

**TREATMENT of INDIVIDUALS WITH PROLONGED and COMPLICATED GRIEF
AND TRAUMATIC BEREAVEMENT**

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COMPLICATED GRIEF versus TRAUMATIC BEREAVEMENT

There is value in drawing a distinction between individuals who experience Prolonged and Complicated Grief versus Traumatic Bereavement in response to the loss of a loved one or for someone for whom an individual has a strong attachment relationship. Survivors are likely to experience **deaths as traumatic** if the loss is sudden, unexpected, untimely, often violent, and perceived as preventable, unjust, and resulting from an intentional human act. If the death involved violence or mutilation, or if the survivor believes that his/her loved one suffered during his/her final moments, then there is a high likelihood of mental anguish, an overwhelming sense of loss and difficulty accepting the death. They often struggle making sense of what happened and may experience guilt, self-blame, manifest preoccupation with the circumstances of the death and the deceased experience of suffering. Such shocking deaths may cause survivors to question their faith and experience “spiritual struggles.” (Pearlman et al., 2014). In addition, individuals who experience traumatic bereavement with accompanying PTSD are likely to experience intrusive thoughts, avoidance behaviors, cognitive and mood alterations, physiological arousal, loss of meaning, affect dysregulation, impaired concentration and being consumed by memories (rumination). They are prone to disengage from the present in favor of yearning for the deceased and focusing on the past. They evidence an avoidance of engaging in pleasurable activities and social contacts.

In terms of Prolonged and Complicated Grief, Prigerson et al., (2009) have proposed a **Prolonged Grief Disorder (PGD)** that is associated with intense, unremitting and disruptive impact on central roles and relationships and that contribute to enduring mental and physical health problems and that are slow to resolve and will persist if left untreated. At least 6-12 months following the loss, the individual with **PGD** experiences intense yearning or longing for the deceased, either daily or to a disabling degree, as well as 5 or more of the following symptoms on a daily basis, or to a disabling degree:

feel stunned, dazed or shocked by the death; avoid reminders of the reality of the loss; have trouble accepting the death; have trouble trusting others; feel bitterness or anger related to the loss; experience difficulties moving on with life; experience confusion about one’s role in life or a diminished sense of self; feel that life is unfulfilling, empty or meaningless and feel numb (absence of emotion) since the loss.

In addition, they may also experience heightened levels of suicidal thinking and behaviors, impaired social functioning and more days of work missed.

The intense yearning for and preoccupation with the deceased, the accompanying pangs of grief in response to the evocation of the “echoes of the past”, the avoidance of loss reminders, social isolation and avoidance of seeking help can contribute to difficulties with occupational and social functioning, self-care behaviors, poor health, impaired sleep, contribute to substance abuse, and in some instances, contribute to suicidal thoughts and acts. (*See Pearlman et al., 2014 - - pp. 42-43 – for a list of common responses to the death of a loved one*).

Bereaved individuals with Complicated Grief are more likely to seek professional services than individuals without Complicated Grief.

Thus, the circumstances of the death can influence the nature of the bereavement process, and the type of treatment approach that should be employed. Survivors of natural deaths rarely encounter the problems and challenges that bring about great distress for survivors of traumatic deaths.

INCIDENCE OF COMPLICATED GRIEF

The incidence of Complicated Grief varies depending on the circumstances of the death (e.g. traumatic death due to violence, homicide/suicide), death of a child (as high as 30% to 50%), or whether the death was expected due to natural age-related causes. Some healthy individuals do not show significant distress, nor impaired functioning even shortly after a recent loss (Wortman and Silver, 1989). Most bereft people advance through bereavement without any residual problems (Parkes, 2011).

For most individuals (75%), over time the severity of their grief reactions subside and they grieve adaptively over a period of a few months and evidence resilience (Bonanno, 2002, 2004; et al. 2005; Clayton et al., 1968; Currier et al., 2008; MacCallum & Bryant, 2013). Wortman and Boerner (2007, 2011) have reported that while most survivors improve symptomatically, but they may still have difficulty finding meaning after a sudden traumatic loss, than after a loss stemming from natural causes. Neimeyer and Sands (2011) indicate that the inability to find meaning is a significant predictor of post loss adjustment.

Anywhere from 5% to 20% of bereaved individuals evidence Prolonged and Complicated Grief (PCG) reactions and Complicated Spiritual Grief reactions, chronic depression and related adjustment difficulties. Psychiatric outpatients who are bereaved evidence a higher incidence of PCG (Hensley, 2006).

During the first weeks past the loss, grief-related reactions are normal (Clayton et al., 1968; Pearlman et al., 2014).

- 70% of bereaved individuals report depression, sleep disturbances
- 85% experience bouts of crying
- 50% evidence diminished interest in usual activities, loss of appetite, difficulty concentrating, withdrawal, and a sense of insecurity

Such behavioral patterns of grieving occur across cultures, but there are marked variability in expression.

For a discussion of the controversies concerning the inclusion of Complicated Grief in DSM-V see Boelen & Prigerson, 2013; Jordan & Litz, 2014; Pearlman et al. 2014; Prigerson et al. 2001; Prigerson & Jacobs, 2001; Rando et al. 2012; Shear et al., 2011; and Wakefield, 2013. DSM-V has introduced the diagnostic category of Persistent Complicated Bereavement in the Appendix.

The diagnosis of Prolonged Grief Disorder (PGD) will be used in the International Classification of Diseases (ICD-11) (Maercker et al., 2013).

THE NATURE OF PROLONGED COMPLICATED GRIEF REACTIONS

Complicated Grief Reactions consist of a variety of components including how survivors perceive and appraise interpersonal, intrapersonal (reminders), situational triggers and the emotions they elicit, as well as the accompanying automatic thoughts, images, beliefs, schemas which contribute to how survivors behave (what they do and do not do) and how others react. This interconnective chain can occur in a variety of ways and can lead to a downward “loss spiral”, or can lead to a “recovery process”. The following **CLOCK** metaphor can be used to summarize and educate clients about the mourning process.

Use of a CLOCK Metaphor to Summarize Complicated Grief Reactions

12 o'clock - External and Internal Triggers

3 o'clock - Primary and Secondary Emotions

6 o'clock - Automatic thoughts and images, Thinking Processes, Schemas and Beliefs

9 o'clock - Behavior and Resultant Consequences

12 o'clock - External Triggers - Circumstances of the death
 - Reminders of death, losses
 - Other people's losses act as triggers
 - Memorial events, routines

Internal Triggers – Reminders such as an anniversary and situational reminders (holidays, special times and events)
 - “Echoes of other losses”.

3 o'clock – Primary and Secondary Emotions and The Survivor's Attitude About Emotional Expression

Initially, stunned, shocked, disbelief, confused, emotionally numb, angry, enraged, sad, anxious, bitter, psychologically hyperaroused, devastated, sense of unreality about the loss, dissociated, disgusted, guilty, shamed, humiliated.

This may be followed by feelings of longing, yearning, emptiness, loneliness, fear that something else bad is going to happen, powerlessness, helplessness and hopelessness, separation distress and depression, “emotional anesthesia” and feelings of unreality..

6 o'clock – Automatic thoughts and images, thinking processes, schemas and beliefs

Initially, a sense of disbelief depending on the circumstances of the death, rumination on circumstances of the death, difficulty accepting the loss, disbelief, denial of the death.

Subsequently, sense of purposelessness, ongoing rumination and increased vulnerability to intrusive ideation, hallucinatory experiences, sense of losing control, “going crazy”, overgeneralized memories that contribute to not envisioning a future and that undermines problem-solving, mistrust of others, and identity confusion, enduring search for meaning, engage in contra-factual thinking (Ask “Why Questions” for which there are no satisfactory answers), engage in “Only if” type thinking. Continually replay circumstances of the death, self-blame and critical negative thinking, hold onto unachievable goals. (See Janoff-Bulman, 1989, 1992; Nolen-Hoeksma, 2001; Stroebe & Stroebe, 1999, 2006).

The following are examples of the **LOSS MINDSET** and the accompanying **METAPHORICAL NARRATIVES** that characterize individuals who experience PCG. Such thinking processes and the accompanying emotional reactions contribute to the perpetration of complicated grief. The thinking processes include:

1. **Inconsolable emotional pain.**
2. **A lack of a future outlook.**
3. **Guilt-engendering thoughts, self-blame, “hindsight bias” (judging something in the past on the basis of knowledge that one has now, but did not have then; “Monday Quarterbacking”).**
4. **Ongoing search for meaning.**
5. **Ruminations and self-doubt.**
6. **Contra-factual "If only" and "If then" thinking processes.**
7. **Thoughts that undermine help-seeking.**
8. **Low self-efficacy statements**

Examples of the Narrative of Individuals with PCG

1. Inconsolable Emotional Pain

“I am (lost, adrift, bereft, a cry baby, entangled in a cascade of grief, a loop of unresolved grief).”

“I am experiencing a (fog of grief, bereavement overload, waves of grief).”

“I feel (alone in my suffering, stuck in the past, frozen in Time, an emptiness with a hole in my heart that cannot be filled).”

“I don’t know who I am any more. The light in my life is no longer living.”

2. A Lack of Future Outlook

“There is no future. My life is over.”

“I will never get better.”

"I am stuck in this forever."

"This will never end."

"There is no way to be happy again."

"I don't deserve to be happy, laugh, love again."

"His pain ended, but mine will be forever."

"Time has stopped for me."

"It feels like it just happened."

"I don't have confidence in the future."

"There are more yesterdays than tomorrows. I have nothing to look forward to."

"I feel an impending doom."

"I am waiting for the other shoe to drop."

3. Guilt-engendering thoughts: Influence of Hindsight Bias

"I killed him/her. His/her death was my fault."

