THESIS

Evaluation of a Cognitive Behavioural Group Intervention for the Treatment of Complicated Grief

By:

Angela Pugh, B. Soc. Sc. CQSW, Dip. Psychotherapy (Gestalt)

Supervisors: Dr. Linda Finnegan.
Dr. Barbara Dooley

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Overview of thesis.

Separation and death are inescapable facts of life, experienced by all. Grief refers to the response of a bereaved person to the loss of a significant attachment figure, and will generally manifest itself in a variety of forms of distress which can be severe, debilitating and persistent. Much has been written about the effects of bereavement upon individuals, and upon the duration, stages or tasks which are assumed to define the normal course of grief, and to culminate ultimately in recovery from this phenomenon (Bowlby, 1998; Parkes, 1972; Rando,1993; Stroebe & Stroebe,1993; Worden, 1991). However, despite it's almost universal and normative nature, grief like all human experience, is essentially idiosyncratic in nature. Indeed, whilst the majority of bereaved individuals appear to recover after a period of distress and disorganisation, bereavement for some can be associated with increased risk for a variety of psychological and somatic complaints and illnesses, in addition to a personal experience of intense and enduring suffering which can effect capacity to function in all aspects of life. These individuals are described as suffering from complicated or pathological grief.

Despite the frequency with which symptoms of depression and anxiety have been found to coexist in this population, and the intensity of suffering associated with grief response, little attention has been given to date to the possibility of applying cognitive therapy to this non-traditional area. Indeed until relatively recently, the role of emotion in the conceptualisation of grief response has held primacy. Despite this, there is an increasing recognition that for grief to be resolved, some reconstruction of personal meaning must take place. A cognitive formulation of loss could facilitate such a reconstruction. The central problem of complicated grief is the failure to adapt to the loss experienced and a cognitive perspective would focus upon those appraisals of loss which might lead to the development of strategies which compound pain and block effective processing. This rationale has provided the basis for the development of a cognitive behavioural treatment program to address the problems of complicated grief.

This thesis will provide an overview of the principal theoretical approaches to the understanding of grief. It will review empirical applications of theory to treatment, and strategies recommended in the cognitive treatment of grief.

It will highlight those areas identified as influential in successful adaptation to bereavement, and will present a cognitive formulation of complicated grief which has been developed in the light of findings from this review.

The Methodology Section will outline selection procedure, study design, instruments and procedures used in the study. A description of treatment modules will be contained in the appendix section.

Finally, results of a controlled psychotherapeutic intervention will be presented, and key findings emerging from the study will be discussed in the light of the literature review and the research questions posed. Limitations of the study, and suggestions for future research will be discussed, as well as implications for clinical practice.

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This thesis marks the fulfilment of an ambition I have entertained for a number of years. The journey has at times been challenging and there have been moments when I have questioned the wisdom of my endeavours in the light of the time, energy and commitment involved in completing the undertaking.
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For Julian

TABLE OF CONTENTS

Appendices

Index of Figures

Index of Tables

On Loss

Do not go gentle into that good night
Old age should burn and rave at close of day
Rage, Rage against the dying of the light.

by Dylan Thomas

Invocation

Pain can turn the hearts cradle
to stone and there is in each life
a time that cuts so deep
that the soul would unmesh,
lose itself and its wish to gather
glimpses of the face
that calls like an icon,
that the earth breathing in the heart
would harden like winter ground,
choke on its own growth,
that the distance to the outside is too far,
voices become echoes that struggle to return,
the pulse slows to a thud .

by John O'Donoghue

Abstract

In recent years, there has been a shift away from theoretical conceptualisations of grief response to an increasing emphasis upon the central place of meaning reconstruction in the process of adaptation to significant loss. This exploratory study evaluated a group cognitive behaviour therapy intervention which treated twelve individuals diagnosed with complicated grief. Participants were randomly assigned to a treatment and a control group. In phase one of the study, the treatment group received the intervention. In phase two, the control group were treated, using the same intervention model. Positive outcomes were reported for both groups in terms of a significant reduction in symptoms of depression. In addition, a positive outcome was observed for one treatment group on a measure of complicated grief, indicating a significant effect for the intervention. Similar gains were not reported for the second treatment group and this failure has been linked to the higher anxiety levels measured in this group. Given the failure to achieve a significant reduction in complicated grief symptoms at time of replication, the results of this exploratory study are inconclusive. Findings suggest that those whose grief response was loss focussed showed greater effect for treatment than those for whom loss was appraised as threatening. These findings have implications in terms of formulation and treatment planning. Success in reducing depression affirms the value of a cognitive approach for the treatment of bereavement-related depression.

Key words: complicated grief: cognitive: meaning: group: anxiety:

Chapter 1

Theoretical Review of Psychological Literature on Grief

1.1 Introduction

Separation and loss, the breaking of bonds, death and the pain of grief are all acknowledged as normal, universal and inextricable aspects of ruptured human experience. Indeed, death can justifiably be described as the greatest of all losses, a loss which cannot be recovered.

Grief is the name given to the reaction to loss. Even within the animal kingdom, the capacity to react with distress to the breaking of attachment bonds is well documented. The greylag goose pines and searches for its dead mate, the maternally deprived monkey clings to it's wire substitute, the hospitalised or institutionalised child, separated from it's attachment source, becomes apathetic, withdrawn and dejected, the bereaved spouse gives up on living and is dead within a short period of time (Harlow, 1959; Lorenz, 1965; Spitz, 1946; Stroebe et al, 1981-2).

There are many questions raised by an exploration of the complex human phenomenon of grief. What is grief? How does it manifest? What factors influence it? What are the effects of grief and how long should it last? When does grief cease to be a normal reaction? Why does grief persist? When does grief require treatment? These are some of the questions which this thesis will attempt to address in the light of a review of the wealth of literature which exists on the topic. The purpose of the review will be to elucidate those factors which could inform a psychotherapeutic treatment intervention targeting complicated grief.

1.2 Core Definitions

To bereave is, according to definition, 'to deprive ruthlessly or by force'.

Grief is a synonym for 'mourning, sorrow or loss' and is a complex evolving process which manifests in symptoms of distress and behavioural reactions which can be severe, debilitating and persistent. These responses are reflective of the struggle to integrate the loss experience through a process of intense and oftentimes enduring

suffering which can diminish an individual's capacity to function effectively in all aspects of life.

Mourning refers to the manner in which grief is expressed and is influenced by societal and individualistic factors to form a multitudinous constellation of signs and symptoms, loosely termed as grief (Bowen1976; Worden,1991).

1.3 Normal Grief Response

There is little disagreement concerning the types of responses exhibited by some, though not all bereaved individuals. Lindemann's study of bereaved individuals, following the famous 'Coconut Grove' fire in Boston, provided the first research description into the pattern of what was described as 'normal' grief response (Lindemann, 1944). Since then, there have been a number of relatively similar descriptions of what are regarded as typical manifestations of the normal response to loss. (Bowlby, 1998; Parkes, 1972; Schucter & Zisook, 1993).

Worden's (1991) classification provides a useful synopsis of grief response .

Table 1 Grief Responses

Feelings	Sadness, anger, guilt, self reproach, anxiety, loneliness, fatigue, helplessness, yearning, numbness, shock, relief and emancipation
Physical sensations	Hollowness, tightness in chest or throat, breathlessness, depersonalisation, lack of energy, over-sensitivity to noise, dry mouth, and muscular weakness
Cognitions:	Preoccupation, sense of presence, hallucinations, disbelief, and a variety of negative cognitions relating to the death experience
Behaviours	Sleep and appetite disturbance, absentmindedness, withdrawal, dreaming of the deceased, searching and calling out, avoidance behaviours, crying, visiting places that remind the survivor of the deceased

Regarding the duration or course of normal grief, there is growing realisation that traditional assumptions and expectations may need to be revised in the light of research findings (Johnson & Rosenblatt, 1981). Indeed, Bowlby (1998) concludes that several responses previously regarded as pathological, are in fact commonly found in the responses of mentally healthy adults. It appears then that there are few definitive rules regarding what constitutes adaptive as opposed to maladaptive styles of coping (Bowlby, 1982, 1998; Parkes, 1972, 1975,1985 ; Parkes & Weiss,1983; Rando,1984; Stroebe & Stroebe,1993; Worden, 1991). Early investigators such as Engel (1961) and Lindemann(1944) suggested that grief subsided within a period of weeks to months. However, Stroebe et al (1994: 198) have noted " …that a few bereaved people continue to suffer intensely for much longer than the majority."

There is general agreement that whilst painful, grief is also crucial, necessary and for many, unavoidable for successful adaptation to loss. Worden (1991) suggests that for resolution to occur, the bereaved must be able to think and feel without intense pain. Wortman and Silver (1987,1989) report however that contrary to existing expectations, a substantial number of bereaved do not appear to suffer an experience of intense distress in the wake of major loss. Indeed, their findings are that initial response appears highly predictive of long-term adjustment. Furthermore, they argue that there is no relationship between resolution and the process of working through loss, nor between positive adaptation and level of depression. They have found that those who are depressed immediately following loss are likely to be depressed two years later. Similar findings are reported by Stroebe et al(1993). Zisook and Shuchter (1986), in discussing adjustment to bereavement, argue that "…there is no prescription for how to grieve properly … and no research-validated guideposts for what is normal versus deviant mourning… We are just beginning to realise the full range of what may be considered normal" (p. 288).

1.4 The Impact of Social context and the Role of Social Support

Rosenblatt (1993) emphasises the role of cultural expectations both in prescribing a definition of what is normal, acceptable and expected in terms of grief expression, and in influencing the quality of ritualised responses deemed appropriate as marks of closure. "Culture is such a crucial part of the context of bereavement that it is often impossible to separate an individuals grief from culturally required mourning."(p.104) Neimeyer (1997a, 2000) maintains that relationships have shared meanings and occur within an interactive or interpersonal context. He suggests that it is within this shared social context that identity is reconstructed following loss. This context can support, ignore or oppose an individual's experience of loss and need to change.

The extent to which an individual defines self in terms of role/relationship to the deceased seems likely therefore to be influential in determining loss response (Talbot, 1996-1997). Gender role socialisation has been found to influence the manner in which males and females experience and express grief, with existent norms supporting emotional expression in women whilst discouraging disclosure for men (Eisler et al, 1988; Martin & Doka, 2000; Rando1984; Sanders,1993; Schut et al, 1997; Stroebe et al, 2001). Thus it seems that perceptions, attributions and behaviours of individuals are both influenced by and interactive with the social context within which loss occurs (Miller& Omarzu, 1998).

Stroebe and Stroebe (1993) argue that bereavement outcome will be influenced by the deficit experienced by a surviving spouse in the various support functions previously exercised by the deceased. Such deficit will be a major determinant of the stress experience in bereavement. In buffering this, the role of social support has been shown to be of major influence in determining bereavement outcome, with the pervasive problem of loneliness identified as the most common reported difficulty of older bereaved spouses (Lund et al, 1993; Parkes, 1973; Raphael, 1983; Stilianos & Vachon, 1993). However, it has also been found that provision of too much social support can impede the development of functional coping skills, leading to the development of dependence and the social reinforcement of the mourning role beyond what might be regarded as adaptive (Clayton et al, 1973; Gauthier &Marshall, 1977; Kahn,1975; Parkes, 1972; Worden, 1991).

1.5 Personality Determinants

It is widely assumed that pre-loss personality characteristics will have implications for the manner in which loss is experienced subjectively and responded to in grief.
A factor highlighted as likely to influence grief resolution is that of emotional stability. In the Tubingen (1991) study cited in Stroebe & Stroebe(1993), individuals assessed as more emotionally stable, were shown to react with lower levels of somatic and depressive symptoms. However, findings suggest that whilst emotional stability may effect vulnerability to grief, long term adjustment to loss is not influenced by this characteristic. The theory of learned helplessness, which delineates the concept of locus of control, might suggest that those who perceive an outcome to be dependent upon their own behaviour or personal attributes, might also have greater difficulty in adjusting to the uncontrollable fact of death of a loved one than those who lack such a belief (Abramson et al, 1978). However, Stroebe and Stroebe (1993) have found no evidence to support the view that control beliefs act as a buffer for individuals against the impact of loss or exert a differential impact upon the depression of the bereaved.

A factor widely recognised as a mediator of bereavement response is the developmental history of the bereaved (Parkes, 1972). Ainsworth and Eichberg (1991) have delineated the complex manner in w hich attachment themes which have developed in response to early patterns of attachment, emerge and influence response to loss, whilst Grossman and Grossman (1991) have demonstrated the persistence of such themes over time. Fraley and Shaver (1999) argue that loss of an attachment figure may activate an anxiously primed attachment system or schema, leading to extreme anxiety or sorrow. Such an argument is in line with Young's (1999) identification of an abandonment schema, which has special relevance in the light of the permanence of the death experience.

