proposing a stage-like or linear progression through bereavement, the DPM views grief as waxing and waning, with loss-oriented coping dominant early on in bereavement and restoration-oriented coping more prevalent later. Further, Stroebe and Schut (1999, 2010) argued that their model provides a means of understanding gender differences in bereavement, as women tend to be more emotion-focused, and hence more loss-oriented, whereas men tend to be more problem-focused, and hence more restoration-oriented in their coping behaviors. The DPM has proven attractive to grief therapists, as well as researchers, suggesting that counselors help clients take a "time out" from preoccupation with their grief through greater restoration coping, and mitigate brittle emotional avoidance through greater confrontation with the loss (Zech & Arnold, 2011). Preliminary evidence for the DPM derives from research on widowed persons, who report considerable oscillation over the course of bereavement (Caserta & Lund, 2007), but also greater focus on restoration-oriented coping over time (Caserta, Utz, Lund, Swenson, & de Vries, 2014).

## Two-Track Model of Bereavement

A further integrative theory of grief is Rubin's (Rubin, 1999; Rubin, Malkinson, & Witztum, 2003) Two-Track Model of Bereavement (TTMB), which posits that grief proceeds along two dimensions simultaneously; the first is concerned with the mourner's biopsychosocial functioning, and the second is focused on his or her relationship to the deceased, not only prior to the death, but also in ongoing life. The first and more widely recognized track encompasses the mourner's efforts to surmount such problems as disruptions in the realms of emotion, concentration, social relationships, physical health, and self-esteem, roughly coextensive with the symptomatology of CG: depression, anxiety states, and dysfunctional behaviors.

The second and less acknowledged track, however, reflects the bereaved person's efforts to access or avoid memories of times spent with the deceased, carry out public or private rituals of remembrance that might be associated with a particular religious practice, pursue legacy projects that honor the memory of the loved one, or feel compelled to grieve as a sign of loyalty to him or her. The development of the TTMB Questionnaire (TTBQ; Rubin, Nadav, Malkinson, Koren, & Michaeli, 2009), which measures symptomatic and relational tracks through grief, as well as a third track concerned with traumatic responses, helps operationalize the model for research and clinical application, as discussed following. One use of the TTMB is in clinical conceptualization of a client's difficulties in bereavement that arise on one or both tracks of the model, serving as a useful guide to clinical assessment and intervention (Rubin, Malkinson, & Witztum, 2011). For example, evidence that "unfinished business," such as unresolved regret or conflict in relation to the deceased, is associated with poorer bereavement outcomes (Klingspon, Holland, Neimeyer, & Lichtenthal, 2015) and underscores the importance of assessing and intervening in the postmortem relationship, as emphasized in the TTMB.

## Meaning Reconstruction

A final, recent perspective on bereavement is not so much a theory about grief as it is a metatheory, that is an approach that can inform a variety of models by

emphasizing that a central process of grieving is the attempt to reaffirm or reconstruct a world of meaning that has been challenged by loss (Neimeyer, 2002). In this meaning-reconstruction view, the death of an important person is seen as posing two narrative challenges to the mourner: (a) to process the *event story* of the death in an effort to make sense of what has happened and its implications for the mourner's ongoing life, and (b) to access the *back story* of the relationship with the loved one as a means of reconstructing a continuing bond (Neimeyer & Sands, 2011). For example, mourners struggling with the event story of the death may contend with several questions ("How do I make sense of what has happened, and what is the meaning of my life now in its wake?" "What is my role or responsibility in what has come to pass?" "How does this loss fit with my sense of justice, predictability, and compassion in the universe?" "Who in my life can understand and accept what this loss means to me?"). Conversely, mourners who are attempting to reaccess and reconstruct the back story of the relationship with the loved one often grapple with implicit questions ("How can I recover or rebuild a sustaining sense of connection to my loved one that can survive his or her physical death?" "What memories of our relationship bring pain, guilt, or despair and require some form of redress or reprieve now?" "What memories bring joy, security, or pride and invite commemoration or celebration?" "What lessons about living or about loving have I learned over the course of our shared lives?" "Who in my world can help me keep my loved one's stories alive?"; Neimeyer & Thompson, 2014).

In a sense, then, the bereaved are prompted to "rewrite" important parts of their life story to accommodate the death, and project themselves into a changed, but nonetheless meaningful future, one that retains continuity with a past shared with the loved one. Therefore, grieving is viewed as an often-anguished search for meaning in a life and relational field that have been perturbed, sometimes traumatically, by loss. To a greater extent than the more purely psychological grief theories previously reviewed, this perspective coheres with a *social constructionist* view of grief, as the significance of the loss is narrated, validated and contested on levels

that range from the individual through the family system to communal and ultimately cultural levels (Neimeyer et al., 2014).

Support for this meaning-reconstruction view derives from research that has demonstrated a link between an inability to find sense or significance in the loss and intense, prolonged and disruptive grief in groups as varied as bereaved young people (Holland, Currier, & Neimeyer, 2006), parents (Keesee et al., 2008), and older adults (Coleman & Neimeyer, 2010). Furthermore, struggles with spiritual meanings of the loss specifically have been linked to poorer bereavement outcomes in studies of diverse populations (Burke & Neimeyer, 2014; Burke, Neimeyer, McDevitt-Murphy, Ippolito, & Roberts, 2011). Conversely, higher levels of sense making about the death have been found prospectively to predict greater well-being (e.g., interest, excitement, accomplishment) among widowed persons 1 to 4 years later (Coleman & Neimeyer, 2010), and success over time in integrating the loss into one's meaning system is associated with a significant reduction in CG symptomatology (Holland, Currier, Coleman, & Neimeyer, 2010). Moreover, accumulating evidence suggests that the inability to integrate the meaning of the death is a powerful mediator of the impact of homicide, suicide, and other violent deaths (Currier, Holland, & Neimeyer, 2006), just as it also appears to partially mediate the impact of spiritual crisis on CG symptomatology (Lichtenthal, Burke, & Neimeyer, 2011). A meaning-reconstruction view has therefore begun to contribute significantly to the refinement of assessment and intervention strategies in the field, as described following.