"I was too busy and too self-absorbed that I overlooked (denied) the warning signs."

"I didn't do anything right when he/she was alive."

"I am a bad person for letting this happen."

"I must suffer like he suffered. It is not right to enjoy myself."

"This is God's punishment."

"I feel guilty about all of the unfinished business between us. I never got a chance to say 'I was sorry'."

"I never got a chance to say a proper goodbye."

"I was not there to comfort him when he died. He died alone."

4. Ongoing Search for Meaning

"I haven't been able to put the pieces of my life together since this event."

"I have trouble making sense of her death."

"How unfair that he/she died. It makes no sense?"

"His/her death was useless. What did he/she sacrifice his/her life for?"

"I am devastated. Since his/her death life has no meaning. It is purposeless."

"I feel cheated."

"I asked God to protect her, and He did not."

"I was betrayed."

"His/her death has robbed my life of meaning."

"Since _____ died, I feel worthless, directionless."

"Life has nothing to offer me."

"I am trapped. I am up against a wall."

"I keep asking why questions, but there are no satisfactory answers."

5. Rumination – "Not Let It Go"- "Reenactment Story; Desire for Retribution

"I keep thinking about how he/she died."

"I replay it over and over."

"I repeatedly think about how things could have been different."

"It is too painful. I do not want to think about it, but I can't stop thinking about his/her death."

"I keep asking, 'Why me?'; 'Why my child?'"

"I continually dream about revenge."

"I am suffocated by my anger."

"I can never feel completely safe again."

6. Contra-factual Thinking Processes: "If only" and "If then..." Thinking

"If only X (I had, or I had not), I could have prevented his/her death."

"Only if I had X, he/she would be alive today."

"If I did X before and things turned out badly, how can I ever trust myself to make good decisions?"

"If only he/she were here now."

"If I get better, then his/her death has no meaning."

"If I don't continue mourning, there is no one to hold onto his memory."

"My grieving keeps his/her memory in the public "eye."

7. Thoughts That Undermine Using Social Supports and Accessing Help

"No one knows how bad I feel."

"No one can help me."

"This is too painful to bear and share."

"This is the worst thing that could happen. If I talk about his/her death, I will go crazy."

"I cannot confront the reality of his/her death."

"Nothing and no one can ease my pain."

"No one will want to be around me when I am so miserable."

"I am not whole. I have lost an important piece of me and it is not reparable."

"I can't trust anyone."

"I feel shut out, a stigma over my head, like I had the plague."

"I avoid and limit contacts with others."

8. Lacking Ability to Cope: Low Self-efficacy

"I can't cope."

"I am emotionally worn out."

"I can't cope with anything that reminds me of him/her."

"I can't make myself better. I am trapped."

"I will never have someone this close again, this important."

"I don't want to have someone this close to me again, and have them die on me."

"Others will die and I won't be able to bear it."

"I was so dependent on _____. I cannot function without him/her."

"Here I go again. The same vicious cycle that I cannot stop."

"I don't mourn the way I should."

"I feel as if part of me has died."

“I can’t trust my own judgment any longer.”

“Drained my vitality. My life has no purpose and meaning.”

“My life is now filled with never agains.”

9 o’clock – Behavior and Resultant Consequences

Uncontrollable crying spells, sighing, fatigue, decreased appetite, difficulty sleeping, nightmares, neglect of self-care, increased use of substances, increased tobacco use. Difficulty concentrating, irritability, restlessness and difficulty reinvesting in life.

Proximity seeking behaviors- - wear deceased cloths, sleep in his/her bed, lie near the grave, hallucinatory experiences, hard to part with loved one’s possessions.

Avoidance of emotions and reminders, withdrawal, disengaged from usual activities that give pleasure, engage in mindless self-distraction activities, keeping busy, lack of acceptance of death, denial. Attempts to control rumination by suppressing thoughts and engaging in avoidance behaviors.

Difficulty “moving on” with life, failure to engage in memorial, commemorative ceremonies, avoid seeking social supports and help/treatment.

Social withdrawal can contribute to feelings of isolation, estrangement, loneliness. Self-isolation is an important factor associated with health problems, PTSD and complicated grief. Not participating in leisure activities that one enjoyed with the deceased because they trigger bittersweet memories; not participating in religious-based activities because disillusioned with one’s faith, engaging in overprotective behaviors with surviving loved ones can each contribute to PCG. Such reactions by survivors can be exacerbated by the social ineptitude of others who minimize the loss, or who offer “moving on” statements, or who avoid contact or fail to offer comforting supportive emotional and tangible assistance. (Dyregov, 2003-2004; Wolfert, 2006).

The grieving process can also be impacted by the legal system and media coverage in the aftermath of traumatic violent death of the deceased and by the need for victim impact statements.

Challenges of fulfilling new social roles and responsibilities (financial, parenting, role models). Loss of self-identity (e.g. being a “military spouse”) can contribute to Prolonged and Complicated Grief.

ASSESSMENT PROCEDURES

(See Neimeyer 2016 and Neimeyer et al. 2008 for a discussion of measurement of grief)

- 1. Guided Interview and the “Art of Questioning”**
- 2. Self-report Measures**
- 3. Self-monitoring Procedures**
- 4. Risk assessment” Past and Present (Potential Suicidality)**
- 5. Checklist of Coping Strategies with Grief**

A number of event-related and person-related factors have been found to contribute to the mourning process. In terms of event-related factors these include: the characteristics and type of death - - natural versus traumatic violent death (suicide, homicide, accident; finding or viewing the loved one’s body after a violent death; death in a hospital versus home and not being present when one’s loved one died); treatment related factors (perceived failure or negligence of treatment, perceived as a preventable death), caregiver burden, medical and related expenses; dissatisfaction with death notification; multiple deaths “bereavement overload”; threat to one’s own life, or witnessed the death.

The person-related factors include: gender - - female (especially mothers), close kinship to the dying patient, especially spouse or child, being a widow/widower; high pre-loss marital dependency, vulnerability factors - - developmental adversities including trauma history and prior losses; insecure attachment history; current physical health and degree of self-care behaviors; coping strategies such as optimism and use of one’s faith and spiritual/religious beliefs; supportive social network and kinship relationships. (See Pearlman et al. 2011 for a discussion of how event and person-related factors interact. For example, the loss of a spouse versus loss of a child interacting with the gender of the survivor and how Complicated Grief and Traumatic Bereavement overlap).

1. GUIDED INTERVIEW AND “ART OF QUESTIONING”

For a Guided Interview see Rando (1993) Grief and Mourning Status Interview and Inventory (GAMSII) that assesses the client’s mourning process and areas that need to be addressed. Topics include:

- Circumstances surrounding the death
- Nature and meaning of what has been lost
- The mourner’s reactions to the death
- Changes in the mourner’s life since the death

- The history of the mourner's relationship to the deceased
- The mourner's self-assessment of how well he/she is coping with the loss. Has his/her symptoms worsened, maintained or reduced since the traumatic event or death of your loved one?
- The mourner's comprehension of the mourning processes and his/her expectations regarded the mourning process.

The following questions are designed to help identify the complex combination of grief, trauma and psycho-social problems (secondary losses) that clients experience. Clinicians should sample from this list of questions. Note that most of the questions are “**How**” and “**What**” questions. As Neimeyer and Thompson (2014) highlight, the interview should cover both the story of the events (“Event Story”) and the “Back Story” about the changed relationship with the deceased, and an account of the lingering impact and accompanying coping abilities. The interview should begin with Permission Gathering Questions.

Permission Gathering Questions.

Would this be a good time to talk about _____ ?

How would it be for you if we talked about (the deceased- use name and relationship. “the death of your dad, husband”)?

Is there at least one person you have (can) talked to about your grief? Who is that person?

Who would be a good person for you to share your grief?

Could we begin that conversation now?

You can stop at any time you want. Just share that which you feel comfortable with.

Questions about the circumstances of the death.

Follow the clients lead, but consider the circumstances - - violent traumatic death due to homicide, suicide, body mutilation, multiple deaths, suddenness, out of time death, death-child, death perceived as avoidable and unnecessary (“useless”).

What do you recall about how you responded at the time of the event?

Put yourself back there now.

How did you hear about the death?

How did you respond at the time of notification? Who was there?

How have your feelings changed over time?

Did you have to bear your grief alone?

What was the most emotionally difficult part of the experience for you?

How did you make sense of the death at the time?

Query about a “proper goodbye” and funeral arrangements. “In your eyes, was this a fitting goodbye?”

Questions concerning how currently experiencing grief.

“I would like you to think about how the death of _____ has impacted (influenced) your life.”

Please describe how your life has been since _____ died.

How are you doing with your grieving?

What impact has the death of _____ had on you?

How much does your grief still interfere with your life?

How much trouble are you having accepting the death of _____?

What has it been like for you to go through your daily routine without _____?

What has been going on in your life since the death of _____?

What changes have come about as a result of the death of _____? (Question pulls for possible secondary losses).

What has been lost since his/her death?

What lingers from this loss?

How have you dealt with your loved one’s belongings?

Besides sadness and missing _____, what else are you feeling?

When you talk about these feelings, what else comes to mind?

Can you tell me more about that?

Is there anything you would like me to know about your past experiences?

Do you think it is possible that some of what you are feeling right now, might be related to earlier experiences you have had? (Question designed to assess earlier losses and developmental adversities)

Might some feelings be tied to your concerns (fears, uncertainty) about the future?

Are you struggling to make sense or find meaning in what happened?

What has helped you cope with this loss?

Are there people to support you in your loss?

What have you found helpful and what was of little or no help?

What areas of your life have not been influenced by your loss?

How are these coping strategies useful?