Sanders et al (1989) have highlighted the increased risk of pathological bereavement outcome which can be associated with personalities characterised by feelings of insecurity, inadequacy or inferiority, whilst Parkes and Weiss(1983) describe the grief-prone personality as characterised by excessive clinging and pining, and also

maintain that the excessively angry or self-reproachful individual may be at risk of pathological reaction. There is certainly evidence to suggest that the more an individual's identity is threatened by loss, the greater the difficulty in processing the event. Indeed the more intertwined two lives become, the more difficult it may be to rebuild or find meaning following loss and the more likely it is that separation distress will occur (Archer, 1999; Neimeyer, 1998; Parkes & Weiss, 1983). Prigerson et al (1997) suggest that if a relationship has performed a stabilising or compensatory function, individuals with insecure attachment styles may experience a traumatic grief reaction, because bereavement may awaken an experience of abandonment, resulting in a reaction of intense separation anxiety and traumatic grief, even if the circumstances of the death were not traumatic.

1.6 Quality of Relationship with the Deceased

Qualities inherent to the relationship with the deceased, such as ambivalence or a legacy of a negative or conflicted relationship, have been found to impact upon grief response. Where present, the bereaved is faced with the challenge of resolving unfinished business in the absence of the deceased, often leading to feelings of anger, guilt, sadness and frustration (Rando, 1984; Raphael 1978,1983; Parkes & Weiss, 1983). An imbalanced perception of normal imperfections inherent to relationships can also give rise to an exaggerated sense of failure or responsibility. Such cognitive distortion, which is a common feature of depressive thinking, is also associated with bereavement response both in the early stages of mourning, and subsequently in those who exhibit a more pathological form of mourning (Beck, 1976; Rando, 1984). Piper et al (2001) challenge the traditionally held view that ambivalent relationships are automatically linked to complicated grief reactions. They report findings of an inverse relationship between severity of grief symptoms and ambivalence in a group of psychiatric outpatients. In contrast, degree of affiliation and dependence in positive relationships was linked to severity of grief symptoms. In effect, the better the quality of relationship, the greater the loss experienced by the death.

1.7 Mode of Death

Finally, response to loss has been linked to circumstances or characteristics of the death, i.e. whether, sudden, untimely, preventable, traumatic or following a lengthy illness, and also to the nature and effects of that illness. Schut et al (cited in Middleton et al, 1993), have reported findings that perceptions that death was unanticipated or that there was insufficient time to make farewells were correlated with higher risk for development of PTSD. In short, a myriad of factors can interact to determine the nature of the idiosyncratic response to loss (Bowlby,1998; Parkes & Weiss,1983: Rando,1986; Raphael,1997,1983,1986; Rynearson,1987; Sanders,1982-83; Worden, 1991).

1.8 Effects of Grief

Bereavement has been shown to effect both physical and psychological health, with an associated increased risk for a variety of physical and psychosomatic conditions, for increased risk of depression and even increased risk of death (Clayton et al,1972; Osterweis et al, 1984; Stroebe et al, 1993).

A relationship appears to exist between bereavement, susceptibility to disease and immune system activity (Bartrop et al, 1977; Irwin et al, 1987b; Schleifer et al, 1983, all cited in Irwin & Pike, 1993), with a statistical association between bereavement and death from heart disease, which seems to lend some credibility to the 'broken heart phenomenon' (Parkes, 1985).

Depression is well recognised as a fundamental aspect of normal grief, indeed, the price of developing relationships which are close and meaningful (Clayton, 1990; Zisook, 2001). Although these reactions may be severe enough to warrant treatment, they are generally considered to be normal and to abate over time without intervention. Nevertheless between 2 months and 2 years after bereavement, the prevalence of major depressive episodes has been shown to be greater in bereaved individuals than in demographically matched non- bereaved populations (Futterman et al, 1990).

In addition to major depressions, bereavement is associated with a higher risk for panic disorders, generalised anxiety disorders, posttraumatic stress disorders, increased alcohol use and abuse and suicidal ideation (Jacobs et al, 2000; Prigerson et al, 1997b). Indeed, rates of distress, use of medication, physical illness health measures (measured by number of visits to doctors and days sick), and even mortality, are generally reported to be higher for those who are widowed than for comparable still-married individuals. In addition, it has been found that men suffer more serious consequences of partner loss than do women, a fact linked to gender differences in the manner in which grief is expressed (Stroebe et al, 2001).

1.9 Towards a Definition of Complicated or Traumatic Grief

Where does normality end and pathology begin? Despite some developing consensus in the area, there are to date no universally agreed upon definitions derived from scientific studies, delineating the difference between normal and pathological grief. Whilst it is generally accepted that grief tends to diminish over time, a marked variability of response is recognised, with grief for some manifesting as chronic, painful and debilitating (Shear et al, 2002; Wortman et al, 1993). Parkes (1975a) identified three principal forms of pathological grief: chronic grief, which denotes an indefinite prolongation of grief with exaggerated symptoms; inhibited or absent grief in which normal manifestations are absent; and delayed grief in which the pain of grief is avoided, at least temporarily. Similar definitions identify pathology as the intensification, inhibition or prolongation of the normal phenomena of grief (Lieberman & Jacobs, 1987; Middleton et al, 1993). It can however be argued that neither time nor duration reliably measure the significance of what is by definition a personally defined experience (Hoagland, 1984). If personally defined, then grief could arguably be experienced to any degree of intensity or for any duration considered necessary in the light of the personal meaning attributed to the loss. Robinson and Fleming (1989), in emphasising the importance of personal meaning, suggest that what differentiates complicated grief from normal grief is the presence of cognitive distortion. They maintain that these distortions are rarely present in normal grief response.

How can pathological grief reactions be clearly differentiated in the absence of a scientific measure? Zisook and Lyons (1988), in arguing that some grief can be tenacious, persistent and chronic, suggest that a self rating of adjustment might be used as an indicator of abnormal response. Horowitz et al (1997), who have found a relationship between complicated grief and a previous history of major depression, propose a 7- item criteria set to enable identification of this phenomenon. These criteria include the presence of intrusive thoughts and memories, strong pangs of emotion relating to the loss, excessive yearnings for the deceased, excessive feelings of loneliness or emptiness, excessive avoidance of people, places or things evoking memories of the deceased, sleep disturbance, and loss of interest.

More recently, a panel of American experts have proposed a new nosologic entity named 'Traumatic grief.' It is suggested that this term, whilst interchangeable with the term 'Complicated Grief', nevertheless captures more accurately the essential character and dimensions of this syndrome (Prigerson et al, 1999; Jacobs et al, 2000). The term 'Traumatic Grief' is essentially phenomenological in nature, with an emphasis upon the personal meaning of death rather than the aetiology of the condition. The new diagnostic criteria proposed, identify this as a disorder arising out of personal vulnerability in attachment style, or as a consequence of the traumatic circumstances of a death. Traumatic grief comprises a unidimensional cluster of symptoms, consisting of the constructs of separation anxiety and traumatic distress. Symptoms include yearning, searching, and excessive loneliness for the deceased along with intrusive thoughts about the deceased, feelings of numbness and disbelief, feelings of being stunned or dazed, and a fragmented sense of security and trust. The group maintain that bereavement itself does not put individuals at risk of adverse health outcomes, arguing instead that it is the psychological sequaleae of bereavement that create vulnerability to illness. They maintain that given the strong association with psychiatric and physical morbidity, periods of distress lasting several months and meeting the criteria for major depressive episode or traumatic grief warrant clinical intervention (Frank et al, 1997; Jacobs et al, 2000). It is suggested that treatment should target separation anxiety as an entity separate and distinct from the symptom clusters of depression and anxiety (Prigerson et al, 1996).

This definition of grief is likened to existing descriptions of pathological grief and its criteria are similar to those proposed by Horowitz. For the purposes of this study, I

have adopted the criteria of complicated or traumatic grief as outlined by the Prigerson group and measured by the ICG (1995).

1.10 Summary

Literature has identified what are generally accepted normal responses to bereavement. There is a growing recognition however that grief response is idiosyncratic in nature and that a wide variability exists in terms of the duration and intensity with which symptoms can be experienced and expressed. Research demonstrates that bereavement can be associated with an experience of intense suffering which impacts negatively upon both the physical and psychological health of individuals. The manner in which loss is responded to has been linked to personality variables, the quality of relationship with the deceased, the circumstances of the death, and the availability of social support. Such factors are believed to determine whether the response to loss is normal and adaptive or whether it is pathological. Whilst there is as of yet no universally agreed upon criteria determining when grief response ceases to be normal, there is some developing consensus, and specific measures have been developed which attempt to isolate those features which differentiate complicated or traumatic grief from normal grief response.

Chapter 2
Psychological Theories and Models of Grief

2.1 Theories of Loss

A number of distinct theoretical perspectives on grief exist, all of which have given rise to the development of assumptions, expectations and prescriptions as to the origins, constituents, process and appropriate treatment of complicated grief. These include psychoanalytic/ psychodynamic theory, attachment theory/ stage theory, stress theory, narrative theory, personal construct theory and a number of theories broadly described as cognitive theories of grief.

2.1.1 Psychoanalytic Theory of Grief

In Freud's (1917/1957) seminal work on Mourning and Melancholia, he differentiated the features of normal mourning from those of depression or melancholia, likening the latter to a state of pathological grief which is associated with ambivalent attachment and with premorbid features of the bereaved. For Freud, what differentiated the sadness of the bereaved from depression, was the feature of negative self-regard and self-blame. He posited that the specific function of normal grief was to enable detachment of the survivor's memories and hopes from the dead, so as to enable reinvestment in a new relationship. Withdrawal of investment in the deceased involved time and a degree of cathectic or psychic energy, which once accomplished, could enable the completion of grieving and the freeing of the ego to reinvest in a new object. The modern psychoanalytic approach developed from this theory of grief sees the role of therapist as a temporary substitute for the deceased. Through the process of transference in the therapeutic relationship, the bereaved is enabled to resolve guilt and ambivalence so as to facilitate the process of recovery (Sanders 1989).

Since Freud's initial contribution to this subject, much has been learned about grief and the manner in which the individual responds to the breaking of primary bonds. The assumption that the root of melancholia lies in pathological mourning is now challenged, with the place of depressive symptomatology in normal, healthy grief response now accepted. The relationship between depression, low self esteem and

negative cognitions is now also recognised, whilst the role of ambivalence is identified as a feature of normal as well as pathological grief (Beck, 1976; Fennell, 1999; Horowitz et al, 1980).

2.1.2 Attachment theory and its influence on Stage Theory Development.

The view that the breaking of the bonds of attachment is likely to lead to distress is well supported in literature and consistent with the construction of grief as a natural and instinctual response. A key figure in the development of attachment theory and its application to an understanding of grief, Bowlby was greatly influenced by Freud**.** However, his definition of grief is broader and reflects a growing realisation that reaction to loss can endure and it's effects last. He describes normal grief as a phased accommodation process motivated by a desire to restore attachment after loss and including "all the psychological processes, conscious and unconscious, that are set in train by loss" (1998:18).

In his seminal work on the subject of separation, loss and attachment, he argues that the process of grief involves yearning for the lost person and an effort to re-establish the tie that has been broken. His conclusions are heavily influenced by the earlier findings of Robertson (1953), among others, which detail observations of young children separated from parents and institutionalised. He argues that loss in childhood and bereavement in adulthood are similar and that loss leads to the establishment of defensive processes which once set in motion are apt to stabilise and persist. He suggests that "defensive processes are a regular constituent of mourning at every age and what characterises pathology is not their occurrence but the forms they take and especially the degree to which they are reversible" (1998:21).

According to Bowlby, grief progresses through stages which resemble the processes observed in young children separated from their attachment figures. These stages include a brief phase in which the individual experiences shock or denial, a phase of searching and protest, which is seen as an attempt to undo the loss and a final phase in which the bereaved reacts to the loss by recognition of it's reality and by a reaction of sadness and withdrawal. What differentiates individuals with normal grief from those with complicated grief may be the possession of an internal representational model of

an available, responsive attachment figure and a model of self as lovable and valuable. This internal model can provide protection from the feelings of self reproach and abandonment so often found in those who grieve chronically. The separation of a child from it's attachment figure or an experience of insecure attachment may lay the seeds of psychological damage, thereby leading to a complicated grief reaction arising out of the absence of such an internal model.

The development of the stage model of grief has been prominent in bereavement literature, as has the idea of detachment from the deceased. There is a similarity between Freud's theory of withdrawal of libido and Bowlby's theory of phased accommodation to loss, in that for both, healing is represented by detachment from the deceased and reinvestment in new relationships. Lindemann (1994) also described the work of grief as "emancipation from the bondage to the deceased, readjustment to the environment in which the deceased is missing, and the formation of new relationships" (p.143). Understood this way, grief is a process that passes through stages, as an individual adjusts to loss through regaining balance in the face of a major stressor, and is thus ultimately restored to a state of equilibrium.
The transposition of the five stage model of adjustment to loss which was developed by Kubler Ross (1969) in her work with the dying, represents an alternative attempt to structure the process of mourning into a set of stages to be passed through if the individual is to be enabled to assimilate loss. Although this model was not intended as a description of the mourning process, it has been widely used. Its value has been in its description of reactions to unavoidable threat. Similar models by Canine (1990) and Parkes (1972) also define stages to the grief process along lines similar to the model of Bowlby.