## ASSESSMENT

Only 15 years ago, the field of bereavement studies faced the ironic position of advocating for greater research on the causes, correlates, and consequences of clinically significant grief, but in a context in which even bereavement researchers rarely evaluated grief as an outcome. Instead, investigators tended to study more readily measured phenomena, such as generic physical and mental health and depression, even if these failed to capture much that was uniquely relevant to bereavement. Moreover,

when researchers attempted to study grief per se, they typically relied on poorly validated or psychometrically flawed scales that badly mapped the variables of interest (Neimeyer & Hogan, 2001).

Across the first decade of the present century, this situation began to change significantly, as several well established general purpose measures (e.g., Core Bereavement Items, Inventory of Complicated Grief—Revised) and those designed for specialized populations or responses (e.g., Perinatal Grief Scale, Continuing Bonds Scale) were developed, validated, and incorporated into numerous published studies (Neimeyer, Hogan, & Laurie, 2008). Brief summaries are provided next of some of the more promising contemporary measures of bereavement outcomes and processes posited as critical mechanisms or mediators of adaptation. Each is well situated to contribute to more sophisticated clinical assessment in research and applied contexts (Neimeyer, 2015).

### Prolonged Grief Disorder–13

Of the various assessments of maladaptive grief evaluated to date, the symptom criteria for CG propounded by Prigerson and her colleagues (2009) are the most sophisticated. Drawing on data from 291 bereaved adults studied across 2 years of bereavement, these investigators winnowed a large pool of candidate symptoms to identify a small set of informative and unbiased indicators with strong internal consistency, which, in combination, yielded a diagnosis of prolonged grief disorder with a sensitivity of 1.00 and specificity of .99. The resulting measure, termed the Prolonged Grief Disorder–13 (PG-13), requires that respondents meet an event criterion (e.g., death of a loved one), endorse substantial separation distress daily, satisfy a duration criterion of 6 months of intense yearning or grief, experience five or more cognitive, emotional, and behavioral symptoms once a day or “quite a bit,” and report on the impairment criterion that these result in a substantial decrement of their functioning in social, occupational, or domestic domains (Prigerson et al., 2009). Most items are formulated on straightforward 5-point rating scales (e.g., In the last month, how often have you had intense feelings of emotional pain, sorrow, or pangs of grief related to the

loss? [1 = *not at all* to 5 = *several times a day*]; Do you feel bitter over your loss? [1 = *not at all* to 5 = *overwhelmingly*]). The PG-13 can be administered as a self-report measure of grief symptomatology for research purposes or to evaluate response to treatment. However, formal diagnosis requires assessment by a qualified mental health practitioner.

### Persistent Complex Bereavement Inventory

The construct of persistent complex bereavement disorder was developed by expert consensus following a review of research on CG and prolonged grief disorder (PGD) for inclusion as a “condition for further study” in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013)*. However, the precise criteria adopted for its definition were not reflected in any existing instrument, making such study difficult. The Persistent Complex Bereavement Inventory (PCBI) was constructed as a self-report scale to meet this need (Lee, 2015).

Closely mirroring *DSM-5* criteria, the PCBI includes 16 items mapping three domains: Core Grief (e.g., felt intense sorrow and emotional pain because of the loss), Reactive Distress (e.g., avoided anything that reminded you of the loss), and Social/Identity Disruption (e.g., felt alone or detached from others because of the loss), each of which is rated for its frequency or intensity following the death (0 = *not at all* to 4 = *severe*). Mean scores can be computed for the PCBI in its entirety or for each symptom cluster separately.

Two related studies by Lee (2015) investigated the concurrent, incremental, factorial, and predictive validity of the inventory as well as its internal consistency and stability. In the first, 135 bereaved college students responded to the PCBI along with self-report assessments of various risk factors, functional consequences, and associated features of dysfunctional grief identified by the *DSM-5*. They also completed assessments of the circumstances of the death and the nature of the relationship to the deceased, as well as measures of related constructs including PGD, depression, and PTSD. As expected, an exploratory factor analysis revealed three distinct clusters of items closely corresponding

to the symptom domains previously described, each of which displayed strong internal consistency. Moreover, the construct validity of the overall scale and its component factors was supported by their significant association with a host of identified risk factors for CG (e.g., neuroticism, violent death loss, negative religious coping) and functional consequences of the disorder (e.g., somatic complaints, impairments in quality of life, suicide ideation). Convergent and discriminant validity was reflected in the consistently higher relations between the various PCBI factor scores and PG-13 symptoms than with measures of theoretically less closely related constructs, namely PTSD, separation anxiety, and depression. Moreover, in a stringent test of incremental validity, the PCBI added unique variance to the prediction of life impairment even after these variables and PGD were taken into account.

Finally, in a second study of 228 bereaved young adults, Lee (2015) reported a confirmatory factor analysis of the PCBI that supported a modified three-factor model, established the scale’s fair test–retest reliability over a period of a few weeks, and documented the ability of the Social/Identity Disruption subscale (but not Core Grief or Reactive Distress) to predict harmful health behaviors, somatic distress, negative religious coping, medical conditions, and suicidal ideation several weeks in the future. In summary, the PCBI offers a useful assessment of the *DSM-5*’s diagnostic algorithm for dysfunctional grief, one that is closely related to PGD while retaining its own incremental and predictive validity.