Questions Concerning Emotional Reactions

Litz et al., (2016, p. 106) offer the following questions:

“What are you most sad about?

What are you most troubled by?

How do you think this event has changed you?

Is there anything that could have been different?

What do you think will happen if you let yourself feel the intensity of your grief?

Have there been other times when you’ve lost someone? If so, how is this similar or different?

How did you mourn/grieve in the past?”

In the aftermath of the death of a loved one, individuals may experience a mixture of different feelings? Some may feel sadness, anxiety about the future, anger, guilt, shame and other feelings. Some may even experience positive emotions of relief, gratitude, forgiveness, pride. Can we take a moment to discuss how you felt at the time of _____ death and what feelings linger now?

Can you tell me about your feelings and how they have changed over time?

When you have such feelings, what do you do with those feelings?

Do you ever feel like you have a need to suffer?

Do you feel that you need to live with your (guilt, shame, anger, sadness)?

What gets in the way of your sharing your grief with others or you getting help?

Do you have any goals at the present time?

What would you like to be doing if you were no longer grieving? How can we work on ways to meet these goals?

Can you describe something you did, or something that happened to you that made you feel good and that was meaningful to you and that helped you get through the day?

Questions Designed to Tap Past History of Coping and Current Sense of Self-efficacy.

Can we take a moment to discuss what challenges, setbacks, losses you have experienced in the past? What were these?

How did you handle (overcome) these challenges (losses)?

What coping skills and support from others did you use to handle these challenges?

What helped you then?

Who was most helpful? What did he/she say or do that was helpful?

Is there anything that helped you then that you can use now?

What contributed to your ability to “bounce back”, be resilient, in spite of _____?

Could you answer the following question? “Although I am sad, I am still able to _____”

Can you mobilize your own self-healing?

Is it okay for you to be okay?

Questions Designed to Tap Relational History (Past, Present, Future).

(Assess for the importance of the deceased person(s) in the client’s life and in terms of future adjustment - - see Magariel, 2016).

Is it okay if I ask you some questions about your past relationship with your _____?

Can you tell me about your relationship with the deceased? (Use the deceased husband, son, etc - - use the deceased name).

What did you most appreciate about him/her?

What do you think he/she most appreciated about you and your relationship?

If I was watching you earlier in your life, what moments would I have seen that would help me best understand the connection you two shared?

What were the challenges the two of you faced and how did you handle (overcome) them?

What was unique about your relationship?

When did you feel your closest connection with _____?

When did the two of you spend time together?
In what ways did you two care for each other?
Was your spouse (husband/wife) the person in your life who would encourage (help) you through difficult times?
If your _____ were here now, what advice (guidance), if any, would he/she offer?
Do you ever hear his/her words of encouragement in your mind?
How would he/she want you to remember him/her?
Do you think you could develop an 'internal' relationship with your _____?
What do you think _____ would want you to do now?
What would you like others to know about your relationship with _____?
What would you like others to know about the legacy (gifts) he/she has left you?
Is there anything you wish you would have said or done before he/she died? What was that?
Is there any "unfinished business", or any regrets that you have about your relationship with _____?
Is this the first time you shared this with anyone?
What was this discussion like for you?

Lichtenthal & Breitbart (2016) have proposed a set of questions "Who am I?" to help clients engage in collaborative goal-setting.

Who was I before my loved one died?
Who was I while my loved one was sick?
Who am I now?
Who do I want to be?

Assessment of Meaning-making, Spiritual and Religious Beliefs and Practices

For clients who believe in God, Pearlman et al. (2014), suggest asking, "*In dealing with the death of X, do you feel supported, abandoned, or betrayed by God?*"

For clients who attended religious services prior to the death, "*Has the death of X affected your participation in your religious community?*"

Do you think that for you this event holds meaning other than loss?
How have you made sense of the death at the time? How do you view the loss now?
What spiritual or religious beliefs help you cope now?
Are there ways that his/her loss has affected the direction of your life?
How in the long run, do you imagine that you will give this loss meaning in your life?

See Meichenbaum's Handout on www.melissainstitute.org for ways to assess spiritual/religious coping strategies. On the Home Page, click Resources on the top of the page. Scroll down to Author Index and then to Meichenbaum. See paper "Trauma, spirituality and recovery".

Assessment of any benefit -finding*Has anything good come of this loss (his/her death)?**Have you found any insight, benefits or gifts that came from your grieving? If so, what?**What qualities in yourself have you drawn on that have contributed to your resilience?**Has your loss affected your sense of priorities? What is most important to you now?**What lessons, if any, about loving and being close to others you care for, has this loss taught you?**Has this loss deepened your love, your gratitude for anyone or anything you have?**How has this loss contributed to a new outlook on your life?***2. SELF-REPORT MEASURES**

Inventory of Complicated Grief (ICG) and Briefer Version ICG-13, Revised	Prigerson et al., 1995; Prigerson & Jacobs, 2001
Texas Revised Inventory of Grief (TRIG) Two-track Bereavement Questionnaire for Complicated Grief (TTBQ-CG31)	Faschingbauer, 1981 Rubin & Bar-Nadav, 2016
Trauma and Attachment Belief Scale (TABS)	Pearlman, 2003
Continuing Bands Scale	Field et al., 2003
Hogan Grief Reaction Checklist (HGRC)	Hogan and Schmidt, 2016
Grief and Meaning Reconstruction Inventory (GMRI)	Neimeyer et al., 2016
Inventory of Complicated Spiritual Grief	Burke et al., 2014; Burke & Neimeyer, 2016
Moral Injury Questionnaire- Military Version (MIQ-M)	Currier, 2016
Post Traumatic Adjustment Scale	O'Donnell et al., 2008
Inner Experience Questionnaire	Brock et al., 2006
Inventory of Self-Capacities	Briere & Runtz, 2002
Inventory of Daily Widowed Life (IDWL)	Caserta & Lund, 2007; Caserta et al., 2016
Inventory of Stressful Life Experiences Scale (ISLES)	Holland et al., 2010, 2014; Holland, 2016
Inventory of Social Support (ISS)	Hogan & Schmidt, 2016

Perceived Life Significance Scale	Hibberd, 2016
World Assumption Scale	Janoff-Bulman, 1989
Affect Balance Sheet	Bradburn, 1969
Professional Quality of Life Scale (PROQOL)	Stamm, 2005
Meaning of Loss Codebook	Milman et al, 2016
Analysis of Narratives: Meaning of Loss	Gilles et al, 2014
Collaborative Goal-setting “SMART” Goals Specific, Measurable, Attainable, Relevant, and Time-limited	Meichenbaum, 2013; Sage et al., 2008
Use Time-lines of Chronological Losses	Neimeyer, 2012
Asses Genograms and Social Supports	Neimeyer, 2002; Wolfert, 2006

Follow up this assessment of Social Supports with detailed questions that probe for:

- Who is in the client’s social network? (Note names and relationships)*
- Which network members provide effective emotional, informational and tangible supports?*
- Which members were in the network prior to the loss, but have since backed away?*
- Which members (activities, settings) do you intentionally try to avoid? Why?*
- What “insensitive” comments and questions have you experienced?*
- What impact have these comments or actions had on you?*
- How have you coped with them?*
- Have you actively sought out social supports (church, work, school, survivor groups, internet)?*
- Have you gone online and used the Internet to connect with others who have experienced a similar loss; or visited Internet resources like griefnet.org, Memorial Groups or commemorated and memorialized X (the person you lost)?*
- What types of social support do you need now?*
- What are some barriers/obstacles that get in the way of your accessing such support?*

3. SELF-MONITORING PROCEDURES

Grief Monitoring Diary - - Turret & Shear (2012)

Ask clients to rate their grief intensity on a 0 to 10 scale, where 0 is “no grief at all” and 10 is “the most grief they ever experienced.” Record the highest and lowest level of grief experienced that day.

As Turret and Shear (2012) highlight, such Grief Monitoring serves several functions:

1. Helps clients map and observe the variability in their grief reactions, pinpoint

triggers and “stuck points” and “hot spots.”

2. Help clients figure out what feelings are grief and what other emotions are being experienced. “What is grief and what is not grief?”
3. Provides a basis for collaborative goal-setting and a consideration of alternative coping strategies.

Another form of self-monitoring involves having clients notice when they are engaged in a “vicious cycle”. Use **CLOCK** analysis.

Activity Logs, Day Planners, Monitor engagement activities. (Check in with self and ask “**How am I doing?**”) Record positive activities.

Neimeyer, 2012

4. RISK ASSESSMENT: PAST and PRESENT (Suicidality)

Lobb et al (2010) have identified the following factors as being potential risk factors for the development of Prolonged and Complicated Grief Disorder.

History of prior trauma and loss/History of mood and anxiety disorders/Insecure attachment style/Being a caregiver for the deceased/ Violent cause of death (e.g., suicide, homicide/Lack of social supports after the loss.

Current risk factors include the presence of comorbid disorders such as depression, PTSD, Substance Abuse and the presence of suicidal ideation and behaviors. (See Jordan and Litz, 2014 for a discussion of the distinctions between free-floating depression versus the focalized grief on the deceased that accompanies PCG).

PCG has been associated with 6 to 11 times the general rate of suicidality. For a discussion of ways to assess for the threat of suicidal behaviors accompanying Complicated Grief, visit the Melissa Institute Website www.melissainstitute.org. See papers by Meichenbaum on “35 years of working with suicidal patients, Lessons learned” and “Child and adolescent depression and suicide: Promising hope and facilitating change”.