Despite their influence, stage theories have met with increasing criticism (Neimeyer, 1997; Rando, 1984; Worden, 1991). Neimeyer (1997) argues that there is little empirical evidence to support theoretical assumptions of the existence of distinct psychological stages to the process of grief. Indeed, he contends that the implicit assumptions of traditional models of grief fail to describe or explain the reality of individually mediated responses to loss which occur within the social context of human relatedness.

It is now widely accepted that the grief process is both a uniquely individual, and a dynamic rather than passive process and that any analysis which attempts to confine human response to a progression through predefined stages or as dependent for recovery upon completion of a linear process of task accomplishment seems essentially to deny the essence of human individuality and capacity for creative and adaptive behaviour.

A further criticism of stage theory is the implicit assumption that once the process has been accomplished, grief ends. It is now generally accepted that as emotional intensity lessens, and the cognitive task of meaning reconstruction is negotiated overtime, grief changes, and the bereaved becomes more oriented towards the future rather than the past, whilst retaining a continuing bond with the deceased (Janoff-Bulman, 1992; Neimeyer, 1997; Silverman & Klass, 1996; Stroebe, 1993; Weiss, 1993). Rando maintains that resolution of loss necessitates the reclaiming of life, which process requires detachment from grief without necessitating detachment from the deceased. Attachment is maintained, and "…people do not relinquish their ties to the deceased, withdraw their cathexes, or 'let them go'. Rather they retain their internalised, symbolic and imagined relatedness, whilst letting go of the actual "living and breathing relationship" (Shuchter & Zisook, 1993:34).

Despite these criticisms however, stage theories have identified important features of grief response, and it would be foolish to dismiss totally what are undoubtedly valuable, if somewhat constricted insights.

2.1.3 Stress Theory

In viewing bereavement within the stress-coping model, it is argued that the impact of this stressor is of sufficient magnitude as to demand greater adjustment than most other life stressors and it is suggested that this stressor can directly impact upon physical and mental health as well as through cognitive and behavioural pathways (Cohen & Williamson, 1991; Lazarus & Folkman, 1984; Reynolds, 1994; Stroebe & Stroebe, 1993). Indeed, Holmes and Rahe (1967) identify bereavement as the most stressful of all life events on their Social Readjustment Scale of 43 items. Seyle

(1956) suggests that change such as that which occurs as a response to a major life event, creates a disequilibrium which can leave an individual vulnerable to stress. Individual variations in terms both of dispositional and preferred coping styles will have obvious implications in terms of how individuals cope with such stress (Carver et al, 1989; Epstein & Meier,1989). Holahan et al (1996) argue that relatively stable environmental and personality variables interact in response to life crises and transitions faced by individuals. They emphasise the mediating role of cognitive appraisal and coping responses in the stress process, suggesting that people who rely more on approach coping rather than avoidance coping will tend to adapt better to life stressors and to experience fewer psychological problems. On the other hand, Carver et al note that avoidance coping may also serve a useful function in the short term, by offering a psychological break from constant pressure.

Lazarus and Folkman (1984) have viewed coping as a response to specific stressors, as opposed to a stable feature of personality. Active and conscious cognitive appraisals of events that are potentially threatening, function as mediators between life stressors and an individuals coping responses. Those who appraise an event as stressful and who appraise their own coping resources as inadequate, are thereby more likely to suffer adverse effects. Major stressors are likely to have long lasting and cumulative effects. Thus seen, bereavement is as much a coping process as a reaction to loss and change (Hansson, Carpenter & Fairchild, 1993).

A major advantage of stress appraisal theory over stage models is the ability to explain the divergent outcomes and manifestations of bereavement. A further advantage is the implicit assumption that most people eventually recover from stressful life events, although it is recognised that those with greater resources, or with more social support are likely to be at an advantage. Both the stage and stress models however assume that bereavement response is characterised by an initial period of intense distress and both assume that ultimately, recovery will take place. Such assumptions have not been shown to be universally applicable. Reference will be made to the extension of stress appraisal theory to the understanding of grief reaction in response to trauma, at a further point in this discussion.

2.1.4 Narrative Theory

A narrative view refers to the manner in which the retelling of stories leads to new meaning and validation. Neimeyer argues that life can be viewed as a story and loss can be viewed as a dislocation which causes a disruption in the continuity of the narrative (1997). Attig(1996) argues that grieving is a process of relearning the self and the world, whilst Meichenbaum(1994) emphasises the stories which are developed in the face of experience of change, loss or trauma. He argues that the challenge for the traumatised individual is to reframe or transform their story so as to reflect survival and dignity in the face of challenge. Walter (1996) has developed a model of grief which focuses specifically upon the process of meaning making through the construction of biography, whilst White and Epston (1990) suggest that in order to make sense of life, experience must be 'storied' and it is this 'storying' that determines the meanings ascribed to experience. Thus, the story can be seen as an organising framework for accommodating an emerging understanding of loss.

2.1.5 Personal Construct Theory

" . . . to see the world as it really is (is) devastating and terrifying . . . it makes routine, automatic, secure, self-confident activity impossible. It makes thoughtless living in the world of men an impossibility. It places a trembling animal at the mercy of the entire cosmos and the problem of the meaning of it." (Ernst Becker, 1973:26.)

Kelly's (1955) personal construct theory proposes that people perceive their world through patterns or constructs, through which the elements of experience are construed or interpreted. Objective reality is beyond grasp, so individuals are forced to judge constructions on the basis of utility, internal coherence and the validation of others. An event failing to mirror an individual's construction of it can therefore cease to have meaning.

"Death as an event can validate or invalidate the constructions that form the basis on which we live, or it may stand as a novel experience for which we have no constructions" (Neimeyer, 1997:165). Neimeyer has been a particularly strong critic of the traditional portrayal of emotion as a problem to be overcome (1997,1998). He identifies meaning reconstruction as central to the process of grief resolution and as an

activity that is " . . . a predominantly tacit, passionate process that unfolds in a social field"(2000: 552). Here, the role of denial represents an attempt to suspend an event that cannot be assimilated until such a time as the meaning of it can be grasped, and as such it can be seen to have an adaptive function. Depression is represented as the constriction of the experiential world against further invalidation, whilst anxiety represents a reaction to awareness of the uncontrollability or unpredictability of death and the implications of this for future living. Guilt refers to an admission of failure to live up to self imposed standards, which failure contradicts the structure of identity, whilst the hostility so often seen after a loss represents the attempt to force events to conform to prior constructions of the order and predictability of the world and the individuals sense of self. Thus seen, grief is an active process involving choices as to how the numerous dimensions of its aftermath are dealt with. We can attend to the emotional aspects of it or can avoid or suppress the pain. We can actively reconstruct our assumptive worlds or we can stay locked in our rigid constructions which are no longer related to the objective reality of the loss experienced. In this, grief challenges the bereaved with a series of decisions, both existentially and practically.

Epstein (1993) conceptualises bereavement as a trauma, maintaining that death can pose a challenge to existent meaning systems, at rational, experiential and unconscious levels. Failure to assimilate the event leads to destabilisation of the personality which, if enduring, will preclude basic need fulfilment and thus lead to dysphoria, loss of motivation, withdrawal and disorganisation. Generally resolution will occur in time, thereby enabling need fulfilment to successfully re-establish. For this to occur however, the trauma must be 'worked through' in an emotionally meaningful way. Failure to integrate can occur when distress is avoided through the adoption of maladaptive coping strategies or through the reconstruction of meaning in a manner precluding need fulfilment, thus leading to depression, anxiety or anger.

In the constructivist approach adopted by Woodfield and Viney (1984-85), the denial, idealisation and hostility so common to grief manifestations can be seen as attempts to assimilate the event. The extent to which an individual's constructs are permeable will determine the extent to which the reality of the loss and the challenge to adapt can be accommodated. The danger for the individual lies in the adoption of a rigidly defensive approach which may lead to imprisonment within a defunct construct system.

Constructivist Theory is essentially cognitive in orientation, with it's emphasis on the personal meaning or construction of reality and as such contributes to a broadening understanding of the mechanisms determining idiosyncratic response to loss.

2.1.6 Cognitive Theories of Loss

The core tenet of cognitive theory is that individuals actively construct their own realities, attaching highly personal, idiosyncratic meanings to events, which meanings may reflect inaccurate representations of those events (Beck, 1991). As previously noted however, the emphasis of traditional conceptualisations of grief was upon the emotional dimension of the process, with the benefit of catharsis a cornerstone of much psychotherapeutic endeavour (Breuer & Freud, 1895/1966). As a consequence, until recently little attention was awarded to the importance of the cognitive dimension. Indeed, recent emphasis upon the cognitive task of meaning reconstruction and an exploration of a continuance of relationship with the deceased represents a major shift away from the psychoanalytic model of grief with its emphasis upon disengagement (Fleming & Robinson, 2001; Neimeyer, 1997, 2000; Raphael et al, 1993; Stroebe & Schut, 2001). However, despite this changing emphasis, few have outlined specific approaches that are cognitive in orientation (Abrams, 1981; Woodfield & Viney, 1984; Fleming & Robinson, 1991, 2001).

In emphasising the primacy of cognition over affect, cognitive theorists do not deny the intrinsic interrelatedness of these factors. Indeed, it is proposed that cognitive, behavioural and affective factors are reciprocally interacting constructs and the role of affect as an ally in the therapeutic process is increasingly emphasised (Hackman, 1989; Safran & Greenberg, 1986; Safran & Segal, 1996). It is now recognised that much of early life experience and thereby, the development of core constructs or schemata, occurs at a time when cognitive development is at a primitive, preverbal and experiential level and as such, affective response in the conceptualisation of grief is an inextricable element of any theory of loss.

Parkes (1988) has referred to the 'Assumptive World' as meaning "a strongly held set of assumptions about the world and the self which is confidently maintained and used as a means of recognising, planning and acting." In this cognitive processing, it is the

individual's personal experience and history that provide affirmation of the validity of their assumptions. Janoff-Bulman (1992) proposes that central to this conceptual system is a set of abstract, global expectations or assumptions which consist of beliefs about the benevolence and meaningfulness of the world. Such assumptions afford a sense of invulnerability that enable secure functioning in the world. However, life events such as bereavement are so fundamentally challenging, that their stark reality can shatter the sense of self, leading to reactions of intense fear and anxiety. Integration requires the rebuilding of a safe, non threatening assumptive world, which can include the reality of vulnerability within a more balanced, albeit more negative world view. Transformation of this assumptive world is achieved through a process of narration, which facilitates emotional expression and the development of voluntary control over the experience.

One of Freud's earliest contributions to the study of psychopathology was the development of the concept of defence mechanisms. These refer to unconscious psychological manoeuvres adopted by individuals in order to protect themselves from a reality which may be too unacceptable or painful to absorb. This role of denial as a buffer which protects the individual from the pain of loss is a well recognised feature of grief response. Parkes (1972,1988) has proposed that individuals operate an inhibitory tendency, using strategies of avoidance, repression and postponement in order to limit perception of disturbing stimuli. Such a proposal suggests an ability to act in a cognitively conscious manner. Beck (1976) maintains however that much of our information processing occurs at the level of preconscious or automatic thought, although these automatic thought processes are open to exploration at conscious level. Rando(1995) also emphasises the automatic nature of habitual cognitive and behavioural responses which underpin core cognitive assumptions, often leading to a lack of awareness of the significance of relationships, until a death or loss actually occurs.

It has been argued that adaptation to loss requires that it be somehow explained and intellectually accepted (Moos & Schaefer1986). Indeed, cognitive theory contends that when core beliefs have been threatened, the individual is challenged with the demand to make some sense in order that dissonance is reduced. Horowitz (1986), in proposing that individuals are motivated to complete tasks, maintains that this occurs

when differences between new information and existent schemata have been accommodated.

Is then the search for meaning and it's reconstruction an inevitable and essential prerequisite for adjustment to loss? We know that many events challenge our need to see the world as predictable and that when tragedy occurs, sufferers have been observed to engage in a persistent search for reasons, explanation or meaning (Parkes & Weiss 1983). Davis et al (2000) challenge the assumption that the search for meaning is either inevitable or essential for adjustment. Indeed, they assert that success in achieving meaning does not appear to indicate better functioning. In a review of studies, they have found that those who did not pose the meaning question appeared to cope best, whilst those for whom death was experienced as trauma, embarked upon a search for meaning which was painful and often unsuccessful (Davis et al 1999, cited in Davis et al, 2000). Arguably, for such individuals, it may be more fruitful to search for meaning in life, whether in the survivor's life or the life of the deceased, rather than to search for meaning in death (Fleming & Robinson 1991; Neimeyer 2000). Rando(1984) maintains that connection to the deceased should not bind the individual to the past but should rather enable the reestablishment of meaning in the present. Such a task requires the transformation of identity so as to redefine a symbolic connection with the deceased whilst maintaining a relationship with the living" (Klass et al, 1996, cited in Neimeyer1997). Neimeyer maintains that the transformation of the world which arises as a consequence of loss, can cause a profound shift in our sense of who we are. Any meaningful theory of grief therefore should seek to articulate this personal reality, and should acknowledge the active response of individuals in the face of challenge. To some extent, cognitive theories of loss can be seen as incorporating elements of attachment and stress theories, in that they emphasise the manner in which individuals react to the occurrence of a major life event in a manner reflecting their unique assumptions or core beliefs, which cognitions are a product of experience and idiosyncratic appraisal of that experience.