### Hogan Grief Reactions Checklist

Grounded in qualitative research with bereaved parents, the Hogan Grief Reactions Checklist (HGRC) drew on focus group responses to formulate items that were then winnowed psychometrically to comprise the validated 61-item measure (Hogan, Greenfield, & Schmidt, 2001). It has subsequently been used successfully with this population, and also with widowed persons, bereaved college students, and clinical patients. Importantly, and in contrast to the PG-13 and PCBI, no assumption is made that the grief experiences it assesses are necessarily pathological or dysfunctional.

The HGRC is comprised of six factors, each of which is supported by a confirmatory factor analysis of the instrument and the strong internal consistency of its constituent items, which are formatted as simple assertions that the respondent rates on a scale of 1 (*does not describe me at all*) to 5 (*describes me very well*). These factors include Despair (e.g., “my hopes are shattered”), Panic Behavior (e.g., “I worry excessively”), Personal Growth (e.g., “I have more compassion for others”), Blame and Anger (e.g., “I feel revengeful”), Detachment (e.g., “I avoid tenderness”), and Disorganization (e.g., “tasks seem insurmountable”). Because the factors depict different facets of the loss experience, the authors argue against summing them into a single score, recommending instead that factor scores be reported separately. Significantly, and again in distinction from the two measures previously reviewed, the Personal Growth factor acknowledges and assesses possible resilience through grief in the form of existential benefits winnowed from the loss in terms of an individual’s outlook, perceived strength, and greater tolerance of self and others.

The HGRC shows good test–retest reliability and convergence with other validated measures of grief and trauma, and particular subscales show the ability to discriminate groups of bereaved parents on the basis of specific factor scores (e.g., higher Blame and Anger in homicide loss and higher Panic Behavior in homicide and suicide). As expected, of the negative factor scores, Despair, Detachment, and Panic Behavior decline significantly across 2 years of bereavement, though the other factors do not. Conversely, Personal Growth is associated with better overall mental health, suggesting its use in monitoring resilience and positive outcomes of grief therapy (Feigelman, Jordan, & Gorman, 2009). In summary, the HGRC represents a validated omnibus assessment of grief that could have particular value in settings such as preventive intervention efforts in which many bereaved persons will not meet criteria for CG.

### Inventory of Daily Widowed Life

In contrast to the measures previously reviewed, the Inventory of Daily Widowed Life (IDWL) is based not so much on common symptomatology of grief as on a major contemporary theory of coping with

bereavement (Caserta & Lund, 2007). In keeping with the DPM (Stroebe & Schut, 2010), 11 items each represent the Loss Orientation (e.g., imagining how my spouse/partner would react to my behavior) and Restoration Orientation (e.g., learning to do new things), which respondents rate on a scale of 1 (*rarely or not at all*) to 4 (*almost always*) to describe their experience over the last week. Each factor is scored, and Loss Orientation is subtracted from **Reality** Orientation to reflect the relative emphasis on the two dimensions, with total scores of  $-4$  to  $+4$  representing roughly “balanced” coping on the two dimensions.

Data from 163 widowed persons suggest good internal consistency for both subscales (Caserta & Lund, 2007), which was replicated in a subsequent study of 163 bereaved partners (Caserta et al., 2014). The latter study also found evidence for construct validity in that both subscales produced statistically significant relationships with common bereavement outcomes such as grief, depression, and loneliness, but perceived self-care and daily living skills only generated statistically significant relationships with the **Reality** Orientation factor. Finally, again in keeping with the DPM, hierarchical linear modeling revealed progressively greater emphasis on Restoration Orientation coping over a period of time spanning up to 18 months post-loss (Caserta et al., 2014). In sum, the IDWL is positioned to contribute to assessment of shifting coping processes following the loss of a partner, as well as the role of orienting to the loss as opposed to one’s ongoing life in promoting adaptation to bereavement.

### Two-Track Model of Bereavement Questionnaire

A second theory-based measure is the TTbQ, grounded in the work of Rubin (1999) and his associates. In keeping with this model, Rubin and colleagues (2009) initially drafted 70 items bearing on difficulties arising on the Biopsychosocial Track and Relational Track, and winnowed these through exploratory factor analysis to construct an abbreviated 31-item measure. In this form, the TTbQ-CG31 yielded four confirmed factors: relational active grief and trauma (e.g., “I see

images or pictures from the death scene that enter my thoughts”), conflicted relationship with the deceased (e.g., “My relationship with \_\_\_\_\_ had many strong ups and downs”), close and positive relationship with the deceased (e.g., “\_\_\_\_\_ was the person closest to me”), and dysfunction (e.g., “I find it difficult to function socially”). The first three factors fall on the Relational Track and the fourth falls on the Biopsychosocial Track. Rated on a scale of 1 (*true*) to 5 (*not true*), items on each scale display good internal consistency.

Although other instruments might yield a more refined assessment of the symptomatology of the Biopsychosocial Track, the TTMB’s three Relational Track factors offer a more nuanced assessment of the nature of the continuing bond with the deceased, whether positive, conflicted, or overshadowed by trauma and separation distress as a function of the circumstances of the death. For this reason, it can help clinicians target discrete or pervasive problems in postloss attachment to the deceased and select focal interventions, like those described following, of specific relevance to clients.