5. COPING WITH GRIEF CHECKLIST

Another way to conduct assessment is to ask clients with PCG to fill out a Coping With Grief Checklist and then reviewing their responses afterward. The following article describes such a Checklist and how it can be used. This Checklist should be given after several months have passed since the loss of a loved one. Implicit in having clients fill out this Checklist of Coping Strategies, and the subsequent clinical discussion of what coping strategies the client has used and found helpful, are suggestions of additional potential coping strategies that could be tried. The therapist can ask clients:

“Of the Items that are on the Coping with Strategies Checklist, how did you come to choose those? How helpful were they? Can you give me an example? Of the remaining items that you did not check, are there any that you think would be worth trying, adding to your coping repertoire? Which ones? How did you come to choose those? Can you give me an example how you might use them? What would change? What would other people notice changing? Can you foresee anything that might get in the way or undermine your using these coping strategies? I am eager to learn if what you chose will indeed be helpful? Are there any coping strategies in your “tool box” that are not on this checklist that you think we should add and share with others?”

Appendix XX. 1

STRATEGIES FOR COPING WITH GRIEF CHECKLIST

Donald Meichenbaum, PhD and Julie Myers, PsyD

The process of grieving is like going on a “journey.” There are multiple routes and people progress at different rates. There is no right way to grieve, no one path to take, no best coping approach. These grief coping strategies list some of the pathways that others have taken in their journey of grieving. It is *not* meant to be a measure of how well you have coped or how you should cope, since there is no one way to manage the pain following the aftermath of the loss of a loved one, no matter what the cause of his or her death. Rather, the strategies listed are suggestions of things you might consider doing to help you on your journey.

We suggest that you look through this list and put a mark by the coping strategies that you’ve tried. Hopefully, these strategies have helped you. But if you feel that you could use a little extra help, we suggest that you look through the list and then choose some new items that you would like to try. You may find them helpful, and you can add them to the strategies that you’ve already tried. This list is intended to help you discover new ways that you can move forward on your journey through the process of grief. If there are things you have done that you have found helpful that are not on this list of coping strategies, please add them at the end so we can share these with others.

Sought comfort and help from others

1. I examined the thoughts that kept me from seeking help from others, such as the beliefs that “I am a burden to others,” “No one can help me, no one understands,” “I have to do this on my own,” “I should be stronger,” “Listening to the grieving stories of others will make me feel worse,” or “People are tired of hearing about my loss.”
2. I reached-out to family, friends, elders, or colleagues for comfort and companionship, but gave myself permission to back-off when I needed time alone.
3. I took the initiative to reach-out to folks from whom I might not normally seek help. I looked for new friends in church groups, social groups, work, school, or I went on the internet to find others who experienced a similar loss. I made a list of these supports to turn to when I was struggling or experiencing pain.
4. I forced myself to be with people and to do things, even when I didn’t feel like it. I put something on my calendar almost every day, with back-up plans.
5. I allowed myself to tell people how much I loved, admired, and cared for them.
6. I hugged and held others, but felt free to tell people when I did not want to be touched.
7. I learned to grieve and mourn in public.
8. I shared my story with others who I thought would appreciate and benefit from it. I told anyone who would listen to the story of the deceased, even if they had nothing to say back.
9. I gave and received random acts of kindness.
10. I connected with animals and nature, for example, the deceased’s pet, a beautiful sunset, hike, or garden.
11. I cared for or nurtured others. For example I spent time caring for my loved ones or children.

- ___ 12. I found my faith or religion comforting. I participated in religious, cultural, or ethnic mourning practices, such as attending church services, sitting Shiva, participating in a Wake, celebrating the Day of the Dead, visiting a memorial shrine, etc.
- ___ 13. I sought help from organized *supportive* bereavement groups, hospices, religious groups, grief retreats, talking circles, or groups specific to the way the deceased died, such as cancer support groups or survivors of violent loss groups, such as suicide or homicide.
- ___ 14. I sought help from mental health professionals. For instance, attended counseling sessions or took medications as advised by my providers.
- ___ 15. I read books written by others who have coped with the loss of a loved one. I read about the grieving process, loss, and advice books about other issues that arose.
- ___ 16. I made a list of all the professional resources that I could use in a crisis, such as suicide hotlines, mental health crisis lines, mentors, clergy or imam, or mental health providers.
- ___ 17. I decided not to walk through the grieving process alone, so I visited websites that focus on the grieving process (*Refer to the list of websites at the end of this list.*)

Took care of myself physically and emotionally

- ___ 18. I examined the thoughts and feelings that kept me from taking care of myself physically and emotionally, such as guilt, shame, sense of lost self, and loss of the will to live.
- ___ 19. I established routines of daily living. Although things were different, I made new routines and did not berate myself when I was not “perfect.” I maintained personal hygiene, medical care, healthy nutrition, and regular sleep.
- ___ 20. I reconnected with my body through exercise, yoga, Tai Chi, or expressive arts, allowing myself time to get stronger.
- ___ 21. I recognized that my brain needed time to heal and for things to improve, so I forgave myself when I made mistakes, became distracted, couldn’t remember or understand.
- ___ 22. I avoided the excessive use of alcohol, tobacco, recreational drugs, and caffeine as a coping mechanism.
- ___ 23. I relinquished avoidance and learned to face my fears by engaging in life. I participated in activities that had meaning and kept me occupied, such as work, hobbies, crafts, singing or dancing.
- ___ 24. I allowed myself to pursue and feel positive emotions, such as compassion toward myself and others, expressions of gratitude, and emotions of love, joy, awe, and hopefulness.
- ___ 25. I recognized and labeled my feelings, viewing them as a “message” rather than something to avoid. I accepted and dealt with these emotions, understanding that the less I fought them, the more I was able to handle them.
- ___ 26. I regulated my strong negative emotions using slow smooth breathing, coping self-statements, prayer, or other mood-regulating techniques.
- ___ 27. I allowed myself time to cry at times and gave words to my emotional pain. I distinguished feelings of grief from other feelings such as fear, uncertainty, guilt, shame, and anger.
- ___ 28. I expressed difficult feelings through writing and talking to supportive others. I used journaling, reflective writing, letter or poetry writing, or other expressive arts of scrapbooking, dance or music.

- ___ 29. I engaged in gratitude activities, such as telling others how much I appreciate their love and support, reminding myself of the things that I am thankful for, and being grateful that I knew the deceased.
- ___ 30. I established a safe and comforting space for myself, either physically or through imagery.

Stayed connected to the deceased and created a new relationship, while recognizing the reality of the loss.

- ___ 31. I examined the feelings and thoughts that kept me from forming an enduring connection with the deceased, such as the fear of what others would think of me, guilt, shame, humiliation, disgust, or thoughts of anger, revenge or being preoccupied with my grief.
- ___ 32. I participated in practices, such as visiting the grave or memorial site, celebrating special occasions, prayer and candlelight vigils, public memorials, or commemorative services.
- ___ 33. I commemorated the deceased's life with words, pictures, things, or created a small place of honor for the deceased, which I could visit any time I chose.
- ___ 34. I thought about what I received from the deceased and the legacy and mission to be fulfilled. I became involved in a cause or social action that was important to the deceased or myself.
- ___ 35. I created a legacy such as planted a tree, started a scholarship or charity in the deceased's name, started an internet blog, or launched new family or community practices.
- ___ 36. I allowed myself to talk to the deceased and allowed myself to listen. I wrote a letter to my loved one and asked for advice.
- ___ 37. I asked for forgiveness, shared joys and sorrows, and constructed a farewell message.
- ___ 38. I accepted that sadness was normal and learned how to be with my grief. I learned how to contain my grief to a time and place of my choosing. However, I understood that intense upsurges of grief may arise unexpectedly and without warning, and I developed coping strategies to handle such events.
- ___ 39. I used imagery techniques, shared stories and photos of my loved one, or purposefully used reminders such as music or special routines to recall positive memories. I cherished and hung onto specific, meaningful possessions (objects, pets, etc.). I actively reminisced, holding onto our relationship in my heart and mind.
- ___ 40. I reached out to help and support others who are grieving for their loved ones. Helping others is a way to reengage in life and combat loneliness and tendencies to withdraw and avoid social contacts.

Created safety and fostered self-empowerment

- ___ 41. I examined the thoughts that fuel my fears, avoidance, and the belief that I cannot or should not feel happy and that things would never get better.
- ___ 42. I took a breather and gave myself permission to rest knowing that grieving takes time and patience, with no quick fixes.
- ___ 43. I identified memories that trigger or overwhelm me and disengaged and/or established boundaries by limiting people, places, or things that cause me stress or overwhelm me so that I could address them one by one, in my own time. I learned to say "no" to unreasonable requests.

- ___ 44. I identified important activities, places, or things that I was avoiding due to fear of my grief reactions. I slowly reintroduced them or allowed myself to choose those I never wanted to encounter again.
- ___ 45. I began to think of myself as a “survivor,” if not a “thrifer” of my own story, rather than as a “victim.” I reminded myself of my strengths and of all the hard times that I have gotten through in the past.
- ___ 46. I wrote out reminders of how to cope and put them on my fridge, cell phone, or computer. I looked at them when I was struggling and reminded myself of ways to be resilient.
- ___ 47. I created a plan about how to cope with difficult times. I learned to anticipate and recognize potential “hot spots” of when things are most difficult. I rated each day on a 1 to 10 point scale on how well I was doing. I asked myself what I can do to make things better and increase my rating. I worked on increasing the number of good days compared to the number of bad days.
- ___ 48. I avoided thinking “This is just how it is,” realizing that I have choices no matter how hard life is. I came to recognize that emotional pain can be a way to stay connected with my loved one.
- ___ 49. When I was overwhelmed by negative memories of the past, I avoided “time-sliding” into the past. a) I “grounded” myself to the present by refocusing my attention on the environment around me, b) I changed my self-talk by telling myself “I am safe and that this will pass,” c) I controlled my bodily reactions by slowing down my breathing, and d) I oriented to people’s faces, voices or touch or called for help from a friend.