2.2 Models of Grief

Five models of grief will be outlined here. These include the Dual Process Model, a depression model, a post- traumatic stress model, a combined depression-anxiety model and a cognitive formulation of grief.

2.2.1 The Dual Process Model.

The term grief work has been used to describe the process whereby loss is integrated. Freud (1917/ 1957) described this as an absorbing process wherein resolution is achieved through a process of confrontation of the loss. However, there is controversy regarding the importance of confronting death in the early phase of grief and of the necessity to do 'grief work' for resolution to occur (Rando, 1984; Stroebe & Stroebe, 1991; Wortman & Silver, 1989; Parkes & Weiss, 1983). In challenging assumptions implicit to the grief work hypothesis, gender, roles, relationships, coping styles, social context, social support and the place of meaning attribution have all been identified as factors which influence outcome (Schut et al,1997; Stroebe & Schut, 2001).

The Dual Process Model describes the complex and fluctuating manner in which loss is accommodated (Stroebe & Schut, 1999; Stroebe et al, 2001). Stroebe et al suggest that for adjustment to take place, bereaved individuals must undertake both loss and restoration-oriented action. Loss-orientation involves a process of emotionally confronting and expressing the loss, so as to assimilate the experience into pre-existing schemas. Integral to this process are the activities of repetition, rumination and the social expression of grief. Restoration activities involve the mastery of secondary life stressors that now demand attention as a consequence or fall-out of the death. The Dual-Process model suggests that most people oscillate between the two styles of coping, and that adjustment difficulties emerge when there is too little oscillation in either direction. In their review of literature highlighting the divergent findings in relation to the function and adaptive nature of confrontation and avoidance, Stroebe and Schut note that despite research findings supporting the efficacy of confrontation, there is another body of research which argues against such benefits and which demonstrate findings of an independent relationship between

emotional expression and health outcome (Kavanagh, 1990; Pennebaker & Francis 1996; Schut et al, 1996; Schut & Stroebe,1997). They argue that the effect of confrontation can vary, depending upon whether it is positive and problem focussed or negative, passive and ruminative in character. Where thoughts and behaviours focus attention on symptoms of distress and the meanings and consequences of these symptoms, this is associated with negative affect and higher incidence of depression (Capps & Bonanno, in press; Nolen-Hoeksema, Parker & Larson 1994; all cited in Schut & Stroebe, 2001). However, where the confrontation style adopted appraises positive aspects of the loss, or includes a search for positive meaning, this approach is associated with recovery (Folkman, 1997, cited in Schut & Strobe, 2001).

In other words, persistent negative affect intensifies grief, yet working through grief, which is also inclusive of the process of rumination, can lead to adaptation. In contrast, positive reappraisal of loss aspects sustains coping effort, yet if maintained continuously, this can also lead to poor outcome. The model, which postulates a fluctuating dynamic process of adaptation to bereavement through confrontation and avoidance, is cognitive in orientation and recognises the central place of meaning attribution in the determination of grief response.

2.2.2 A Depression Model of Grief.

Support for a depression model of grief emanates from the shared similarities between grief response and depression. Cognitively, grief is conceptualised as a response to the shattering of core beliefs and as a struggle to assimilate the painful reality of meanings integral to loss. Beck's (1976) cognitive theory of depression proposes that it can be understood as an appraisal of loss reflecting negative and distorted cognitive processing. This leads to an interacting chain of responses at behavioural, affective and physiological levels, which is maintained by recurring cognitive errors, and by the activation of core schemas. Such schemas reflect dysfunctional beliefs or assumptions about self, the other and the world. Can a theory of loss-induced depression maintained by cognitive distortion, apply also to the experience of grief, given that however construed, that which is experienced is objective loss, and reactions therefore can be considered both normal and adaptive?

Moorey(1996) has addressed this conundrum for cognitive therapy, by acknowledging the objective nature of adversity, which cannot be ignored, denied, or explained away as if it were a product of dysfunctional thinking. He argues that even if the thoughts of those afflicted appear distorted, this distortion may reflect a normal reaction to stress and suggests that despite the normal, dynamic and evolving nature of the grief process and it's inherent adversity, there may be elements of an individuals cognition which reflect features of distortion which can contribute to increased suffering. These elements are the material of the therapeutic encounter in which the idiosyncratic meanings ascribed to events can be explored, thereby opening up the possibility for transformation of meaning in the light of new evidence.

The question however remains of whether the adoption of the cognitive depression model of grief is appropriate. Indeed, are not sadness and depression different entities? Research has demonstrated that depression is relatively independent of core features of grief such as pining and yearning for the lost relationship (Byrne & Raphael, 1997; Prigerson et al, 1997). The central place of meaning reconstruction proposed by Neimeyer and integral to any cognitive theory of loss, suggests that a more complex formulation of grief is required, which can also reflect the appraisal of loss as a threat and which can reflect the coexistence of other features more closely resembling response to stress or trauma. In short, it would appear that a more flexible cognitive formulation is required, which can take account of all of these considerations.

2.2.3 Post Traumatic Stress Model

It has been found that problematic bereavement reactions are likely to arise in response to traumatic circumstances of a death (Raphael & Madison, 1976; Lehman, Wortman & Williams, 1987). Indeed, in recent years, a broader conceptualisation of grief has been developing, which is inclusive of the element of trauma. With this development, there has been a growing body of discussion regarding whether some of the features of grief resemble features of post-traumatic distress. A study by Pynoos and Nader (1990) found that exposure to threat at time of death was associated with post-traumatic symptomatology, whilst closeness of relationship was associated with symptoms of grief. Their findings suggest that whilst these symptom clusters may

generally remain relatively separate, at times an interaction can occur. They maintain that where grief reaction manifests in traumatic anxiety, this element must be relieved before the symptoms of mourning can be addressed. Thus, whilst a clear argument is made for the separation of PTSD and grief, it is recognised that bereavement can lead to a post-traumatic stress reaction which may complicate outcome and interfere with grief resolution (Middleton et al, 1993).

Horowitz likens bereavement to a trauma, suggesting the operation of a denial-intrusion cycle in grief, which is central to the stress response syndrome. He maintains that the enforced assimilation of threatening material such as the reality of loss, demands change at the level of schemas, to which resistance is a natural response (Horowitz, 1986; Horowitz et al, 1997). Similar views have been put forward by other theorists (Janoff-Bulman1992; Rando, 1993,1997). Such views can illuminate understanding of the impact of loss, especially upon those with a heightened sense of vulnerability arising out of past experience, which vulnerability may take on the character of 'learned alarm.'(Parrot and Howes, 1991: 93).

In the light of findings of the place of trauma in the conceptualisation of grief, the cognitive model of posttraumatic stress disorder developed by Clark and Ehlers (2000) is worth reviewing. Here, the nature of emotional response is determined by idiosyncratic appraisals of the trauma and it's sequelae. Appraisals of loss will lead to sadness, of violation to anger and of threat to anxiety. Maladaptive strategies adopted to deal with the trauma will be determined by the types of appraisals made and beliefs regarding how best to cope. Maladaptive behaviours include thought suppression, selective attention, and the adoption of safety behaviours designed to control symptoms. Avoidance and rumination are identified as maladaptive coping strategies which maintain symptoms and prevent integration. Clark and Ehlers propose that those who ruminate, fail to assimilate trauma because of the manner in which they think or talk about the event. Such individuals talk in a non- emotional way or in a manner that prevents elaboration of the full meaning of the event within their meaning system. For trauma to be integrated, the memory must be elaborated, problematic appraisals modified and maladaptive behavioural and cognitive strategies replaced. Treatment involves processing the trauma, reversing maintaining factors, and cognitive restructuring. Such a model offers a conceptual framework which may have broad relevance for the understanding and treatment of grief. The importance in

trauma conceptualisation of the maintaining factors of rumination and avoidance is emphasised, and echoes the findings of other theorists (Fleming & Robinson, 2001; Kavanagh, 1990; Stroebe et al, 2001). The maladaptive nature of rumination has also been emphasised by Persons (1989), who describes it as a repetitive, unproductive, and generally negative style of thinking which blocks productive problem solving.

2.2.4 Combined Depression-Anxiety Model

Kavanagh (1990) proposes a combined depression-anxiety model to explain the processes involved in both normal and chronic grief, while also accounting for some of the features found in PTSD. Whilst arguing that loss challenges existing schemas and can lead to anxiety, he maintains that avoidance forms only one type of complicated grief reaction, which whilst generally understood as a feature of anxiety, could equally be described as depressive withdrawal. Citing the research of Parkes (1965), he argues that the most common problem of the bereaved is chronicity. He contends that bereaved people ruminate excessively and that bereavement related depression is maintained by an emotional feedback loop whereby exposure to a sustained experience of induced sadness leads to the triggering of negative cognitions, behaviours and physiological responses that serve to maintain the depressed mood. He postulates that factors such as the social reinforcement of grief, and the difficulty in avoiding bereavement related cues may explain why the majority of bereaved individuals do not develop major disorders as a consequence of the experience and why there is a low correlation between measures of life events and depression (Brown & Harris, 1978; Beck et al 1979). He describes skills for dealing with the emotional distress of grief as falling into the categories of problem solving, distraction and mood induction, the ability to counteract negative thoughts and the skill of acquiring social support when this is needed. In bereavement, as in all stressful events, these skills have to be developed, shaped and modified so as to enable the individual to face the challenge of life without the presence of the deceased. Failure to adapt or to resolve existential issues presented by death may lead to chronic anger, negative attributions or depressive nihilism.

Fleming and Robinson (1991) have developed a model which defines the grief process as “the transition of losing what one has to having what one has lost” (p.139),

which is characterised as a transition from resentment to gratefulness, with the task of grieving as one of reappraisal of meaning. Reappraisal requires the development of an understanding of relationship with the deceased as a legacy. Pain represents the amalgam of responses to grief which are normal and commonly experienced during this transition period. Not everyone passes directly from grief through to resolution. Some take alternative routes towards adjustment which this model delineates. The chronic griever becomes stuck when strong and intense emotions continue to be experienced and the individual fails to relinquish emotional attachment to the deceased. The task here is to assist the survivor to say goodbye to grief by facilitating it's exploration. What impedes the path to recovery here can be fear of the future, dependency or secondary gain. An alternate response to grief can be when the response is avoided through inhibition, suppression or postponement. Reasons for this may be lack of social support, concurrent stressors, the nature of the relationship or the personal meaning of the loss. Here the therapist seeks to assist the survivor to identify factors preventing the full experience of loss, so as to facilitate expression of grief and to explore the meaning of the loss in the light of the relationship.

2.2.5 A Cognitive Formulation of Grief

Parkes and Weiss (1983) suggest that a lack of confidence in the ability to survive safely without the deceased can lead to holding on to the past in preference to moving forward. The disarming of avoidance of death's reality and implications at both cognitive and affective levels seems crucial therefore. In short, a fully integrated cognitive conceptualisation of grief is indicated, which can indicate specific pathways to treatment. Such an approach should target those factors likely to maintain grief, whilst building on those factors influential in grief resolution. It must include a focus on exploration of the meaning of loss, and it's psychological sequaelae, meaning reconstruction, through focus on the legacy of the deceased, and the life of the survivor, the development of resilience and the marshalling of supports.

Drawing upon the theoretical insights of cognitive theory, a formulation of complicated grief is suggested by this author which reflects the pivotal place of meaning reconstruction in the manner in which loss is experienced and appraised. Such meaning will be influenced by core beliefs and schemas derived from

attachment history as well as by factors relating to the specific nature and circumstances of the loss and it's sequaelae. Where bereavement is appraised as a threat, this will give rise to anxiety and will thereby lead to avoidant strategies designed to protect against the full reality of that loss. Such behaviours will include ineffective attempts to suppress cognitions and affect relating to the loss experience and will give rise to features characteristic of post-traumatic distress. These will include an ongoing sense of disbelief and numbness, intrusive thoughts and images accompanied by episodes of intense distress, and a heightened sense of danger. Where bereavement is appraised as a loss, this will give rise to a preoccupation with that loss that is reflective of separation distress. This will manifest as yearning, searching and pining for the deceased and all that has been lost. Behaviour will tend to have a negative, ruminative quality and will often be accompanied by depressive withdrawal or avoidance. Thus, avoidance may reflect either a strategy to deal with threat, or a strategy to deal with grief induced depression that is maintained by rumination. See Figure 1, page 28.

2.3 Summary

This discussion has reviewed the wealth of theoretical perspectives on grief which inform this complex area. The central importance of attachment theory and the insights of stage and stress theories have been reviewed, and arguments against some assumptions of these traditional approaches explored. The variability of response to grief and factors which might explain this variation have been examined, including the influence of developmental history, social context and the importance of social support. The dual process model and various cognitive conceptualisations of grief have been discussed, and the non-linear, oscillating tendency between confrontation and avoidance, which is also a common feature of PTSD, has been identified. The centrality of meaning reconstruction in the process of loss integration has been emphasised and cognitive models that illuminate the conceptualisation of complicated grief have been surveyed. If grief is to be understood, and where necessary treated, then the challenge ahead may be to assist those grieving to confront the reality of the death, to express grief appropriate to their appraisal of that loss and to reconstruct new meaning in a life without the deceased, whilst maintaining an ongoing symbolic connection to them. To achieve this, maintaining factors will need to be explored

and dismantled, and factors supportive of change marshalled. The development by this author of a cognitive formulation of complicated grief appears to offer such a therapeutic tool.