### Integration of Stressful Life Experiences Scale

A third theory-based measure of bereavement adaptation is the 16-item Integration of Stressful Life Experiences Scale (ISLES; Holland et al., 2010), which is predicated on a meaning reconstruction perspective (Neimeyer & Sands, 2011). The ISLES was devised as an easy-to-use, multidimensional measure of the meaning made after a stressful life event, including bereavement. Items take the form of simple declarative statements (e.g., “This loss is incomprehensible to me”) to which the respondent indicates agreement on a Likert scale ranging from 1 (*strongly agree*) to 5 (*strongly disagree*). In two samples of young adults—178 who experienced a variety of stressors and 150 who experienced a recent bereavement—ISLES scores were shown to have strong internal consistency and, among a subsample of participants, also exhibited moderate test–retest reliability. In both samples, support was also found for a two-factor structure, with one factor assessing one’s sense of footing in the world (e.g., “This event made me feel less purposeful”)

and a second factor measuring the comprehensibility of the event (e.g., “I am perplexed by what happened”). Convergent validity analyses revealed that ISLES scores are strongly associated with other theoretically related measures and with mental and physical health outcomes, offering support for the potential utility of this measure in research and clinical settings. Subsequent research on a large sample of 741 bereaved adults confirmed the factor structure of the scale in its original and in an abbreviated six-item form, and demonstrated the incremental validity of both formats in predicting health and mental health outcomes even after such factors as demographics, circumstances of the death and prolonged grief symptoms were taken into account (Holland, Currier, & Neimeyer, 2014).

### Grief and Meaning Reconstruction Inventory

A complementary approach to meaning assessment is grounded in the qualitative analysis of the narrative responses of a diverse sample of bereaved adults concerning their attempts to make sense of loss and find some compensatory benefit in the experience. Unlike the ISLES, which assesses the extent to which the loss experience has been assimilated into the respondent’s meaning system, the Grief and Meaning Reconstruction Inventory (GMRI) assesses the type of meanings made in the wake of loss. On the basis of a content analysis of the narratives of 162 mourners, 65 items (e.g., “The time I spent with my loved one was a blessing”) were formatted as Likert scales ranging from 1 (*strongly disagree*) to 5 (*strongly agree*) and then tested with a second sample of 332 mourners to identify coherent subscales and assess their psychometric adequacy (Gillies, Neimeyer, & Milman, 2015). The resulting scale includes 29 items factored into five subscales, of which four—Continuing Bonds (e.g., “Memories of my loved one bring me a sense of peace and solace”), Personal Growth (e.g., “Since this loss, I’m a stronger person”), Sense of Peace (e.g., “This death ended my loved one’s suffering”), and Valuing Life (e.g., “I value and appreciate life more”)—are positive, and one—Emptiness and Meaninglessness (e.g., “I feel pain from regrets I have in regard to this loss”)—is negative. In calculating an overall score

representing adaptive meaning making, items on the latter factor are reverse scored.

The GMRI shows strong overall internal consistency and test–retest reliability, and its various factors correlate as predicted with measures of CG (negatively, except for Emptiness and Meaninglessness), grief related distress and personal growth subscales of the HGRC, and general measures of psychiatric distress. As a final reflection of its validity, respondents scoring high on the GMRI also reported significantly more engagement in behaviors reflective of making meaning of the loss, such as volunteering to help other bereaved persons; contributing to grief support groups; enjoying new hobbies and activities; donating to charitable causes; talking about spiritual, existential, and philosophical issues; and taking time to enjoy the little things in life. As a measure of the degree to which people engage in adaptive meaning making about loss, the GMRI therefore seems appropriate for clinical and research applications (Neimeyer, Gillies, & Milman, 2015).



### Inventory of Complicated Spiritual Grief

Finally, research on meaning reconstruction in bereavement has highlighted that for many religiously inclined mourners, and especially those contending with the death of children (Lichtenthal et al., 2011) or the violent death of a loved one (Burke, Neimeyer, Young, Bonin, & Davis, 2014; Burke et al., 2011), the loss can traumatically disrupt their assumptive world and precipitate a crisis of faith. However, this bereavement-specific sense of spiritual struggle is almost completely neglected in other measures of bereavement distress or meaning making. Therefore, the Inventory of Complicated Spiritual Grief (ICSG; Burke, Neimeyer, Holland, et al., 2014) was constructed to address this omission.

Initial item content was derived from the reports of Christian congregants who reported spiritual struggle in the context of loss, yielding 28 items (e.g., “I no longer feel safe and protected by God”), which respondents endorse on a scale of 0 (*not at all true*) to 4 (*very definitely true*). With two diverse samples of bereaved adult Christians (N = 304), the refined 18-item ICSG displayed strong internal

consistency and high test–retest reliability for its constituent subscales in a subsample of participants. Analyses of both samples supported a two-factor model, with one factor measuring insecurity with God (e.g., “I don’t understand why God has made it so hard for me”) and the other assessing disruption in religious practice (e.g., “I go out of my way to avoid spiritual/religious activities [prayer, worship, Bible reading]”). Analyses further supported the convergent and incremental validity of the ICSG relative to other theoretically similar instruments and measures of poor bereavement outcome, suggesting its specific relevance to studying spiritual crisis in bereavement and guiding interventions addressing such religious struggles (Burke & Neimeyer, 2015).

### TREATMENT

A generation ago bereavement support was a fairly generic affair: underpinned principally by a simplistic stage theory of grief; emotions like anger and depression were given expression and “normalized” in the accepting atmosphere of individual or group therapy (Neimeyer, 2013). Now, however, a host of different therapeutic approaches and techniques have been inspired by the contemporary theories reviewed earlier in this chapter, some of which focus on supporting normal or adaptive grief, whereas others specifically target bereavement complications (Neimeyer, 2012c, 2015). In this section some of the most promising of those procedures that are beginning to garner an evidence base supporting their efficacy are reviewed and brief illustrations of their use in clinical practice are offered.