Moved toward a future outlook and a stronger sense of self

- ___ 50. I examined the thoughts and feelings that kept me from moving forward, such as “I am dishonoring the deceased by getting better,” or “I am leaving him/her behind,” or “Feeling happier means that he/she is no longer important to me,” or that “My love for him/her is fading.”
- ___ 51. I regained my sense of hope for the future. I worked to reestablish a sense of purpose, with meaningful short-, mid-, and long-term goals. I am creating a life worth living, taking control of my future.
- ___ 52. I worked on regaining my sense of self-identity, knowing that my life had changed, but that I am still *me*. I focus on what is most important. I developed new goals and action plans, consistent with what I value.
- ___ 53. I created purpose by keeping the memory of the deceased alive in others. I kept others aware of the circumstances of the death, so that some good could come from the loss. I transformed my grief and emotional pain into meaning-making activities that created something “good and helpful,” for example Mothers Against Drunk Driving and the Melissa Institute for Violence Prevention.
- ___ 54. I use my faith-based and religious and spiritual beliefs to comfort me and move on. People hold different beliefs, such as “My loved one can continue to influence the lives of others in the world,” or “My loved one is no longer suffering and is in a safe place,” or “We will be reunited in the future.”
- ___ 55. I examined the reasons why some of the activities that have been helpful to others in the grief process were not helpful for me, and what I can do to help myself further in the journey through grief.

Other coping activities or strategies I have used to cope with my loss

Please feel free to let us know if you have any comments about this list, so we can be of assistance to others like yourself. You can reach the authors by e-mail at dhmeich@aol.com or at Julie.Myers100@gmail.com

Helpful websites:

- [*www.griefnet.org*](http://www.griefnet.org)
- [*www.compassionatefriends.org*](http://www.compassionatefriends.org)
- [*www.dougy.org*](http://www.dougy.org)
- [*www.taps.org*](http://www.taps.org)
- [*www.missfoundation.org*](http://www.missfoundation.org)
- [*www.afsp.org/coping-with-suicide*](http://www.afsp.org/coping-with-suicide)
- [*www.opentohope.com*](http://www.opentohope.com)

NEED FOR ECOLOGICAL ASSESSMENT: OTHER LOSSES

Hobfoll and de Jong (2014) highlight the impact of various resource losses (material, psychological, social, spiritual), according to Conservation of Resources (COR) theory. Such losses are a major predictor of PTSD and the negative consequences of trauma. They underscore that the loss of “social and cultural capital” is exacerbated by ecological, contextual, and systemic factors such as:

1. the degree of the material resource loss and the length of time to receive assistance (meet basic needs, housing, insurance);
2. the ability to activate and renew their life course;
3. the ease and support during a reentry and reintegration processes;
4. the degree of safety and access to sustainable supportive attachment relationships;
5. the enactment of cultural and societal recuperative processes.

Any interventions need to assess and address these losses that can lead to prolonged and complicated grief. There is a need to address more than the cognitive and emotional responses at the time of the trauma and its aftermath. See Meichenbaum (2013) for a discussion of ways to bolster individual, familial and community-based ecological resilience.

EVIDENCE-BASED PRINCIPLES AND PRACTICES FOR CLIENTS WITH COMPLICATED GRIEF AND TRAUMATIC BEREAVEMENT

(Guidelines gleaned from Allen, 2013; Dyregov & Dyregov, 2002; Foa et al., 2007; Holland et al., 2014; Klass et al., 1996; Meichenbaum, 2013; Neimeyer et al., 2011; Jordan & Litz, 2014; Pearlman et al., 2014; Rando, 1993; Shear et al., 2006, 2011; Shear & Frank, 2006; Stroebe & Schut, 1999, 2010; Stroebe et al., 2013)

1. Grief work or working through the loss may involve loss-oriented coping efforts that include experiencing the pain associated with the loss, reminiscing about life as it had been, ruminating about the circumstances surrounding the death, pining about the future. Restorative-oriented coping efforts include the survivor's efforts to replenish psychological resources, mastering new skills and engaging in new activities and pursuits, making new social contacts and relationships, and creating a new identity. Each of these restorative efforts provide a respite from the loss and mourning process. Individuals oscillate between loss-oriented and restorative coping efforts.
2. Positive emotions can facilitate the healing process, adjustment and sustain hope. Such positive emotions as happiness, forgiveness, gratitude, a sense of awe, can nurture coping with loss. Positive emotions can bolster resilience. Such resilience-building behaviors can increase affect management capacities by increasing hippocampal volume, decrease amygdala activity and size, increase serotonin and endorphin production and activate the prefrontal cortex (McEwen & Gianaras, 2011; Southwick et al., 2011).
3. The process of mourning in many instances can be viewed as a search for meaning, or an attempt to make sense out of what happened. For some, their faith can act as a coping resource in the attempt to find meaning. The search for meaning may occur at many levels from the material ("**How did my loved one die?**"); from the relational ("**Who am I now that I am no longer a spouse?**"); from the spiritual or existential ("**Why did God allow this to happen?**"). Holland, Currier and Neimeyer (2014) report that from a bereavement standpoint, more adaptive meaning made of a loss has been shown to be associated with greater physical and mental health, over and above complicated grief symptoms, circumstances of the loss, and demographic factors.
4. The failure to find meaning or some form of consoling explanation of what happened can contribute to prolong and complicated grief, for those who are seeking meaning (Kesse et al., 2008; Pearlman et al., 2014). But for some survivors, the search for meaning is not a priority, need or realistic goal and they may not be preoccupied with issues of meaning, or sense making. Some individuals may not need to engage in a quest for meaning.
5. Grieving individuals do not go through a universal, nor normative pattern of mourning consisting of phases of denial, anger, bargaining, depression and ultimately acceptance, as initially proposed by Kubler-Ross (1969). There is considerable variability in the kinds of emotional experiences after loss. Psychotherapists who convey a so-called stage model of emotional reactions to death and dying may inadvertently undermine the healing process. (Doka & Tucci, 2011; Wortman & Boerner, 2001; Wortman and Silver, 1984).

6. There is a need for therapists to be culturally sensitive when treating clients with prolonged and complicated grief. See the following references for varied cultural mourning practices - - Rosenblatt & Wallace (2005) for African American grief practices; Houben (2012) for Hispanic traditions; and Klass and Chow (2011) for other cultural variations.
7. For many individuals using some form of spirituality and religious faith practices may be comforting to address bereavement issues. For instance, Bryant and Anderson (2014) report that in the aftermath of the Asian tsunami local monks were employed to pray with the survivors in order to encourage adaptive responses and help them cope with multiple losses. Consider the following examples of spiritually-based coping strategies. A mother of a child, who was killed in the Newton school shooting, had the remains of her son cremated and placed in an urn that she keeps in her bedroom. She has a discussion each morning with these remains. The parents of a firefighter who died at the September 11 terrorist attack, but whose body was never found, discovered that he had donated blood before the tragedy. They had a formal funeral and buried his vial of blood as a proper farewell to their son. Many other examples could be offered including the Hispanic annual ceremony of the “Day of the Dead”, Jewish mourners sitting Shiva, Irish wakes, New Orleans jazz send off, and the like.
8. Interactions in various forms between survivors and the deceased are normative and not a sign of some form of pathology or mental disorders (Klass et al., 1996; Klugman, 2006; Pearlman et al., 2014; Sanger, 2008-2009). In fact, encouraging bereaved persons to break the bonds with the deceased may actually be harmful. A continuing connection with the deceased can be beneficial. A symbolic bond can serve as a “safe haven” for the bereaved and have a significant presence in the survivor’s life.

TREATMENT GUIDELINES AND OUTCOME STUDIES

1. The scientific basis for counseling for grief is weak (Bonanno & Lilienfeld; Currier et al., 2008; Jordon & Neimeyer, 2003; Neimeyer & Currier, 2009; Pearlman et al., 2014; Zhang et al., 2006). Interventions implemented shortly after death has limited effects (small effect sizes). Intervention between 6 to 18 months after the loss has proven more effective than those provided sooner. Moreover, there is a need to customize interventions to the different phases of mourning, and where indicated address the need to help clients cope with both trauma, as well as grief.
2. There is increasing literature on effective modes of treatment with Complicated Grief and Traumatic Bereavement (Boelen et al., 2007; Currier et al., 2008; Horsley & Horsley, 2011; Pearlman et al., 2014; Rando, 1993; Rosner et al., 2011; Rynearson, 2011; Rynearson & Salloum, 2011; Shear & Gorsack, 2013; Shear et al., 2005, 2011 Wittouck et al., 2011). Although, in some studies up to 50% of individuals failed to respond to treatment and the dropout rate is 20% to 30%. Self-referred clients respond more favorably to treatment.
3. Some individuals may not be ready for active treatment because of the competing demands of the acute posttraumatic phase, or due to a number of more pressing demands due to dislocation, financial, legal and physical individual needs. Until these immediate, more pressing psychosocial needs are met, then psychotherapeutic interventions may be contra-indicated. (Hobfoll & De Jong, 2014).
4. Specialized forms of interventions have been developed for individuals who are trauma survivors (Barski-Carrow, 2010; De Leo et al., 2014); individuals who are grieving the suicide of a loved one (Jordan & Mcintosh, 2011); homicide (Armour, 2003; Barske et al., 2010); loss due to infertility interventions and pregnancy losses (Kersting et al., 2013; Shapiro, 2010), and for individuals who are trying to bolster their level of resilience (Meichenbaum, 2013).
5. A number of innovative forms of interventions have been employed with clients experiencing traumatic bereavement and prolonged and complicated grief. See Neimeyer (2012, 2016) for a summary. These include:

Treatment

Adaptive Disclosure

Behavioral Activation and Exercise

Expressive writing through bereavement
(diary work, journaling, letter writing)

References

Gray et al., 2012; Litz et al., 2016
Steenkamp et al., 2011

Acierno et al. 2012; Addis &
Martell, 2001; Dimidjian et al.,
Papa et al., 2013

Adams, 1999; Neimeyer et al.,
2009; Pennebaker, 1997;
Thompson & Neimeyer, 2014

Expressive arts such as visual arts, music, dance movement therapies, theatrical enactments and horticultural therapy	Neimeyer, 2012, 2016; and Thompson & Neimeyer, 2014
Physical therapy, massage	Doka, 2012
Acceptance therapy	Hayes et al., 1999
Mindfulness Training Yoga, Tai Chi, Compassion and Loving Kindness Meditation, Engaging in repetitive tasks (woodwork, knitting), and other self-soothing activities.	Gupta & Bonanno, 2001 Stang, 2014, 2016
Companioning the bereaved	Wolfert, 2006
Various Narrative forms of treatment	Litz et al., 2016; Meichenbaum, 2015; Neimeyer et al., 2010,2014; Neimeyer & Thompson, 2014; Rubin et al., 2012; Saakvitne et al., 2000; White & Epton, 1990; Young et al., 2000
Spiritually-based and religious activities (Use of prayer and connections with congregants)	Dyregov & Dyregov, 2008; Horsley & Horsley, 2011 Wortman & Park, 2000
Imaginal conversations, or “chair work” (Restorative retelling)	Allen, 2013; Klass et al., 1996; Klugman, 2006; McCallum & Bryant, 2013; Paivio & Greenberg, 1995; Rynearson & Salloum, 2011
Family Therapy	Kissane & Hooglie, 2011
Group Therapy	Piper et al., 2007
Public and private Bereavement Ritual and creation of a legacy, Memorialize, create an online memorial	Caroll & Landry, 2010; Lewis & Hoy, 2011
Self-help Workbooks	Rando, 2014; Saakvitne et al., 1996
Internet Therapies	Sofka et al., 2012; Wagner, 2013

6. Cognitive-behavior approaches have been used with children and youth who have experienced traumatic bereavement and complicated grief (Cohen et al., 2006; Currier et al., 2007; Murray et al., 2008, 2013). (See www.musc.tfcbt.edu for training).
7. Antidepressant medication has little impact on the symptoms and adjustment associated with complicated grief (Zhang et al., 2006), but in combination with CBT it has been found to have some benefits (Jordan and Litz, 2014; Simon, 2013).
8. Internet-based cognitive behavior therapy has been employed successfully with individuals experiencing prolonged and complicated grief (Dominick et al., 2009-2010; Gilbert & Horsley, 2011; Kersting et al., 2013; Litz et al., 2014; Wagner, 2006, 2007, 2013). Carroll and Landry (2010), Lynn and Roth (2012) and William and Merten (2009) have described the use of online social networking to help individuals grieve and mourn.
9. Finally, there is a need to provide “help to the helpers” in order to reduce secondary or vicarious trauma, compassion fatigue and burnout, and transform these reactions into “vicarious resilience.” A number of authors have provided specific strategies to address Vicarious Traumatization (Bober & Regehr, 2006; Dalenberg, 2000; Elwood et al., 2011; Hernandez et al., 2007; Jordan, 2010; Norcross & Guy, 2007; Pearlman et al., 2014; Pearlman & Saakvitne, 1995; Saakvitne et al., 1996; Stamm, 2005; Wilson & Thomas, 2004) (*Also see Meichenbaum, 2007 “Self-care for psychotherapists and caregivers-Individual social and organizational interventions” on www.melissainstitute.org - - under Author Index*).

CORE TASKS AND PROCESSES OF GRIEVING

Worden (2009) has described the core tasks of grieving as consisting of:

- a) acknowledging and accepting the reality of the loss, (balancing denial and reality);
- b) experiencing and processing the pain and grief, (externalizing emotional pain);
- c) adjusting to the world without the deceased, (adapting life assumptions and meanings);
- d) finding an enduring connection with the deceased in the midst of embarking on a new life, (continuing bonds with their deceased loved ones or other loss object).

These overlapping tasks are flexible, since they can be addressed in different orders depending on the client's needs and can be revisited and reworked over time.

Rando (1993, 2013, 2014) and Pearlman et al., (2014) have outlined the tasks of psychotherapy as the need for survivors to progress through six "R" processes:

1. Recognize the loss
2. React to the separation
3. Recollect and reexperience the deceased and the relationship
4. Relinquish the old attachments to the deceased and the old assumptive world
5. Readjust to move adaptively into the New World
6. Reinvest in life

Neimeyer (2002) has highlighted that the mourner needs to:

1. formulate a coherent narrative of the loss;
2. retain access to the bittersweet memories and emotions and cope with troubling feelings;
3. revise, rather than relinquish one's relationship with the deceased;
4. redefine one's life goals and experiment with new roles and relationships.

IMPLICATIONS FOR PSYCHOTHERAPY

An analysis of the grieving processes underscore the variety of core psychotherapy tasks that need to be incorporated in work with individuals who evidence Prolonged and Complicated Grief and Traumatic Bereavement. The Core Tasks include the need to:

1. Establish, maintain and monitor the psychotherapeutic alliance with the client and significant others;
2. Conduct initial and ongoing assessments and provide the client with feedback, using a Case Conceptualization Model of risk and protective factors. Be sure to assess for the client's "strengths" and for any evidence of resilience. Be sensitive to cultural, developmental gender issues, and the presence of any co-occurring disorders. Also, assess for the client's implicit theory or belief about the potential to change, as being a member of his/her ethnic or religious group. How should one cope with loss and negotiate the mourning process in a culturally-sensitive fashion?
3. Ensure the client's safety (possible suicidal tendencies), and address self-care needs and the presence of any therapy-interfering factors. Do so on an ongoing basis;
4. Employ motivational enhancement procedures and involve significant others, where indicated;
5. Conduct psychoeducation about grief. Validate and help normalize the client's grief. Use the **CLOCK** metaphor to help clients learn how feelings, thoughts and behaviors are interconnected, and how the client may inadvertently, unknowingly, and unwittingly contribute to his/her adjustment difficulties. Help the client appreciate the nature and influence of their narratives and "story-telling" style;
6. Engage the client in collaborative goal-setting that nurtures hope. Help the client create concrete plans with **SMART** goals (Specific, Measurable, Attainable, Relevant, Timely). Help clients identify new aspirations and activities;
7. Encourage the client to reengage in pleasurable and reconfirming activities with others (seek new companionship). For example, use Behavioral Activation (exercise) with others. Promote social reengagement. Use the Strategies for Coping with Grief Checklist;
8. Conduct emotion-regulation and behavioral skills training in order to nurture self-efficacy and as a way to enhance social supports (networking). Build in generalization guidelines and reinforce any resilience-engendering activities. Include self-attribution ("taking credit") training;
9. Use Cognitive Restructuring procedures in order to help clients identify and correct any inappropriate self-blaming, mental defeating and unhelpful thoughts, and accompanying behaviors;

10. Have clients engage in loss-focused restorative retelling and reconnecting exercises that may take various forms such as:
 - A. Intentional repeated retelling that facilitates the acceptance and emotional processing of the reality of the loss. Vividly narrate with eyes closed, the loss and listen to the tape of the narrative account;
 - B. Use the Gestalt empty-chair procedure, art expressive and journaling procedures, writing about positive and negative memories of the deceased;
 - C. Use graduated exposure exercises in order to help clients confront people, places and events that they have been avoiding. Use imaginal and behavioral exposure activities.
11. Engage in meaning-making activities, including the client's use of his/her faith and spirituality, where indicated. Incorporate the client's cultural group's ceremonial rituals, as part of the grieving process;
12. Address specific bereavement issues such as "Anniversary" events, evocative reminders of the loss, lingering legal and medical issues, and the like. Conduct relapse prevention and provide ongoing follow-up contacts.

EXAMPLES OF THE CORE TASKS OF PSYCHOTHERAPY

1. Establishing, Maintaining and Monitoring the Psychotherapeutic Alliance

The psychotherapist should act as a non-judgmental, “compassionate guide” who uses empathetic attunement, encouragement, supportive collaboration, understanding and respect for the client’s symptoms and struggles. For instance, validate the client’s feelings so the client feels heard and understood.

“I am so sorry this happened to your loved one.”

“I think you are brave for seeking help in the midst of your grief.”

“You seem connected to your experience and can still be able to talk about it.”

“I wonder if you have allowed yourself to express and share the full (fear, anger, guilt) you experience?”

“What do you fear will happen if you allow yourself to feel (your emotions, grief, anger, fears)?”

“I can see that you are learning to express your feelings without trying to escape from them.”

“There may be obstacles along your path, but we can address them in a way that frees you up.”

The therapist can also employ the language of possibilities, change and becoming. For example, bathe the social discourse with such evocative verbs as “notice, catch, handle, tolerate, confront, take control, choose” and a variety of “**RE**” verbs - - “regain, reclaim, redefine, reaffirm, reauthor, restore, reconcile, reengage, remind, reconnect.” See Meichenbaum’s Roadmap to resilience book (pp. 127-128 and 136-137 for a discussion of how psychotherapists can ask clients for examples for each “RE” activity, and moreover, what does this mean for the client’s journey? In this way, the psychotherapist can use a Constructive Narrative strength-based approach to help client’s develop a “coherent healing story.”

As Perlman (2016) highlights, the therapist needs to explore collaboratively with the client, empathize, educate and encourage.