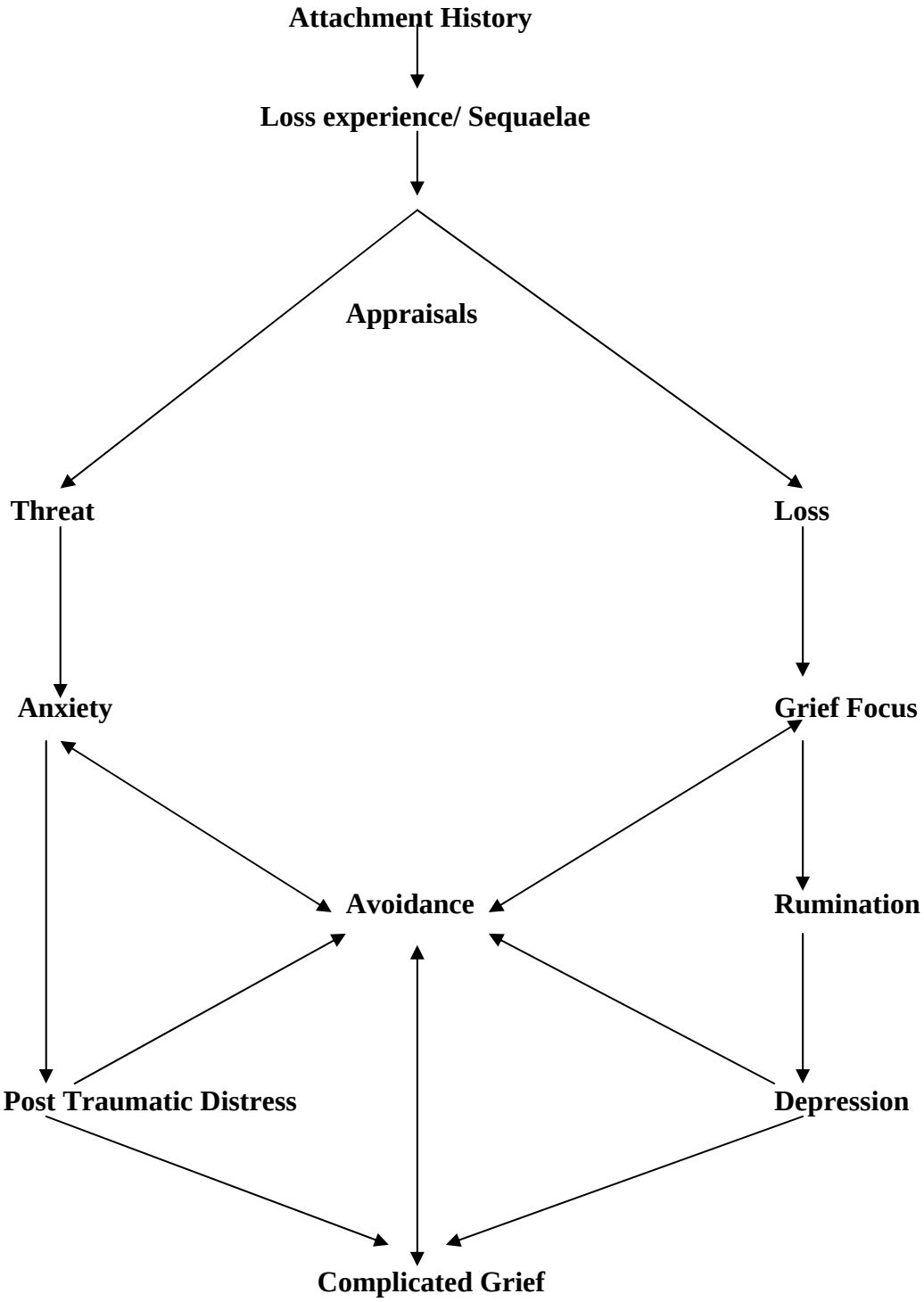

Figure 1 Cognitive Formulation of Complicated Grief

Chapter 3
A Review of Treatment Approaches for the Bereaved

3.1 Introduction

This section will address the key issues facing clinicians in the field of complicated grief and will review the nature and outcome of studies that have sought to address this phenomenon. In the light of the literature already reviewed, the question of whom to treat will be discussed, and primary treatment targets will be identified. Finally, recommendations for future intervention will be reviewed in the light of findings.

3.2 Treatment of Grief: Brief overview

Treatments for grief have for the most part evolved from psychotherapeutic approaches to treatment of the individual, though with some extension to the group and family (Raphael et al, 1993). In addition to formal therapeutic approaches to treatment, there has been a proliferation of bereavement services providing support from volunteers or self help groups. In this regard, a major study of note is that of Parkes (1981) which positively evaluated the support provided by a bereavement group manned with volunteers which targeted high risk bereaved individuals.
Vachon's(1980) controlled study of a widow-to-widow self-help program also demonstrated some success in facilitating widows to commence processing their loss. The early intervention resulted in a lowering of distress especially in the high risk group, as compared to the control group. This review will not be focussing further on this type of intervention.

Allied to different theoretical formulations of grief, a number of broad psychotherapeutic approaches have developed. These are summarised in Table 2.

Table 2 Theory Based Interventions with the bereaved

Psychodynamic Psychotherapy :	**(1) Crisis Intervention** **(2) Brief Psychotherapy**
Narrative Therapy	
Behavioural Therapy	
Cognitive Psychotherapy	**(1) Grief Focussed** **(2) Trauma Focussed** **(3) Integrative Model**
Group Psychotherapy	

3.2.1 Psychodynamic therapy: Crisis Intervention

The psychodynamic approach of crisis intervention evolves from a theoretical framework which sees death as a major stressor which precipitates an emotional crisis. Therapy is designed to facilitate management of this stressor through the use of a practical, short term problem solving format (Lindemann, 1944; Caplan,1964). One of the first controlled preventative studies used crisis intervention to treat bereavement related depression, but failed to demonstrate the effectiveness of the approach (Polak et al, 1975). However, Raphael's (1977) study of 200 widows assessed within 7 weeks of the death of their spouse, found preventive interventions at an early stage to have some effect. In another study, Raphael undertook a three month preventative intervention with a group of 31 high risk, bereaved widows at an early stage in their bereavement. Individuals received four 2-hour sessions with the therapist and focussed on facilitation of the mourning process and promotion of social interaction. Findings suggest a positive relationship between facilitation of the grief process and subsequent health outcome, indicating that preventive interventions at an early stage may have some effect.

Using a similar theoretical framework, Gerber, Weiner et al (1975) compared brief psychotherapy with a no-treatment control condition for elderly subjects experiencing the loss of a spouse. This was not a controlled intervention study but it did result in a

positive result, with a reduction in use of psychotropic medication noted and fewer medical services subsequently required by the experimental group. Given that grief symptoms were not specifically targeted however, it is possible that such an improvement in functioning might have occurred without any decrease in grief intensity, begging the question as to whether this type of 'grief' therapy intervention, though useful in terms of improving functioning, is likely to achieve any real change in an individuals grief experience.

3.2.2 Psychodynamic therapy: Brief Psychotherapy

There is evidence that treatment with brief psychotherapy can have some value for bereaved individuals who are suffering adjustment difficulties. Here, grief is seen in the context of stress response syndromes. In a study by Horowitz et al (1984a), 52 individuals were treated with time-limited dynamic psychotherapy for complicated grief following the death of a husband or parent. The relationship between dispositional and process variables was studied. Treatment focussed on separation, loss and termination issues, and outcomes were generally favourable in terms of a substantial reduction in symptoms.

In another study, Horowitz et al (1984b) treated 35 individuals (two of whom were male) with brief psychotherapy. Both the treated and the untreated comparison group showed significant stress-specific and general symptomatic relief over the course of the study. In a follow-up study a year later, no significant difference between the two groups was noted, though avoidant themes and emotions evoked by the death appeared somewhat reduced in the treatment group.

In a further study of brief psychotherapy with a sample of eight vulnerable elderly individuals, half of the sample had a positive outcome with half having a fair to poor outcome. Krupnick and Horowitz (1985) have deduced from this that brief therapy may be useful in stemming a downward course, a deduction which seems to provide some rather limited encouragement for such an approach with this type of patient. In a controlled comparative trial of the effects of brief psychotherapy and a mutual self help group for unresolved grief, Marmer et al (1988) treated 61 widows, 4 months to 3 years after the death of their spouse. Results demonstrated a reduction in stress-

specific symptoms of intrusion and avoidance as well as in general symptoms and in social and work functioning for both groups. Some effect from this type of approach is therefore evident.

3.3 Narrative Therapy

The facilitation of individuals in the telling of their story has traditionally been regarded as an important component of therapeutic work which can both enable emotional events to be captured and can assist individuals in achieving mastery over experience previously perceived as uncontrollable. Pennebaker et al maintain that the resources used in the inhibition of thoughts or feelings related to specific events compound stress, and that expression of stressful material leads to a reduction in stress. They have developed a technique that involves instructing people to write about their negative experiences for 20 minutes a day for four days (1996, 1998). As a result of a controlled study of the effect of writing upon health, they conclude that positive health gains are associated with writing or speaking about a trauma even in the absence of another person.

In maintaining that "some meanings are too embedded in our lives, too embodied in our actions" to be verbally formulated or communicated, Neimeyer (2000:554) proposes that creative, metaphoric, poetic, and narrative strategies for exploring meaning be used, and suggests that writing and journals be used to help consolidate and integrate implications of the loss experience. Similar approaches recommending the imposition of a narrative structure on feelings and cognitions are recommended by Reisk & Schnike(1992; cited in Neimeyer, 2000), Van der Hart (1988) and Janoff-Bulman (1992). The facilitation of emotional expression and cognitive assimilation through the use of ritual and the completion of unfinished business has also been shown to be effective in the treatment of grief (Rando, 1993; Van Gennep, 1960; van der Hart,1988).

3.4 Behaviour Therapy

The conceptualisation of grief within the framework of a phobic model has led to the development of a behavioural approach focussing upon the treatment of problematic grief reactions using the techniques of graduated exposure and habituation to feared or avoided grief eliciting stimuli (Lieberman, 1978; Mawson et al, 1981). Most studies have used some form of re-grief or guided mourning model of intervention designed to facilitate integration through the revisiting of the trauma. Unfortunately, many of the studies reporting benefits are small and uncontrolled (Gauthier & Pye, 1979; Lieberman 1978).

Melges and De Maso(1980) have used a form of grief resolution designed for those whose grief reflects a wish to redo and reunite with the past. The method employs guided imagery to assist individuals to relive, revise and revisit events surrounding the loss. The resulting response to this form of intervention is the initial reawakening of the full yearning for the lost attachment figure. The individual is then encouraged to undo bonds with the deceased and to make new choices enabling the integration of past with future.

In a controlled clinical trial of behaviour therapy, Mawson et al (1981) adopted a model of guided mourning which resulted in improvement in symptoms of grief as measured by the Texas Inventory of Grief (Faschingbauer, 1981) as well as significant improvement in phobic and distress symptom. Depression scores did not however show significant improvement. Sireling et al (1988) have replicated the guided mourning approach in a controlled study of 26 adults with ‘morbid grief’. The control group were instructed to avoid painful and feared bereavement cues whilst the treatment group received the program of guided mourning. Results showed a reduction in avoidance of cues and somatic symptoms. However, both treatment and controls showed improvement in grief, anxiety or depression symptoms, suggesting that avoidance of bereavement related cues may be independent of both depression and separation anxiety.

Gauthier and Marshall (1977) highlight the influence of social response to grief manifestations, the role of social reinforcement and the consequences of the conspiracy of silence adopted by some families in the wake of a death, all of which can positively or negatively reinforce grief expression, and thereby contribute to the development of maladaptive behavioural responses. They cite the findings of Napalkov (1963) which have been further elaborated by Eysenck(1968). These demonstrate that attempts to avoid grief cues are impossible, and that repeated brief exposure to grief cues followed by attempts at suppression, can lead to increasing intensity of experience and to incubation of distressed responses. Analysis therefore suggests that avoidance is likely to prolong grief and that forced prolonged exposure to that which is avoided should reduce symptoms. Equally, social reinforcement of grief response and failure to encourage alternative adaptive behaviour may exacerbate or prolong grief. Gauthier and Marshall report successful treatment of four patients, using a method of exposure, flooding and encouragement of adaptive behaviours.

Trauma Desensitization is a behavioural therapy which involves exposure to trauma related stimuli and relaxation techniques. Through the use of relaxation, the individual is gradually desensitised, leading to a lowering of distress through habituation. Kleber and Brom (1987) have compared the effectiveness of trauma desensitisation with two other approaches, one using hypnosis and one using brief psychodynamic psychotherapy. All participants were manifesting symptoms of PTSD. Treatment resulted in a reduction of intrusive, avoidant, anxious and somatic symptoms. Davis et al (2000) recommend this approach, and suggest that therapists act as container for the bereaved, and use education and training in affect modulation as additional treatment strategies.