### Restorative Retelling

Mourners who have lost loved ones to violent death typically struggle with the event story of their loved one’s death, but rarely do they give voice to its most painful particulars (e.g., the identification of their child’s mutilated body at the morgue, their own helplessness to protect a sibling from a random act of violence, the picture of their partner having died by self-inflicted gunshot in their marital bed). Instead, these often fragmentary images live only as “silent stories” (Neimeyer, 2006) in their own thoughts and nightmares, persisting as a haunting

and unspoken subtext to the highly edited stories shared with others.



In *restorative retelling*, Rynearson and his colleagues (Rynearson, 2006; Rynearson & Salloum, 2011) first **established** a safe relational “container” for reentering the detailed story of the dying, grounding the mourner in a more secure story of their lives as family members before the loss (e.g., discussing what family members meant to one another, what philosophic or religious beliefs they have relied on to deal with difficult times). Then, in individual, family, or group therapy with other mourners who have lost loved ones to violent deaths, restorative retelling invites a step-by-step recounting of the narrative of the dying, as remembered or, as is commonly the case in violent death, imagined in gruesome detail. The retelling procedure encourages the mourner to “walk through” a slow-motion replay of the events of the dying, often repeating the process on multiple occasions as the mourner fills in details, modulates difficult emotions with the therapist’s assistance, and gradually gains greater mastery of the painful narrative.

The goal of restorative retelling is to help the mourner integrate the story of the death in the presence of a compassionate witness (or in group therapies, witnesses) and ultimately, across several sessions, be able to revisit the story with less avoidant coping, less emotional reactivity, and greater meaning. Equally important, such retelling commonly invites the narrator to vividly imagine a compassionate caretaking role in the story of the dying (e.g., caressing or comforting the loved one, even if she or he could not be saved), thereby restoring a measure of participation and empowerment to mourners who are otherwise rendered marginal and powerless by the circumstances of the dying. Further procedures to enhance the power of retelling are available elsewhere (Neimeyer, 2012b). Data from an open trial on restorative retelling are encouraging in suggesting its efficacy in reducing traumatic arousal (Saindon et al., 2014), and in documenting its acceptability to clients suffering with the homicide, suicide or violent accidental death of a loved one. In addition, a similar procedure for imaginal revisiting of the event story of the loss is a key component of Shear’s CG Treatment (CGT),

which has outperformed evidence-based therapy for depression in treating bereaved people in two major randomized clinical trials (Shear, Frank, Houck, & Reynolds, 2005; Shear et al., 2014).

An illustration of restorative retelling can be seen in the case example of Robert, a 60-year-old businessman whose son, Jeremy, had died by suicide. Long a leader in his community, Robert was no stranger to the struggles of many of the urban youth with whom he worked in various volunteer efforts aimed at mitigating the impact of drugs and related violence in the youths’ lives. But the insidious substance abuse and depression that undermined the academic and career aspirations of his own young adult son proved more difficult to address, despite Robert’s heroic efforts to secure effective treatment and help him get through his early years of college. Finally, following months of increasingly erratic and avoidant behavior, Jeremy effectively disappeared, after sending a series of worrisome texts to his brother implying that he would not be a “dead weight” around the family’s neck much longer. Robert quickly summarized his search for his son, which ended in the discovery of his body in a rundown hotel 2 days following his disappearance. Months after the funeral, Robert remained harrowed by the traumatic death, but described himself as “at a loss” regarding how to deal with it.

Noting the prominence of intrusive imagery of Jeremy’s dying in his daytime preoccupations as well as in the night terrors that continued to erode Robert’s sleep, the therapist began by asking for more details about his family in better times. Robert smiled sadly in recalling times coaching his son’s Little League team, giving Jeremy the fielder’s mitt his own father had once given Robert. He proudly recounted Jeremy’s grade school and middle school successes and his engagement in the youth group at their church, as well as his comical antics with his older brother. Gradually, though, the idyllic story grew more problematic; Robert and his wife grew further apart, and ultimately divorced when the boys were entering their teenage years. It was Robert’s reduced participation in their lives, he feared, that led to Jeremy’s “falling in with the wrong crowd,” and embarking on the emotionally turbulent path that ultimately led to his violent death.

Briefly explaining the rationale of restorative retelling—to help Robert put together the troubling and unspoken parts of the story of the loss in an effort to master them—the therapist secured Robert’s readiness to then review more fully the downturn in the story that began with a concerned call from his older son on the receipt of his brother’s text messages. Showing the therapist the forwarded texts he had kept on his phone, Robert then began a play-by-play recounting the unanswered messages left for Jeremy and the phone calls to family, friends, and police, which began the search. Slowing the pace of his narration, the therapist elicited the internal, emotion-focused narrative (“What did you feel in that moment when you heard the concern in your son’s voice or when you read the texts?”) and reflexive, meaning-oriented narrative (“What sense did you make of Jeremy’s not answering your calls?” “What did you think was happening?”), punctuating the external account of the plot of the unfolding story (“What do you recall about what happened next?”).

Step-by-step, Robert braided together the narrative, creating a more coherent account that concluded tragically in the dingy hotel room to which he had ultimately been led by tracing the electronic signal sent by Jeremy’s phone, long after the gunshot to the chest ended his son’s life. Staying with the indelible imagery and overpowering emotions of horror and helplessness that arose in that final encounter, the therapist and Robert slowly and literally “breathed through” the trauma of the scene, speaking aloud the conversation Robert had with his son’s broken body as he sat stoically in the room, waiting for the police to arrive in response to his call. As nearly 40 minutes of retelling came to a close, Robert wiped his eyes, and thanked the therapist for being able to share a story that he had not previously been able to acknowledge to others, or even fully to himself. Having held its hard reality more fully, he then felt ready to attend to the complicated relational implications of Jeremy’s suicide, including his paternal guilt for not being able to intervene in time. This, and the meaning of the life that was left to him, then became the topics of further therapeutic conversations.