2. Conducting Psychoeducation

Psychoeducation may take various forms that include the art of questioning; client feedback on assessment; descriptive sharing of information about specific topics such as the nature and rationale of treatment; the role of avoidance, specific bereavement issues; “myths” about the mourning process; self-monitoring procedures, coping skills and self-attributional training and relapse prevention procedures.

Psychoeducation is not a didactic process, but a highly collaborative, discovery-oriented Socratic questioning approach. Psychoeducation is ongoing and occurs throughout the course

of treatment. It is not as if one does psychoeducation and then one does treatment. The two processes are highly interweaved, as in the case of the Coping with Grief Checklist.

Examples of Psychoeducation

1. Provide a description of what therapy entails and the rationale for each aspect of treatment. Check for the client's understanding throughout.
2. Discuss the nature of grief and the mourning process. Highlight the following:
 - a) Grief is often accompanied with sadness, anxiety and uncertainty about the future, and feelings of yearning and longing;
 - b) There is no one right way to cope with the death of loved ones. There is no timetable. The grief process unfolds naturally over time.
 - c) There are no specific stages that individuals go through in the mourning process.
 - d) Most individuals are impacted by the death of loved ones, but they go onto evidence resilience or the ability to "bounce back". Some individuals need the assistance (help) of others. Joy and sorrow can co-exist.
 - e) Individuals can learn to contain their grief, like putting it in a "grief drawer" (see Harris, 2016). They can choose when and to whom to share their grief. They can put their emotional pain into words, or into some other forms of expression (painting, dance), and they can embed their loss into a life-time autobiographical history. Some individuals go back and look at photographs and cherish their memories and their legacy. They learn to support themselves in ways that no other person can. They come to live life fully, even in the wake of their losses.
 - f) Highlight that relationships are not really lost when a loved one dies, and who is not physically present, but the relationship is "changed."
 - g) Ask if the client can learn to leave a space in his or her life for their loved one's presence?"
3. Discuss the nature of avoidance and its impact. For instance:

"It is human nature for individuals to desire to avoid painful events, disturbing thoughts and distressing feelings about the loss and avoid any reminders that may trigger such emotional pain. But such avoidance actually prolongs the pain in the long run. Unfortunately, such avoidance usually does not work, and pain finds its way into our lives, one way or another" (with the therapist's assistance, have the client give examples).

Convey how treatment can help individuals, in a safe and supportive environment, develop the courage to express and share their emotional pain, without becoming overwhelmed, and even learn to view such “emotional pain” as a form of connection with the deceased (reframe the pain). Address the client’s attitude toward expressing feelings and discuss and train emotion-regulation skills on how to tolerate and manage negative emotions and “broaden and build” positive emotions (See Meichenbaum, 2013).

4. Use a **CLOCK** metaphor to help clients better appreciate the interconnections, and links between how they appraise events, experience primary and secondary emotions, have automatic thoughts and beliefs, and behave and the consequent reactions from others.
5. Psychoeducation can also be used to have the client reexamine “realistically”, the nature of his/her relationship with the deceased (both positive and any negative/disappointing aspects) of their relationships. The therapist can ask:

“What are some things you most appreciated in your relationship with your loved one (spouse, parent, friend, coworker)? What do you miss the most?”

“Permit me to ask, what do you wish could have been different in your relationship with X? Is there anything you did not appreciate or wish was different in your relationship with X?”

Such questioning reduces the likelihood of the survivor idealizing the past relationship and may help the client be open to developing new relationships. Also, conduct goal-setting that nurtures hopefulness and the language of becoming.

“What would you like to be doing if you were no longer grieving?” (See the Section on Questioning)

6. Psychoeducation should include a discussion of possible barriers/obstacles that may undermine the client's personal journey of mourning. Reinforce the client’s development of a “New Identity”, a “New Me.” The therapist can convey:

“Each person is unique. Each person’s situation is different. Each person negotiates the mourning process at his/her own pace and manner. What, if anything, might get in the way of your personal journey? How can you learn to anticipate these potential barriers and address them ahead of time?”

“How can you learn to reengage the most painful aspects of your account of loss (narrative), while also learning how to contain the emotional pain and come to terms with it?”

“Is there any way you can mobilize social supports?”

“Healing, in the case of grief, involves hearing. Is there someone in your life you can count on, or with whom you can share your story?”

3. **Restorative Retelling Procedures**

Restorative retelling procedures may take many different forms (Neimeyer, 2002, 2012). Each of these procedures are designed to help the survivor to process grief and establish a new relationship with the deceased, but maintain the deceased person’s presence in the life of the survivor. One prominent procedure is to use the Gestalt empty-chair technique (“chair work” Paivio & Greenberg, 1995). In Litz et al.’s (2016) Adaptive Disclosure therapeutic approach, they use the “empty chair” procedure as a vehicle to generate a conversation with the deceased person. It facilitates corrective information, especially when loss and guilt are entangled. They divide the imaginal dialogue into three sequential steps:

1. Preparing the client for the processing of the loss;
2. Engaging in this breakout procedure of loss in which the client has a conversation with the deceased person, in real time (right now);
3. Post breakout component discussion about the meaning and implications of the loss and the client’s experience of talking to his or her loss person.

As described by Litz et al. (2016, pp. 107-117), the following clinical guidelines should be followed. (A similar approach has been used with clients who have experienced “moral injuries” (See Litz et al., 2016 pp. 117-139). When clients experience moral injuries, the empty chair procedure may employ a “moral mentor”, rather than a deceased person (Litz, 2004).

I. Preparing the client for the Breakout Imaginal Dialogue Procedure

The therapist should describe the “empty chair” procedure and address the client’s questions, concerns and possible sources of resistance. The therapist should offer a rationale for the need to emotionally process the nature of the loss. Discuss the impact of avoidance behaviors. The therapist can ask the client:

“By focusing on the impact of the death of X, you will have an opportunity to understand and begin to recover and heal and master your grief. This can create a positive ripple effect in your life. Does this make sense? Do you have any questions?”

“What do you imagine may be any concerns you may have in engaging in this empty-chair activity? Can we discuss these?”

II. Imaginal Dialogue with the Deceased

1. The client is asked to have a conversation with the deceased person, in real time right now, as if the deceased person was sitting in the empty chair.
2. The conversation with the deceased uses the first person present tense and the client is encouraged to tell the deceased anything he/she wants, highlighting how the loss is affecting him or her. The client should be encouraged to provide a real emotional confession of how the client feels (haunted, guilty, unhappy). The client may wish to close his/her eyes when conducting the empty chair activity. The therapist may use prompts, as suggested by Litz et al. 2016, p. 108).

“Now I want you to go back to the image of [person who died]. This time, I want you to have an actual conversation with X. What would you like to tell him/her, here, now?”

“I know he/she is gone, but take this chance to talk to him/her and make it real.”

If the client gets stuck, the therapist should guide him/her by suggesting:

“Why don’t you start with what you remember from when he or she was alive? Why don’t you talk a bit about how much you miss him/her; how sorry you are and why?”

After a period of time, the therapist can ask the client to tell the deceased person what has changed behaviorally in him/her since the loss. As suggested by Litz et al. (2016, p.108).

“Tell him/her what changed for you after his/her death, and tell him/her how his/her death has affected you. Tell him/her how his/her death has changed your views of yourself, others, and the world.”

“Tell him/her how stuck you are, and be sure to describe any struggles you are now having.”

To this imaginal dialogue, the client can be encouraged to share what efforts he/she has taken to honor the memory of the deceased and what coping activities he/she has taken. To facilitate level of resilience, Litz et al. (2016) propose that the therapist ask the client to share what the dead person would say to him/her right now, after hearing all of this.

“What is she/he telling you now, after hearing all you have said?”

“What advice would he/she have for you?”

If the client has difficulty coming up with positive forgiveness-type statements, the therapist can offer suggestions:

Does he/she want :

“You to carry on?”

“What is best for you?”

“You to live the fullest life possible?”

“You to claim your life and live it fully for both of you?”

The imaginal dialogue may be repeated during multiple sessions in order to help the client shift his/her perspective and contribute to benefit-finding, meaning-making narratives that nurture healing. This form of restorative retelling can contribute to the reconstructing, rather than to severing one’s relationship with the deceased.

III. Post-breakout Component

The therapist starts this phase by asking the client to open his eyes and return to the here and now and then to discuss his/her experience of what just happened.

“What was that like for you?”

“What are you going to take from this session to think about throughout this week?”

“What really stood out for you?”

The therapist can also provide normalizing and reassuring comments, and encourage the use of coping behaviors should the client become emotionally upset. Litz et al. (2016, p.117) offer the following examples of possible therapist’s comments:

“I know this was difficult, and more than likely you will continue to think about it from time to time throughout this week. This is normal.”

“I often find that as clients start to look at difficult experiences, they sometimes have more unwanted thoughts about the experience. This usually goes away with time.”

See work by Pearlman, Rando, Shear for additional examples of ways to conduct Restorative Retelling Procedures.

Restorative retelling and empty-chair interventions provide individuals with opportunities to reconstruct and reframe the “stories” they tell themselves and others. Making meaning through the construction of stories and the use of metaphorical language contributes to the healing process (Meichenbaum, 2013; Neimeyer et al., 2010).

4. Exposure-based and Supplemental Interventions

In order to address the lingering impact of trauma and to confront avoidance behaviors that undermine recovery, various forms of imaginal and in vivo exposure-based interventions have been developed. Foa et al., (2007), Pearlman et al. (2014), and Steenkamp et al., (2011) provide specific treatment guidelines on how to conduct such exposure-based interventions so clients learn to purposefully tolerate and manage their fears and overcome any avoidant activities. In the case of imaginal exposure, clients are asked to tell and retell their “story” in the first person using the present tense and to listen to the tape recordings of these sessions as “homework”. The in vivo exposure activities are arranged along a gradual hierarchy of increasing demanding challenges. Such exposure exercises should be conducted for at least 45 minutes, three times a week to the point where the client can learn to tolerate his/her fears. The exposure activities may be learning to use coping skills such as breathing retraining and cognitive restructuring.