Whilst behavioural approaches appear to relieve some of the symptoms of post traumatic distress, there is no evidence as to the diminishment of specific grief symptoms as a consequence of treatment. It appears therefore that more may be required than simply a reduction in traumatic phenomena. Stroebe and Stroebe(2001) have concluded that extreme avoidance of grief work is indeed detrimental to adjustment. However, findings of low levels of avoidance in samples of bereaved people suffering from traumatic grief lead Jacobs and Prigerson (2000) to suggest that treatment focussed simply on avoidant symptoms may be aiming at the wrong target

and failing to address the core constituents of grief. Raphael et al (1993) suggest however, that if traumatic anxiety or repression of experience are in evidence, these symptoms must first be targeted, before grief can begin to surface. Such a view is also support by the findings of Pynoos and Nader (1990).

3.5 Cognitive Psychotherapy

Within the cognitive model, there are a number of different conceptual frameworks available, each emphasising different elements that can guide intervention. It is suggested that this flexibility of choice can enable therapists to effectively tailor their interventions according to the problem classification or patient grouping. However, in reviewing differing conceptual frameworks and cognitive strategies which can be adapted to the treatment of grief, Parrott and Howes (1991) maintain that regardless of the theoretical framework or strategies used, it is " the idiosyncratic subjective experience of the patient ' which is 'the basis of the therapeutic exchange. It is the world, whether it be self-oriented, other-oriented, event-oriented or some other combination, *through the patient's eyes*, that is essential in cognitive therapy" (p.5).

3.5.1 Grief Focussed Cognitive Therapy

An exploratory review by Powers and Wampole (1994) investigated the impact of the differential use of cognitive behavioural strategies upon successful adjustment to bereavement in a sample of widows. They conclude that an adaptive capacity to reattribute meaning influences adjustment, as does the capacity to sever association between distress and memory. Capacity to modulate grief-associated distress is also demonstrated as a helpful coping strategy, whilst the tendency of those who might be described as suffering complicated grief to ruminate or alternatively to avoid grief related introspection is linked with negative outcome. The review recommends education in personal health promotion activities and identification of predominant themes of grief as factors which may enable a more problem solving approach to surface, thereby creating a sense of self-efficacy and decreasing the sense of disorganisation and dependence so often experienced by the bereaved (Ben-Sira,(1983), cited in Powers & Wampole).

Emmons, Colby and Kaiser (1998) have found that following major life events, the pursuit of goals becomes difficult (cited in Davis et al, 2000). Nevertheless, the development and pursuit of goals is regarded as fundamental to the search to find meaning and is a strategy which is basic to the practice of cognitive therapy. In working with the bereaved, Parkes recommends the setting of achievable targets as a way of encouraging engagement and increasing self –confidence. Such findings suggest that ability to organise grief experience at the level of cognition and the maintenance of effective health practice is a strong indicator of adjustment. This emphasis upon cognitive management of grief has obvious implications for the planning of future treatment intervention.

As previously mentioned, Moorey's extensive work with those who are facing death with cancer, demonstrates that room for cognitive restructuring does exist even in the face of unbiased negative realism (1996). Malkinson suggests that a full assessment of irrational beliefs blocking grief processing be conducted, with special emphasis upon pain related beliefs, which can lead to avoidance or the over-experiencing of grief (1996). Fleming and Robinson (2001) promote the encouragement of counterfactual thinking so as to enhance a sense of control and to relieve suffering. They recommend cognitive exploration of grief features, including faulty expectations of process, dysfunctional, paradoxical or rigid beliefs and levels of cognitive disruption. They suggest that failed interventions can be used as markers of activation of core structures or schemas, and that " chronic or delayed grief may also indicate resistance to working through the grief process that is related to fundamental, self-related meaning structures" (1991:152).

3.5.2 Trauma Focussed Cognitive Therapy

Research on PTSD shows two elements as essential in effective treatment of trauma, confrontation and cognitive reappraisal. The task of the therapist is to assist the individual to forgo avoidance and to confront the trauma through the use of approach avoidance techniques, whilst the challenge to core schemas occurring as a consequence of a loss of significance will require some cognitive reconstruction of meaning (Rando, 1993; Janoff-Bulman, 1992).

If the task of cognitive reconstruction necessitates the reformulation of assumptions in order for assimilation to occur, then the use of strategies designed to minimise the difference between what was believed before and what has been experienced subsequently will be required, so as to maximise the possibility of rediscovering meaningfulness (Janoff-Bulman, 1992). Strategies suggested as helpful in assisting rebuilding of assumptions include making comparison between the personal experience of trauma and real or imagined experiences of others, interpretation of personal role in the experience, including aspects of self-blame, and re-evaluation of the event in terms of meaning and purpose.

Using a trauma-focussed approach to grief treatment, Shear et al (2001/2002) have developed a new treatment approach, broader than a phobic model, as is recommended by Horowitz et al (1984). This treatment targets features of both traumatic distress and separation anxiety and combines both cognitive behavioural and interpersonal strategies to address the distress arising out of the traumatic experience of separation (Frank, et al, 1997; Shear & Frank, 1998; Shear et al, 2001, 2002). Using a variant of Foa's (1995) model of treatment for PTSD, the piloted program consists of a four month protocol targeting grief symptoms directly. It focuses upon confrontation of traumatic aspects of the loss and uses in vivo exposure to avoided cues. It differs from the behavioural studies of Mawson and of Sireling by an emphasis upon imaginal exposure to feared aspects of memory. The use of this technique has illustrated the presence of trauma distress, as more feared aspects of the trauma are uncovered with each retelling of the experience. This observation has led the group to identify grief as an adult form of separation anxiety. Consequently, treatment involving a leave taking component is also recommended. Other treatment strategies include cognitive strategies to facilitate reattribution, training in emotion management skills, and educational strategies for coping and mitigating the features of traumatic distress and separation anxiety. Whilst there are no objective data on the outcome of this approach, the group argue that consistent with Foa's findings, re-experiencing and exposure can lead to a reduction in symptoms of distress. At present, a randomised controlled trial is underway in order to confirm the efficacy of this approach. It should be noted that whilst there is a strong emphasis yet again in this

model on the behavioural component, there is also recognition of the importance of meaning reconstruction through the use of cognitive restructuring techniques.

3.5.3 An Integrative Cognitive Treatment Model

Kavanagh (1990) proposes an integrative treatment model, encouraging cognitive exploration and moderation of depressed response through building upon existing skills and encouraging self-management. Based on Mawson et als (1981) guided mourning model, the repeated confrontation of stimuli associated with loss is encouraged until affect diminishes. In keeping with the recommendations of Powers and Wampole (1994), treatment is designed to facilitate the development of self-efficacy and to control the extent of depressive rumination. Attention control is taught as a stress coping skill aimed at desensitisation and promotion of access to positive memories. Cognitive strategies are used to elucidate hidden meanings acting as inhibitors to processing, solution focussed action plans are developed and graduated social reintegration is encouraged. This comprehensive approach targets those elements identified in literature as influential in grief response. Here, grief is viewed very much as a challenge to the adaptive capacities of the individual. With this emphasis, the approach differentiates itself from the more traditional dynamic approaches of Horowitz (1984a/b) and Raphael(1975), emphasising the development of insight and the role of defensive behaviour. It also differs from the approach of Sireling et al (1988) by the legitimation of controlled distraction and the inclusion of cognitive strategies. Rumination rather than avoidance is identified as a central constituent of complicated grief.

Can an approach such as this address the element of separation anxiety which is now recognised as a core constituent of grief? In other words, can the complexity of complicated grief be effectively addressed through the combination of guided mourning, a cognitive search for meaning and a planned behavioural program of action? Whilst proposing an integrative model, Kavanagh's emphasis is primarily upon the depression induced by loss and it is important here to note those findings which clearly distinguish grief from depression. For example, Pasternak et al (1993) have reported that it is possible to see a remission in symptoms of depression without any change occurring in grief intensity. If grief exists as a separate entity, then can a

model which primarily emphasises strategies designed to alleviate depression, address it's specific characteristics? Is it all a matter of definition? It is worth noting that Shear's (2001) treatment model, with it's emphasis on imaginal reliving, saying goodbye to the dead and in vivo exposure, does not appear substantially different from the approach of Kavanagh. Both Kavanagh and Shear emphasise that avoidance is not primary, but both give attention to that which is avoided or withdrawn from as a consequence of loss. Both also use cognitive strategies to facilitate meaning reappraisal. If a model of treatment is to meet the challenge, it does appear to require elements targeting a resumption of re-engagement and the confrontation of cognitive or affective impediments to this, which the exploration of meaning encapsulates. Unfortunately, there are no studies available which report scientific findings indicating the effectiveness of either of these approaches, although a controlled study is underway at this time (Shear et al, 2001, 2002).

3.6 Group Psychotherapy

Given the interpersonal and shared nature of many of the problems of the bereaved, a group psychotherapeutic approach has been used by a number of clinicians.
Murphy et al (1998) implemented a brief ten week psychotherapy intervention for a group of highly distressed bereaved parents, four months after the death of a child. They targeted post traumatic stress symptoms, mental distress, delayed loss reactions, deteriorating physical health and marital role strain, using a program of information and skill building, and the building of emotion-focused and problem-focused coping strategies. No benefit was demonstrated for the combined group of females and males, although there was a significant effect for mothers with high levels of distress.

Lieberman and Yalom (1988) undertook research to establish whether preventative therapeutic intervention might benefit the majority of bereaved spouses Thirty-six individuals received eight sessions of group psychotherapy. Rationale for a group treatment was the interpersonal nature of common shared issues of the bereaved. Four outcome areas were examined, two reflecting traditional psychotherapy outcomes (mental health and mourning) and two associated with psychological and social areas known to be affected by spousal bereavement (positive psychological states and social

adjustment). Whilst group members showed increased self esteem (positive psychological state) and decreased role strain (social adjustment) in relation to controls, no significant differences were found for mental health or mourning in the treatment groups. The authors conclude that brief psychotherapeutic intervention may be of limited benefit for the majority of those bereaved, though the question remains as to whether intervention might be effective for bereaved who seek out assistance or who manifest serious pathology (Lieberman & Yalom, 1988; Yalom & Vinogradov, 1988).

There is some question of whether different approaches are more suited to different individuals. Given the variation in response patterns to bereavement, and the types of losses experienced, should interventions be tailored to individuals? In Marmer et Al's (1988) study, they noted a greater attrition rate for group rather than individual treatment, and have linked this to the treatment condition itself. They have pointed out that in individual treatment, the therapist can tailor treatment to the phase-specific needs of the individual and can create a greater sense of safety within which to regulate exposure to conflict-laden and anxiety themes.

3.7 Review of Outcome Studies of Clinical Interventions with the Bereaved

Outcome studies of grief therapy have not yielded consistent results. There are surprisingly few reports of controlled studies of intervention with the bereaved, and the studies that do exist have shown mixed results. One reason for this may be that bereavement is a self–limiting condition with progressive improvement over time expected for the majority of survivors (Lieberman & Yalom,1992; Allumbaugh & Hoyt,1999). This creates difficulty in measuring effects and suggests that for the contribution of therapy to show significance, either clinically or statistically, particularly powerful effects might be necessary. So far, such effects have not been evident. Researchers acknowledge however, that due to a variety of methodological factors, such as the variable statistical power of available studies, lack of reliable or appropriate measures, the limited number of studies available, the failure to measure against controls, and to high attrition and low recruitment rates, it is difficult to evaluate the efficacy of intervention in this area (Lieberman & Yalom, 1992; Jacobs

& Prigerson, 2000; Neimeyer & Hogan, 2001; Neimeyer 2000). Failure to use therapeutic interventions grounded in specific theories, or which are grounded in the theoretical framework of stage theories of grief, may also lead to questionable effects (Corr, 1993).

In a meta-analysis of the effectiveness of grief therapy, Allumbaum and Hoyt (1999) examined 35 outcome studies which used a number of different therapeutic approaches. In addition, they examined the impact of a number of moderator variables linked to effectiveness. These variables included characteristics of the interventions, of the clients, and of design features of the studies involved. Findings indicate a relationship between number of treatment sessions and effect size, suggesting that the greater the number of sessions, the greater the effect size. Client age was also a significant factor, with clients in the intermediate age range faring better than those at either end of the scale. Length of time since bereavement was shown to effect outcome, with an inverse relationship existing between onset and efficacy of treatment, indicating that for treatment to be successful, timing is important. Recruitment method also appeared influential, with higher motivation to change noted among those seeking treatment, who were also more distressed and more at risk of complicated bereavement. Heterogeneous relationships with the deceased seemed to yield greater effect size than homogeneity, again reflecting how an artificial grouping of people changes the normal conditions found in other natural or scientific groupings. Whilst this study offers a detailed quantitative review of grief interventions, inclusion of uncontrolled one-group studies raises uncertainty regarding reported efficacy of some of the reported interventions (Neimeyer, 2000).