## Behavioral Activation

As recognized by the DPM (Stroebe & Schut, 2010) and CBT approaches, coping with bereavement entails not only loss-oriented strategies for attending to emotional dimensions of bereavement, but also restoration-oriented behaviors such as renewing personal goals and reengaging the worlds of work and relationships. Behavioral activation (BA) addresses this feature of adaptation by challenging ruminative and avoidant behaviors that block sources of reinforcement that the client previously enjoyed (Papa, 2015). Importantly, it can also entail identification of impediments to the completion of such activities and graduated exposure to emotionally daunting places and activities, drawing on the principles of systematic desensitization, and addressing a hierarchy of exposure to increasingly challenging stimuli. Practical discussion of the use of BA to remediate the “grief loops” that reinforce self-isolating and symptom-maintaining behaviors can be found elsewhere (Papa, 2015). A randomized open trial comparing an immediate start group to a delayed start group documents the clear feasibility and acceptability of BA, and suggests its efficacy in reducing prolonged grief, depressive, and PTSD symptomatology in bereavement (Papa, Sewell, Garrison-Diehn, & Rummel, 2013).

An illustration of BA can be seen in the following case example. When Brian and Cheryl experienced the sudden and unexplained death of their seemingly robust toddler, Billy, they were disconsolate. Despite their devastation, however, they processed the associated feelings and meanings of the tragic loss remarkably well, drawing on Cheryl’s sensitivity as a creative writer, and Brian’s own emotional intelligence as a manager. But practical adaptation to the loss proved harder for both, as they had temporarily left their small home with its pall of death to seek refuge in the large house of a generous friend. Now, as weeks merged into months, they began to recognize that they needed to move home, at least temporarily, despite all of the painful memories it held, and ultimately make critical decisions about whether they would try again for another child.

To approach this anxiety-generating task, the therapist first reviewed the goals Brian and Cheryl shared about having a home of their own and trying



again for a family. Together with the therapist, they considered manageable steps in that direction in the form of first simply walking by their house together, and later supporting each other as they approached the door and stepped inside. Processing these “field trips” in session, they jointly negotiated each successive activity with the therapist scheduled as literal “homework,” until they were able to remain in the house overnight. Ultimately Brian and Cheryl supported one another through the tearful reentry into Billy’s room and through difficult, but necessary, discussions of which of his furniture, toys, and clothes they would put in storage until they were ready to try to conceive another child, and which they would donate to charity. Reengaging these warded-off places and activities brought with it a sense of healing and hope, even if it also required a graduated confrontation with and mastery of the grief and anxiety that they had long been avoiding.

### Directed Journaling

A good deal of research in the field of trauma and stressful life events in general supports the use of emotional disclosure journaling, in which writers are encouraged to immerse themselves deeply in the thoughts and feelings connected to a difficult event for 20 min to 30 min over a series of three distributed writing sessions (Pennebaker, 1996). However, research has been less clear about the value of this emotionally immersive writing in the context of bereavement, leading some investigators to suggest specialized procedures for processing grief (Neimeyer, van Dyke, & Pennebaker, 2009).

Two such forms of directed journaling that are consonant with a meaning reconstruction perspective focus on sense making and benefit finding (Lichtenthal & Neimeyer, 2012). In the former, clients are encouraged to reflect on questions about how and why the loss occurred, and what it portends for their lives. Prompts might include the following: “How did you make sense of the loss when it occurred?” “How do you interpret it now?” “How does this experience fit with your spiritual views about life, and how, if at all, have you changed those views in light of the loss?” “How has this loss shaped your life, and what meaning would you like it to have for you in the long run?” In contrast,

benefit-finding journaling could be prompted by questions such as the following: “In your view, have you found any unsought gifts in grief?” “If so, what?” “How has this experience affected your sense of priorities?” “How has it affected your sense of yourself?” “What strengths in yourself or in others have you drawn on to get through this difficult transition?” “What lessons about living or about loving has this loss taught you?” “Has this experience deepened your gratitude for anything you’ve been given?” “Is there anyone to whom you would like to express this appreciation now?”

A randomized controlled trial of both forms of directed journaling compared to a standard emotional disclosure paradigm and a neutral control writing condition has established its efficacy and maintenance of improvement over a three month follow up, with the impact of such writing being particularly impressive in the benefit-finding condition (Lichtenthal & Cruess, 2010). The value of such writing between sessions is also consonant with the results of process-outcome studies of grief therapy, where higher salience of “innovative moments” of in-session reflective meaning making sparked by such journaling functions as a reliable harbinger of client reconceptualization of their problem narratives, and of good outcome in general (Alves, Mendes, Gonçalves, & Neimeyer, 2012).

The following case example illustrates the use of directed journaling. The week of his father’s death, George, moving into retirement, found himself journaling about the legacy of his father’s life as reflected in his own. “The older I get,” he began, “the more the old songs come to me unbidden, like Paul Simon’s ‘Slip Slidin’ Away.’” Something in the remembered music captured the essence of his father’s slow slide toward dying, in the hospice in which he passed his final weeks. The many hours George spent at his bedside with his wife and siblings were a blessing, he concluded, as the adult children bridged their religious differences to sing Protestant hymns to their father that he had once taught them, a *pas de deux*, in George’s words, that captured their intimate connection. Bringing the rites and prayers from their respective traditions into the room and into the closing chapter of their father’s life felt fitting, he wrote, reweaving a

tapestry of love that had sometimes grown frayed as each had faced his or her own hardships, missteps, and life losses.