Jordan and Litz (2014) raise questions about the use of imaginal exposure therapies of having clients repeatedly retell (relive) memories of the moment of death, or related scenes. Such exposure-based interventions follow from trauma-focused treatment approaches that embrace a conditioning model that targets fear-based memories. They note that PCG is not characterized by such fearful memories and

“therapeutic rationale for repeated and sustained reliving of the traumatic moment is unclear. Moreover, there is no evidence that ‘working through’ a loss by sustained focus on it is necessary for healing for all individuals” (Jordan & Litz, 2014, p. 186).

Restorative retelling and exposure-based interventions may be supplemented by cognitive restructuring procedures that address the client’s Automatic Thoughts and beliefs (shattered “Assumptive World”). Another procedure is the use of Activity Scheduling that provides a means to address the client’s depression, inactivity and withdrawal by means of physical exercise and related engaging social activities (exercise with others).

The therapist should encourage the client to reengage in pleasurable activities, reattach with others, and pursue various wellness activities. As suggested by Litz et al. (2016, p.114), the therapist can ask:

“What type of pleasurable or healthy activities are you keeping yourself from doing since the death/loss of X?”

“Of those who care about you in your life, who are you not spending quality time with?”

“Are there new challenges you might attempt or activities you might devote specifically to the memory of X? Are there life experiences that you might plan to honor X?”

“Are there ways to memorialize (remember and honor) X?”

The therapist can use the Coping with Grief Checklist (see pages 21 to 25) as a way to review possible coping activities. In a collaborative manner, the therapist should elicit specific client commitments and discuss possible barriers that may interfere with the client implementing specific “homework” activities between sessions.

“What do you think would be useful for you to do before our next session?”

“What would you be willing to try to work on for next week?”

“What kind of practice assignment seems doable in the next week?”

Neimeyer (2012) has proposed another cognitive restructuring activity that asks clients to share “stories” of their relationships with the deceased as a way to reaffirm and reorganize their attachment with their loved one. He proposes the use of the following set of questions as a way to initiate such accounts:

Could you introduce me to _____ ?

What did knowing _____ mean to you?

Are there particular times, places, or ways in which you recall _____ importance to you?

What kind of things did _____ teach you about life, and about how you could manage the challenges you now face?

What might _____ say he/she appreciated most about you?

What strengths did _____ see in you?

In what ways might you strive to grow closer to _____ across time, rather than more distant?

What difference might it make to keep _____ stories and memories alive?

What has _____ given you that has had enduring value?

What do you want _____ to know about you and your relationship?

Can you describe the lasting impact, of _____ on your life?

Litz et al. (2016, pp.115-116) have offered the following exercises as a way to help clients express their grief and develop possible coping strategies. They ask the client to:

“Think or write about the following:

- ***How has losing _____ affected me?***
- ***How would _____ say I impacted him/her?***
- ***How did _____ impact me? How have I grown as a person because of _____?***
- ***How can I honor _____ now and move forward in my life?***
- ***What are some of the positive memories I have of _____?***

The therapist may ask the client to “write a goodbye letter to _____. Include how the loss has changed you; what you will miss most about the person lost; how do you want to remember him/her; and how will you continue to honor him/her?”

The average length of this comprehensive treatment program for clients with Complicated Grief and Traumatic Bereavement is 19 sessions, as described by Pearlman et al., (2014) (See www.guilford.com/pearlman-materials for a collection of client worksheets). Also see Harris (2011) and Jeffreys (2011) for examples of additional supportive activities.

5. Addressing Bereavement Specific Issues

Bereavement-specific issues focus on reawakened intense waves of grief when one least expects it. Rando (1993) have termed these acute grief responses to varied triggers that underscore the absence of the deceased, as Subsequent Temporary Upsurge of Grief (STUG) reactions. These triggers, may occur in social settings, at cyclical times like anniversaries, holidays or in response to particular occasions such as weddings, graduations. The **STUG** reactions, or powerful unexpected waves of grief that trigger a crisis of memory and undermine adaptive functioning, can lead to feelings of losing control, embarrassment, and result in withdrawal and avoidance that reinforces a loss grief cycle.

Psychotherapists need to “validate and normalize” such **STUG** reactions as part of the mourning process. Such emotional pain can be viewed as one way of staying connected to the deceased. In a collaborative fashion, the therapist should help clients anticipate and prepare (have coping strategies in place) in order to handle such episodes or “rough patches”. Role plays and exposure activities can be employed to address **STUG** reactions. There is also a therapeutic need to address any accompanying self-critical automatic thoughts. The therapist can use the **CLOCK** analysis to help clients cope with **STUG** reactions, as well as conduct relapse prevention stress inoculation interventions (Meichenbaum, 2013).

6. Self –attribution training or helping clients “take credit” for changes

A key aspect of relapse prevention interventions is to help clients develop coping skills for bereavement-specific upsurges (“rough patches”) and to ensure that clients monitor their progress and attribute any positive changes to their own personal coping efforts. Psychotherapists can facilitate this process by using Client Checklists, engage in discussions of how clients have handled tough situations, and ways they can anticipate and address future potential challenges (anniversary dates, reminders, and the like). The therapist can “go public with the data” of reported or observed changes. For instance, *“It sounds like you have learned to:*

“Draw upon your resources.”

“Identify warning signs.”

“Tolerate strong feelings.”

“Move back and forth (oscillate) between your loved one and beginning your life again”

“Reach out for help.”

“Do so many of the things your spouse used to do.”

“Trust your judgment.”

“Express difficult feelings.”

“Catch and challenge your negative automatic thoughts.”

“View your emotional pain as a way of remaining in touch with your loved one.”

“That in spite of your fears, you were able to be courageous and not withdraw.”

The therapist should provide specific examples and have the client offer specific examples of each of these changes. This should be followed up with queries of “How” the client was able to accomplish each activity?

There is also value in discussing what the client has gotten out of treatment and what, if any, “unfinished business”, and issues remain to be addressed. Discuss the possibility of seeking future help if the need arises. ***“What was the client like when he/she entered treatment and what has changed?”*** ***“How has the client’s ‘story’ changed and the accompanying new skills and new identity developed?”***

Two additional ways to bolster the client’s level of self-efficacy and resilience is for the therapist to:

- 1) share examples of coping observations that other clients have offered;
- 2) ask the client for examples of “**RE**” based activities that he/she may have engaged in.

I. The therapist can say to the client:

“We have asked other clients, like yourself, to share with us some of the things they have learned over the course of treatment. With their permission, they have offered the following examples and given permission to share them with other clients, like yourself:

**LIST OF COPING OBSERVATIONS OFFERED BY INDIVIDUALS WHO HAVE
LOST LOVED ONES**

“I now recognize that pain is inevitable, but suffering is optional.”

“I unburdened myself by disclosing/sharing my loss with people I can trust and respect.”

“I benefitted from the feedback and advice I received.”

“I reached a turning point, when I began to let go of some of my grief.”

“I am having more good days than bad days.”

“I am in a better place now.”

“I found a new normal, a footing in the world.”

“I have become more buoyant in dealing with the waves of grief.”

“I have learned to compromise with life.”

“I can engage in heart-mending activities.”

“I have been able to transform my pain into compassion for myself and for others.”

“I have learned to invite my emotional pain to tea.”

“I have hope for the future.”

“I cherish life more now. I don’t take life for granted.”

“I now value more of what I have, like my remaining children.”

“I give myself permission to close the lid on my loss and grief in order to turn my energy elsewhere, as needed.”

“I can use my spirituality. I have found God again.”

“I believe they are watching over me.”

“They are in a better place.”

“I can create a space for my loved one to fill in the future.”

“I have chosen not to wrench out of my life, my _____ (loved one), but instead to include him/her to be with me and continue to share my challenges, alongside me.”

“I have a sense of peace.”

“I mastered my grief.”

II. A second intervention strategy that psychotherapists can use is to ask the client to provide examples of behavioral changes they have made, using “RE” verbs. The therapist can say:

“It seems to me, and correct me if I am wrong, or if I am misreading the situation, that you are [Insert one of the following “RE” observations]?... Can you give me an example when, where and how you were able to do that?”

With regard to the Past

Retell your story of loss
Reframe what happened (engage in benefit finding)
Reconcile the past
Revisit your positive memories with _____

With regard to the Present

Regulate your emotions
Reengage emotionally
Relax and release your tension
Regain a sense of control
Rewire your brain
Relinquish old habits
Reestablish your routine
Revisit the places you have worked hard to avoid
Readjust to the loss
Retell your “story” when and to whom you choose
Reevaluate how you think
Restory your life
Redefine yourself
Reclaim your life
Reengage life
Reconnect with others
Rebuild and reestablish connections with others in your life
Repair your relationships
React to the separation in a positive way
Reengage in pleasurable activities

With regard to the Future

Reset your priorities and goals

Rewrite your list of Reasons for Living

Rewrite your “story” of the future

Recognize both the losses and gains in your life and look to the future with hope

Reinvent a “new identity”. Who am I, now? Who do I want to be in the future?

Restore your dignity

Reconstruct a world of meaning

Reaffirm your life

Restore your resilience

Keep in mind that the critical feature of this intervention is to use discovery-oriented processes to help clients generate examples of each “RE” activity that is discussed. There is a need for the client to take “ownership” for behavioral changes that they have brought about.

There is a need for therapeutic aftercare contacts and booster sessions, where indicated.