Kato and Mann (1999) have reviewed eight studies of the effects of group therapy on adjustment to loss. Most were support groups but a few focussed on consciousness raising or cognitive restructuring. Only two, the Constantino (1988) and the Polensky (1990) studies (cited in Kato & Mann) showed any positive effects. The study of a support group for widows by Polinsky showed consistent beneficial effects following treatment. The intervention consisted of educational components including relaxation training, counselling, journal writing and the creation of a memorial to the deceased. Three other studies reviewed, which used similar interventions, failed to demonstrate similar effects. The Constantino study compared a support group to a social activities

group and a control group. Positive effects were shown for the group receiving social support. A study by Walls and Meyers (1985) also cited and reviewed, found no effects for three different types of bereavement interventions, cognitive restructuring, support and a behaviour skills training.

Neimeyer (2000:543) has criticised this review due to a reliance on " impressionistic evaluations of outcome" and it's use of only a small subset of available studies. On the basis of a review of scientifically valid outcome studies of grief interventions between 1975 and 1998, 23 in all, he has concluded that there is evidence of only a small effect size for these (Fortner and Neimeyer1999, cited in Neimeyer, 2000). He argues that few studies measure grief per se, instead assessing outcome on measures of anxiety, depression, health or psychiatric distress, and that those who have measured grief have used measures which have not been validated. The results of Neimeyer's review are sobering in that only 45% of individuals who received an intervention were better off, and nearly 38% were worse off than had they not received treatment, with effect size found to be unrelated to length of treatment, and outcome to type of therapy. Even where positive effect was noted, it was found to be half as robust as that found in psychosocial interventions for other areas, such in the treatment of depression or anxiety. Neimeyer questions whether it is ever possible to relieve symptoms of bereavement. Can time alone heal, or do the interventions simply lack enough power to address the extent and intensity of pain and distress suffered by the bereaved? He suggests that the interventions most likely to have some success are those which target individuals presenting with high distress or on the basis of elevated risk factors, noting that only studies targeting sudden, traumatic or chronic grief have shown any significant positive effect.

3.8 Summary

In conclusion, the studies reviewed, which broadly reflect traditional conceptualisations of grief, demonstrate that treatments of grief so far have shown only a small effect size. The use of a behavioural model has demonstrated a reduction in anxiety symptoms and certainly appears integral to the treatment of grief. The adoption of a psychodynamic approach has in a few cases been shown to facilitate

adjustment, as has the provision of social support, education and stress management training. New cognitive models have adopted a more integrated approach to the treatment of specific grief symptoms, but the efficacy of these models has yet to be established. Indeed, it appears that there may be difficulties in the evaluation of grief treatments that relate to the inherent characteristics of the grief process itself.

The complexity of the area is obvious. Not only are there numerous pathways to recovery, there is also enormous variability in the idiosyncratic manner in which resolution is accomplished (Stroebe and Stroebe, 1991). However, if the challenge to the bereaved is to reconstruct meaning, and if most interventions have so far failed to target this component, then it is not surprising if effect size is small. What may be needed in the words of Neimeyer (1998), is a new wave of grief theory and grief treatments which can address these dilemmas.

3.9 Development of a Treatment Intervention

Based on findings from the above review, the following study has adopted a cognitive approach to the treatment of complicated grief developed by this author, which derives from the cognitive formulation of grief outlined in Chapter 2, Figure 1. It reflects elements common to the models of Shear et al (2001), Kavanagh (1990) and Mawson et al (1981), is informed by the model of PTSD identified by Clark and Ehlers (2000), and will be grounded in the conceptualisations of Janoff-Bulman(1992) and Neimeyer (2000), whose emphasis on meaning reconstruction appears integral to any treatment intervention.

Using a method of quantitative analysis, the study will pose the following questions:

1. Can cognitive therapy successfully reduce the symptoms of complicated grief?

2. Can the gains achieved as a consequence of group CBT for complicated grief be maintained following dissolution of the group?

3. Using qualitative analysis, participants will be asked to evaluate the program with regard to change in grief experience, quality of the program, change in attitude, skills gained and helpful features of the program.

4. Fundamental to the working of the cognitive model is the exploration of meaning. Therefore, using clinical observation, the following question will be addressed: Is reconstruction of meaning necessary for the resolution of complicated grief? However, given the confidential nature of clinical observation, the exploration of this component will be developed in a discussion rather than in a formal results section.

Chapter 4
Methodology

4.1 Research Design

The design used in the current study was a mixed model complex design in which two independent variables were studied in order to address research questions 1 and 2 (as outlined on page 45). In this study, the first independent variable was the group to which participants were randomly assigned. This was as follows: The experimental group receiving the intervention, and a control group awaiting the intervention. This independent variable represents the (I.G.D.) independent group design factor within the research.

The second independent variable was time, where each participant was tested on three separate occasions. The independent variable of time represents the within subjects design factor (WSD**).** Thus, the model mixed both the IGD and the WSD, resulting in a mixed model complex design.

Dependent variables under study were as follows:
Anxiety, as measured by the BAI (Beck 1988).
Depression, as measured by the BDI-11 (Beck et al, 1979).
Complicated Grief, as measured by the ICG (Prigerson, 1995).

The appropriate analysis to test changes in the dependent variables as a function of two independent variables is a 2x3 repeated ANOVA, or analysis of variance. The design for this has two levels:

Design one consists of a 2x2 ANOVA in which the independent variables are tested at two time periods, pre treatment and post treatment. The purpose of this design is to test the efficacy of the treatment intervention. It was hypothesised that the treatment group would benefit from treatment by a reduction in symptoms of grief, depression and anxiety, whereas the waiting list control group would not be expected to show any change in psychological profile.

Table 3 Design 1

Treatment group	Pre	Post
Control group	Pre	Post

Design two is a 2x3 ANOVA, in which participants are tested at three time levels, pre treatment, post treatment and at time of follow up. The waiting list control group are offered the treatment intervention following completion of the program by the treatment group (T1). This design has two main aims:

(1) To look at the effect of treatment over time to establish whether any gains made have been maintained.

(2) To look at the integrity or ecological validity of the program. It is anticipated that if the treatment program is delivered in the same way to both groups, changes will be equal at time of follow up.

Table 4 Design 2

Treatment 1	Pre	Post	Follow-up
Treatment 2	Pre	Post	Follow-up

In a complex design, the two independent variables are combined factorially so as to enable the effect of each of the independent variables to be determined. The overall effect or source of variation of an independent variable in a complex design is called a main effect. The means for a main effect represent the overall performance at each level of a particular independent variable which is collapsed across the levels of the other independent variable.

There are three sources of variation in a 2 way ANOVA, known as systematic variations. One source of variation is due to group assignment (main effect). The second source of variation is due to time (main effect). The third source of variation

is due to the interaction between group and time and is known as a higher order effect. There is a further additional source of variation that is a random or error variation. Together, these add up to the total variation. Results will be interpreted in terms of higher (interaction) and lower order (main) effects.

4.2 Participants

The participants in this study were drawn from three sources: (1) from a hospice waiting list of bereaved individuals who had requested therapy and who were identified as possibly being at risk of complicated bereavement on the basis of established 'at risk' indices, and (2) who were referred by members of the hospice social work team with responsibility for bereavement follow up. The participants were then randomly allocated to a treatment and control group, each of which consisted of six members.

4.3 Inclusion Criteria

Criteria for inclusion in this study were:

- Adult
- Female
- Bereaved for longer than nine months
- Deemed to be capable of verbally interacting with others
- Non suicidal,
- Not receiving Psychiatric treatment
- Suffering symptoms of complicated grief, as assessed by a score of 25 or more on the ICG.
- Willing to participate in the program
- Patients who were not deemed to be suitable on the basis of these criteria were dealt with as part of the normal waiting list.

Table 5 provides a summary of demographic characteristics of the sample characteristics.

Table 5 Demographic characteristics

Descriptive Statistics

	N	Minimum	Maximum	Mean
Age (in years)	12	32	73	52.83
Duration in bereavement (in months)	12	12	216	59.33

4.4 Sampling Considerations.

Given that the participants of this study were not randomly selected, but were identified primarily on the basis of clinical assessment of likely at risk indices, this may have implications for how results are interpreted. In all cases, the participants contacted and interviewed were eager to participate in the program. They may not therefore be fully representative of the population of those with complicated grief.

4.5 Ethical considerations

Approval for the study was obtained from the relevant ethics committee, and also from the hospice research committee, prior to the commencement of the study. Informed consent was obtained from all participants in the study and a confidentiality agreement signed. A copy of sample consent form, and ethical approval are contained in Appendices H and I.

4.6 Procedure

Following referral or identification from the waiting list, participants were telephoned by the researcher to establish whether they were in need of a bereavement service. On the basis of an initial discussion, those who were experiencing obvious difficulty with their bereavement were invited to an interview. Potential participants were informed

that the purpose of the interview would be to establish their suitability for inclusion in the group program, and informed that if either the interviewer or the interviewee decided that the program was not appropriate, an alternative service would be offered to them. Subsequently, each participant was interviewed to assess suitability, to gather necessary background information and establish baseline measures. Interviews covered both qualitative and quantitative factors.

Prior to the intervention, suitable facilities, and refreshment arrangements were negotiated.

4.7 Instruments

A total of 3 instruments were used in the collection of data and the raw scores were used in the analysis of data. Table 6 summarises these instruments.

Table 6 Instruments

1.Beck Depression Inventory (BDI) developed by Beck et al (1979)
2. Beck Anxiety Inventory (BAI) developed by Beck et al (1988)
3.Inventory of Complicated Grief (ICG) developed by Prigerson et al (1995)

4.7.1 Beck Depression Inventory-11

The BDI is a 21-item self-report rating inventory, measuring characteristic attitudes and symptoms of depression (Beck et al, 1979). Respondents are asked to choose the statement that best describes how they have felt over the past week. Each question scores 0-3, with a maximum possible summation of 63 points. Scores may be

interpreted as follows; 0-9, normal range; 10-15, mild depression; 16-19, mild-moderate depression; 20-29, moderate – severe; 30-63, severe depression.
The original version of the BDI was introduced by Beck et al in 1961 and was revised in 1979. Both the original and the revised versions have been found to be highly correlated, measuring within one point of each other for the same variables (Beck et al, 1996). Appendix B contains a copy BDI-11 (Beck, 1996)

Reliability:

Internal consistency for the BDI ranges from .73 to .92 with a mean of .86 (Beck et al, 1988). The BDI demonstrates high internal consistency, with alpha coefficients of .86 and .81 for psychiatric and non- psychiatric populations respectively.

Split-half / Chronbach's Alpha: The BDI has a split-half reliability co-efficient of .93. Test retest reliabilities have been shown to range from .48 to .86, depending on the interval between re-testing and the type of population (Groth-Marnat, 1990).

Validity:

Correlations with clinician ratings of depression range from .62 to .66. Clinical ratings for psychiatric patients are reported as moderate to high, ranging from .55 to .96. Groth-Marnet has reported moderate correlations between the revised BDI and other scales measuring depression, such as the Hamilton Psychiatric Rating Scale for Depression (.76), (Brown, Schulberg & Madonia, 1995).

4.7.2 Beck Anxiety Inventory

Known as the BAI, the Beck Anxiety Inventory is a 21- item self-report instrument designed to measure the severity of physiological and cognitive symptoms of anxiety and to discriminate anxiety from depression (Beck, Epstein, Brown and Steer, 1988).
The respondent is asked to rate how much he or she has been bothered by each symptom over the past week on a 4-point scale ranging from 0 (not at all) to 3 (Severely -could barely stand it). Scores may be interpreted as follows; 0 – 7, minimal anxiety; 8 – 15, mild anxiety; 16 – 25, moderate anxiety, 26-63, severe anxiety.

Reliability:

The scale has obtained high internal consistency and item-total correlations ranging from **.**30 to .71(median = .60). The average reliability coefficient of the BAI is .92 with test-retest reliability measuring .75.

Validity:

The correlations of the BAI with a set of self- report and clinician-rated scales have been found to be significant. The correlation of the BAI with the HARS-R and HRSD-R is .51 and .25, respectively. The correlation of the BAI with the BDI is .48. Convergent and discriminant validity to discriminate homogenous and heterogeneous diagnostic groups were ascertained from three studies. The results confirm the presence of these validities. Appendix C contains a copy of BAI (1990).

4.7.3 Inventory of Complicated Grief

This is a 19-item assessment scale developed for the purpose of discriminating the symptoms of complicated grief from those of bereavement-related depression and anxiety (Prigerson et al, 1995). Respondents are asked to choose the statement that best describes the way they feel at the present time. Responses consist of the points: never, rarely, sometimes, often or always, corresponding to scores 0-4, with a possible total score of 76. Data were derived from 97 conjugally bereaved elderly individuals who completed the ICG, along with other self-report scales, measuring grief, depression and background characteristics. Factor analysis indicates that the ICG measures a single underlying construct of complicated grief. A score higher than 25 on this scale has been found to be predict several types of enduring functional impairment.

Reliability:

The scale has obtained high internal consistency, with Cronbach's alpha of .94.

Test- retest reliability is .80 over 6 months of bereavement (Prigerson, 1995).