Reflecting in writing on a family saga larger than any one of their lives taken in isolation, George recalled a distant memory of a much younger man confronting a much younger father with the angry accusation, “I knew you loved me, but I never heard the words.” The mutual tears that had followed opened doors for both men, through which each had passed in the direction of the other many times in the decades that followed. As a final “Swing Low, Sweet Chariot” swelled into the hospice corridor, the family “sung their father to heaven,” and sung George into a state of deep appreciation and resonant spirituality that he consolidated in his journal entry, and further validated in his appreciative sharing of the entry with his therapist.

### Imaginal Dialogues

In keeping with the TTMB (Rubin et al., 2011) and a meaning reconstruction emphasis on the “back story” of the relationship (Neimeyer & Thompson, 2014), grief therapy often functions as a kind of relationship therapy *in absentia*. That is, just as couples or family therapies frequently promote direct work on important issues in the relation between two people, so too does grief therapy sometimes facilitate deep experiential negotiation of the terms of attachment between the bereaved and the deceased, as the former reconstructs a continuing bond that recognizes the nonphysical presence of the significant other in his or her changed life. Maintaining rather than relinquishing the bond in this way can bring forward relational resources (e.g., the loved one’s belief in the bereaved, proud identification with the deceased person’s accomplishments and values), in effect continuing a story of love that can support the client’s movement into the future (Hedtke, 2012). Alternatively, this work can focus on troubling unfinished business in the relationship, such as the corrosive regret, guilt, disappointments, anger, or relational secrets that have been found to predict CG responses in recent research (Klingspon et al., 2015).

One powerful tool for accomplishing this is the *imaginal dialogue*, in which the client is encouraged

to visualize the deceased and speak aloud (or sometimes silently) that which needs be said in a conversation that was interrupted by the death. Although this can be accomplished by simply asking the client to close his or her eyes, bring to mind an image of the loved one, and imagine what he or she would say and how the deceased might respond, it is usually more powerful to offer the deceased a symbolic empty chair across from the client to promote a clear differentiation of the self and other positions. The therapist can then invite the client to open an honest (and typically emotional) conversation with the deceased about how life has been since the loss, and what he or she now needs in relation to the loved one. As the therapist deepens the client into the conversation with brief encouragement (“Tell him more about that”), he or she also listens for poignant moments when a response from the loved one would be called for, and invites the client physically to take the chair of the other and respond to the client’s initial statement. Guidelines for such experiential chair work are available both for general applications in emotion-focused therapy (Greenberg, 2010) and specifically in the context of bereavement (Neimeyer, 2012a). Evidence supporting the efficacy of imaginal conversations has been provided in two randomized trials of CGT, for which it is a key intervention (Shear et al., 2005; Shear et al., 2014).

An illustration of imaginal dialogues is shown in the case example of John, a successful businessman, who had entered therapy to sort out his life, an effort made more urgent by his father’s worsening pulmonary disease and placement in a nursing facility. For much of his adolescence and young adulthood, John had struggled with the fundamental religiosity of his parents, and its strong emphasis on sin and the very real threat of eternal damnation. “Like a wild horse breaking free,” John recalled jettisoning his faith and family as he left home and pursued his career with a fierce determination to “never go back.” Now, however, John realized that his cut-off from family left his little brother Mike without a “buffer” from a deeply judgmental and alcoholic home environment. As Mike slipped into an adolescence saturated in substance abuse, John recalled that “I also judged him and he felt it.”

Ten years after Mike's ambiguous overdose, John now felt deep remorse but didn't know how to address it, "like an itch I can't scratch."

Sensing his need and readiness to work on the relationship with Mike, the therapist asked John if these were things he would feel ready to discuss with his brother now, were Mike able to join him in the session and be fully open to hear what he had to say. John agreed. Gesturing to the empty chair positioned opposite him, the therapist asked John to close his eyes for a moment and envision Mike there, describing how he would be dressed and seated to conjure his presence more fully. The therapist then invited him to open his eyes and using first-person statements, speak to the broken heart of their relationship. John did so: "I'm sorry I didn't help you. As 10 years have gone by, my perspective has changed so much. I'm sorry for judging you. I hope my love for you now helps carry you forward. You were always good to me, never judged me. I want to pay that forward with my own children." "Try telling him," the therapist suggested, "I am loving my kids for you." Pausing and nodding seriously, John repeated this, and added, "Yes, your memory, your essence, are still part of my family; you are forever in my life." The therapist offered, "You are still my brother." John repeated this, then fell silent with private emotion.

The therapist then gestured to the empty chair, directing John to take Mike's seat and respond to his older brother's honest and anguished comments. Responding as Mike, John answered reassuringly: "John, I've missed you greatly. I feel tremendous regret about my addiction; I just lost the battle. Grieve me. I'm happy you found beauty and purpose in your life. Love your children; thanks for keeping me in their minds and hearts. I accept your apology."

Moving John to a third chair directly across from the therapist and at right angles to the two he had used in the dialogue, the therapist asked him from this "witness position" what had struck him as important in the conversation that had just taken place. John responded that he was impressed by the earnest sincerity in the relationship, the genuine feeling. "The relationship is tremendously significant. I think I carry it with me wherever I go." As he

sat with this recognition, John was suddenly flooded with profound emotion, and sobbing deeply, stammered out, "Of all my family, my brother loved me the best. Now I see so much of my brother in me. Mike never had my mean streak, my severity." Recognizing the seeds of love that his brother had planted in him, which were only now growing and bearing fruit, John concluded, "So now I tell my children every time I see them that I love them just the way they are." Several months later, as therapy drew to a close, John reflected on that pivotal fourth session, which seemed to resolve a longstanding sense of guilt, install more securely a brother's love, and begin to prompt greater compassion for even those wounded souls—including his father—who remained physically present for a deeper dialogue.

### Legacy Work

Also in keeping with a continuing bonds perspective, therapeutic efforts to secure the legacy of the deceased can assuage the grief of mourners, in a sense extending the impact of their loved one's lives beyond the grave. Such efforts can involve memorializing the person in photography or videography (Hochberg, 2014), biographical projects (Walter, 1996), random acts of kindness done in remembrance (Cacciatore, 2012), or contributions to worthy causes or social justice initiatives (Armour, 2003). Mourners can be particularly motivated to pursue legacy work when the deaths they grieve are tragic (drunk driving accidents, suicide, homicide) or premature (deaths of children). Legacy projects comprise a centerpiece of Meaning Centered Grief Therapy, which is currently being evaluated in a randomized controlled trial at Memorial Sloan Kettering Cancer Center in New York (Neimeyer & Lichtenthal, in press).

The following case example illustrates legacy work. When her 19-year-old son Max died in a vehicular accident as he and his friends were returning to university, Gayle found consolation in the spontaneous visits of his friends on the monthly "anniversary" of his death, and in the recovery of his personal journal from the scene of the accident, giving abundant evidence of his growing commitment to social service for those in need. Gradually as the months progressed and with the therapist's

encouragement, Gayle transformed the monthly “Max Meditations” into a gathering for others, especially bereaved parents, who sought solace in one another’s understanding presence. The gatherings included a the 20-minute silent meditation honoring their dead and a shared meal afterward to permit conversation. Simultaneously, Gayle launched “Team Max,” a spontaneous mobilization of volunteers of all ages via social media, who gather on short notice to address a compelling human need in the wake of illness, crisis, or loss. Across dozens such actions, Team Max has brought together hundreds of volunteers to feed the hungry, provide toys to hospitalized children, organize cultural events for homeless people, and send tons of medical supplies to victims of natural disasters. Although not erasing the grief over the tragic loss of a promising young life, the spiritually inflected meditation group and the social action-oriented work of Team Max served as legacies that help give Max’s life and death meaning, for those who knew him intimately and those who came to know him through the compassionate projects his mother launched in his honor.

### Expressive Arts Approaches

At times, the deep stirring of grief defies formulation in literal language, and is better expressed and explored in imagery, music, movement, and creative writing—forms of symbolization that are potentially more “experience near” in capturing the felt sense of loss at an emotional level, rendering it more available for therapeutic work. Regardless of the form of the work, whether visual, auditory, verbal or kinesthetic, such approaches are “low skill and high sensitivity” (McNiff, 2009), in the sense that they emphasize the psychological value of working with grief in imaginative ways, rather than focusing on aesthetics. For example, trained mentors using the Pongo method may help youth in juvenile detention centers craft deeply authentic, anguishing, and sometimes uplifting poetry that gives voice to their many losses, by providing prompts or scaffolds for poetic self-expression (Gold, 2014). Music therapy—in a receptive form using recorded songs and of an expressive kind using simple instruments—has great utility with children, adolescents, and adults who can relate to relevant lyrics as well as to musical scores

that mirror their emotions (Berger, 2006). And visual arts methods have been used to help combat veterans symbolize experiences of trauma and loss, as well as install a sense of strength and hope for a resilient future (Artra, 2014). A substantial compendium manualizing such techniques in the specific context of bereavement can be found elsewhere (Thompson & Neimeyer, 2014).

Research on the use of the arts in grief therapy is germinal, but encouraging. For example, a secular Buddhist treatment program makes extensive use of poetry and creative writing in conjunction with a “self-distancing” narration of one’s own loss in the context of discussions of the universality of suffering and impermanence. An open trial of two iterations of the weekend workshop suggests substantial reductions in grief-related symptomatology, an enhancement of personal growth, and significant gains in meaning making regarding the loss event (Neimeyer & Young-Eisendrath, 2015). A review of qualitative and quantitative research on several art-based interventions in bereavement gives a foundation for further research to establish their efficacy (Torres, Neimeyer, & Neff, 2014).

An illustration of an expressive arts approach can be seen in the following case example of Linda. When Linda lost her husband, Don, to a sudden heart attack, she could find no words that seemed adequate to express the brokenness of her life. Therapy helped her learn to modulate her waves of grief and gradually reopen to engagement with the social world, as well as to pursue a charitable legacy project that honored and extended her husband’s history of civic engagement. As an amateur artist herself, she was more drawn to visual than verbal portrayal of experience, and eagerly accepted my collateral referral to an art therapy colleague for an adjunctive session. Working alongside the art therapist who was also grieving a personal loss, the two women made use of oil pastels to depict and discuss the texture of their grief on a single table-top size sheet of paper, their lines, circles, and swirls melding into a single, vibrant composition. Sharing the work with me afterward, Linda eagerly gestured to the jagged, dark, and clashing forms that she had contributed, which were visually distinguishable from the more fluid, colorful contributions of the art therapist.

Completing the visual duet allowed Linda to understand the impact of Don's death on her life and also gave her hope that her own grief would one day feel lighter and less "edgy," as suggested by the flowing shapes of her partner.

## CONCLUSION

Among the many potentially traumatic events to which individuals may be exposed across the course of their lives, the deaths of loved ones can be distinguished by their near certainty. Although a good deal of evidence suggests that human beings are characteristically resilient in the face of such inevitable transitions, the risk of clinically substantial depressive, traumatic, or grief responses grows large for vulnerable mourners, as well as for those whose losses are sudden, violent, grotesque, or entail complex issues of human intention or inattention. As such conditions benefit from fresh conceptualization from a variety of perspectives, from the development of validated tools for assessing clinically significant grief and its potential mediators and moderators, and from the refinement of evidence-based procedures for helping those who suffer bereavement complications, there is hope that trauma-informed interventions can address this common and tragic form of suffering and contribute to its alleviation.

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