Validity:

The concurrent validity of the ICG has been assessed in relation to other scales and has shown a fairly high association with the BDI total score ($r=0.67$, $p < 0.0001$). The correlation of the ICG with the TRIG Part 11 (Texas Inventory of Grief) is

(.87; P < 0.0001). Whilst TRIG has been shown to better discriminate between good and poor outcome, the ICG has performed better at differentiating individuals with a wide range of functional impairments. Appendix A contains a copy of ICG (1995).

4.8 Data Analysis Procedure

The Statistical Package for the Social Sciences (SPSS for Windows Version11) was used to statistically analyse the data.

4.9 Qualitative Analysis

The qualitative component to this research aimed to examine question 3 (as outlined on page 45). Data for this were collected both at assessment stage prior to treatment, during the treatment program and in a questionnaire issued at the end of the program. The questionnaire was designed to identify those elements of the program experienced as helpful by participants. It was also designed to establish whether any change had taken place as a result of the intervention, in the view of the participants. Clinical observations of group process were recorded and used to further support the qualitative analysis.

4.10 Group Treatment Intervention

The program targeted the following areas:

1. Idiosyncratic meanings of the loss experience.
2. Factors maintaining complicated grief, i.e. Avoidance and rumination.
3. Unresolved issues blocking resolution.
4. Lack of social support.
5. Self esteem.

4.11 Treatment Intervention Goals

1. To facilitate exploration of idiosyncratic meanings of loss.

2. To provide members with a structure within which unresolved issues relating to their loss experience could be processed at cognitive and affective levels.
3. To use the group as a mirror for members, in which maladaptive cognitive and behavioural patterns maintaining grief could be reflected back within a safe environment.
4. To raise awareness of the potential for alternative cognitive and behavioural responses to loss.
5. To use the support of the group to develop realistic goals and to try out new behaviours, both within and outside the group.
6. To facilitate personal growth by encouraging members to take active responsibility for their lives.

4.12 Treatment Procedure

A cognitive behavioural treatment program was designed and two groups (n=6) were selected and treated, using the same intervention. The author facilitated the therapy sessions, accompanied by a co-facilitator, who acted as recorder. Sessions were of one and a half hours duration and refreshments were served prior to commencement of therapy. The treatment group participated in an 8 week cognitive therapy treatment program, followed by a one month follow up session. The control group then received the intervention. Assessment measures were given to participants at pre, post and one month follow up. The objectives, format and material for each session were planned in advance, and modified according to the demands of group process. Following each session, a debriefing meeting took place in which group process was discussed and recordings made. Throughout the program, participants were issued with written materials including agreed homework assignments, information on coping with bereavement and on basic cognitive strategies. At the conclusion of the program, participants were given a feedback questionnaire and asked to return it to the researcher, following completion.

4.13 Treatment Program

A cognitive formulation of grief was developed in which idiosyncratic meanings of the loss experience were identified along with factors maintaining grief. Goals were

operationalised and the processing of obstacles to resolution commenced. This was accompanied by individually crafted behavioural experiments. Facilitation of meaning reconstruction was achieved through focus upon the legacy of the deceased and the life of the survivor, as recommended in the literature (Neimeyer,1989,2000; Fleming and Robinson, 1991). The program used elements of the guided mourning approach recommended by Mawson et al (1981) and the use of a leave taking ritual. The use of the interpersonal dynamic of the group was the primary therapeutic tool through which cognitive assumptions were challenged and reappraisal facilitated. The group process was used as a tool through which social support could be marshalled and resilience highlighted and encouraged. The therapeutic process was supported by the use of homework assignments, help sheets and journaling, as recommended in CBT literature.

Appendix L contains summary reports of the objectives, goals and content of the treatment modules.

Chapter 5
Analysis of Results

This study had both a quantitative and qualitative component. The results of the qualitative component will be presented in Section 5.6 of this chapter.

5.1 Quantitative Analysis

Quantitative data analysis was conducted through the use of statistical tests, as follows:
(1) Reliability analysis of measures used.
(2) Independent t-tests to measure group equivalence.
(3) A 2x2 repeated ANOVA to measure intervention effect. This yielded a between subjects and within subjects design factor.
(4) A 2x3 ANOVA repeated measures analysis assessed the effect of the intervention cross three time periods.

Three dependent variables were utilised using parametric techniques. The BDI reflected changes in depression, the BAI measured changes in anxiety and the ICG measured changes in symptoms of complicated grief.

5.2 Reliability Analysis

Cronbach's alpha coefficients were calculated for two of the three scales used in the study, in order to determine the reliability of these measures. The BDI has well established consistency and validity and a Cronbach's alpha coefficent was therefore not calculated with respect to it.

The ICG is reported by Prigerson et al (1995) to have good internal consistency with a Cronbach's alpha coefficent of .94. In the current study, the Cronbach's alpha coefficent was .704 with an alpha level exceeding the overall acceptable alpha level of > .70. The scale can therefore be considered reliable for this study.

According to Beck, Epstein, Brown and Steer (1988), the BAI has high internal consistency, with an average reliability coefficient of .92, and a test-retest reliability measuring .75. In the current study, Cronbach's alpha coefficent was found to be .8250, thus exceeding the acceptable alpha level of >.70.

5.3 Independent t-tests.

Independent t-tests were carried out in order to check for group equivalence prior to treatment. Unless equivalent at this stage, it would be difficult to attribute change at post treatment stage to the intervention. Table 7 outlines results of the comparison of mean scores for depression, anxiety and grief, prior to treatment intervention.

Table 7 Means and Standard Deviations for Depression (BDI), Anxiety (BAI) and Complicated Grief (ICG)

Group		N	Mean	Std.Deviation	Std.Error Mean
BDI time 1	treatment group	6	24.33	14.431	5.892
	control group	6	27.67	11.978	4.890
ICG time 1	treatment group	6	46.00	12.649	5.164
	control group	6	45.00	7.043	2.875
BAI time 1	treatment group	6	9.00	4.147	1.693
	control group	6	16.17	9.196	3.754

Homogeniety of variance was observed for BDI and BAI but not for ICG. Thus for ICG, df are adjusted. The t-test analyses observed no differences between the groups prior to intervention and thus group equivalence has been established.
Table 8 outlines the results of the independent t-tests.

Table 8 Independent Samples Test

	Levene's Test for Equality of Variances		t-test for equality of means		
	F	Sig	t	df	Sig. (2-tailed)
BDI time 1 equal variance assumed	.844	.380	-.435	10	.673
ICG time 1 equal variance not assumed		.031	.169	7.828	.870
BAI time 1 equal variance assumed	2.524	.143	-1.740	10	.112

5.4 Design 1

The 3 variables analysed for group equivalence served as the main variables for analysis, to determine whether change had occurred in the treatment group. The independent variables were the group (T/C) and time of testing (Pre / Post Treatment). The analysis used was a 2x2 repeated ANOVA.

5.4.1 Variable 1: Depression

The first variable to be analysed was depression, as measured by the BDI.
Results of the 2x2 repeated ANOVA are contained in Appendix D.

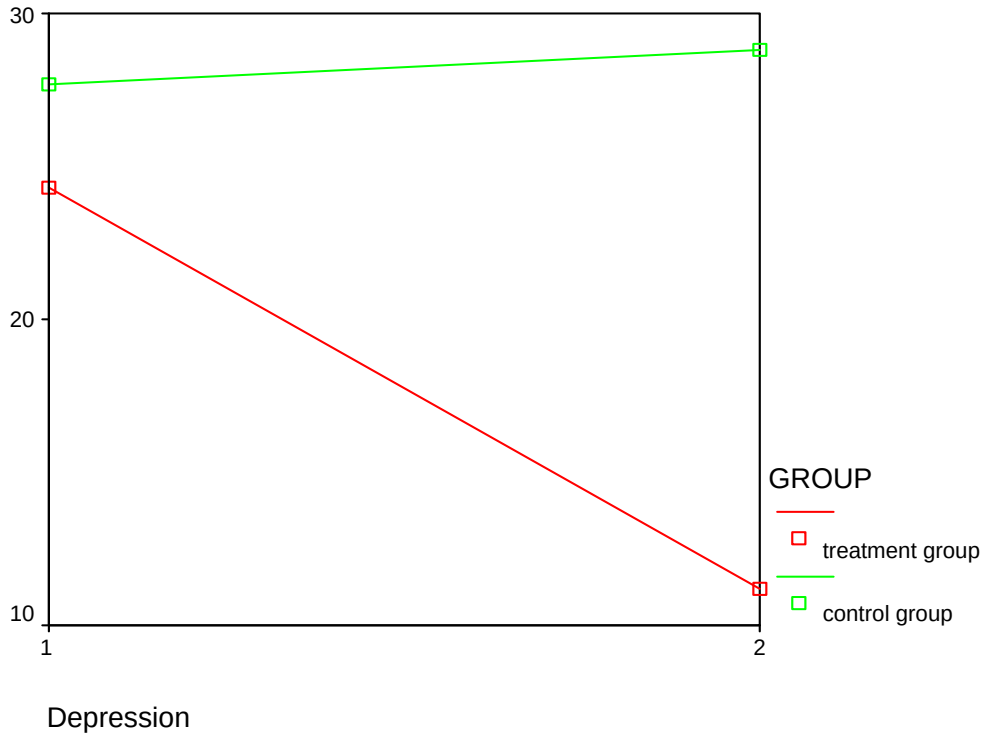

Figure 2 Profile of Depression Changes over Time

The results of the 2X2 repeated ANOVA demonstrated a significant interaction between treatment type and time; ($F = 6.702$; $df = 1, 10$; $p < .05$). In order to locate the source of the interaction, four tests of simple effects were carried out. The first test was to establish whether there were differences between the treatment conditions at pre stage. The treatment conditions were shown not to differ before the treatment began ($F = 0.727$; df = I, 10; $p > .05$). This is in line with the results of the t-test of group equivalence implemented prior to the commencement of treatment.

The second test was to establish if treatment differences existed between the groups post intervention. A significant difference between conditions was observed at time of post testing ($F = 42.512$; $df = 1, 10$; $p < .05$), where the control group had significantly higher levels of depression when compared to the treatment group.

The third test was to establish whether the treatment group differed between the two treatment conditions. The results indicate that there was a significant change between the two treatment conditions ($F = 11.289$; $df = 1,10$; $p < .05$), with depression scores

significantly reduced between times of testing. This indicates that the treatment intervention had a positive impact. (See Figure 2 for profile plot of depression measures across two treatment conditions for the treatment Group (T1) and Control Group (CG). The fourth test was to establish whether there were differences between times of testing for the control group. Given the positive impact of the intervention upon the treatment group, the control group would not be expected to demonstrate a similar change. Results indicated that the control group did not change between treatment conditions ($F = .087$; $df = 1, 10$; $p > .05$). This therefore indicates that the reduction in depression levels observed for the treatment group can be attributed to the positive impact of the intervention. Given that the higher order effect was significant, lower order effects (main effects) are not reported. See Table 9 for mean and standard deviation differences across time.

Table 9 Changes in Mean and Standard Deviation Scores for Depression Across 2 Time Periods

Group		Mean	Std. Deviation	N
BDI time 1	treatment group	24.33	14.431	6
	control group	27.67	11.978	6
	Total	26.00	12.764	12
BDI time 2	treatment group	11.17	9.411	6
	control group	28.83	11.143	6
	Total	20.00	13.484	12

5.4.2 Variable 2: Anxiety

The second variable to be analysed was anxiety, as measured by the BAI.

Results of the 2x2 ANOVA are contained in Appendix E.

There was no interaction between group and time of testing for this variable ($F = 2.064$; $df = 1,10$; $p > .05$). Anxiety was not found to change pre to post testing ($F = .096$; $df = 1,10$; $p = > .05$). There was a significant effect observed for the independent variable of group ($F = 8.529$; $df = 1,10$; $p = .05$), indicating that the groups differed in

terms of their level of anxiety where the control group overall had higher levels of anxiety. See Table 10 for mean and standard deviation measures of anxiety across two treatment conditions.

Table 10 Changes in Mean and Standard Deviation Scores for Anxiety Across 2 Time Periods

Group	Mean	Std. Deviation	N
BAI time 1 treatment group	8.50	4.848	6
control group	15.83	9.475	6
Total	12.17	8.133	12
BAI time 2 treatment group	3.33	3.077	6
control group	19.17	12.024	6
Total	11.25	11.764	12

5.4.3 Variable 3: Grief

The third variable to be analysed was grief. Results of the 2x2 repeated ANOVA are contained in Appendix F.

A significant interaction was observed between treatment type and time of testing for the variable of complicated grief ($F = 15.509$; $df = 1,10$; $p < .05$), indicating a significant higher order effect. Given this interaction, tests of simple effects were carried out to locate the source of interaction. The first test established that the treatment conditions did not differ at time of testing, as previously demonstrated by the t-test performed prior to treatment commencement ($F = .016$; $df = 1, 10$; $p > .05$). Using the test of simple effects, a significant difference between conditions was observed at time of post testing ($F = 29.544$; $df = 1,10$; $p < .05$), where the control group had significantly higher levels of grief when compared to the treatment group. See Figure 4 for profile of complicated grief measures for the groups Treatment Group (T1) and Control group (CG) across two treatment conditions.

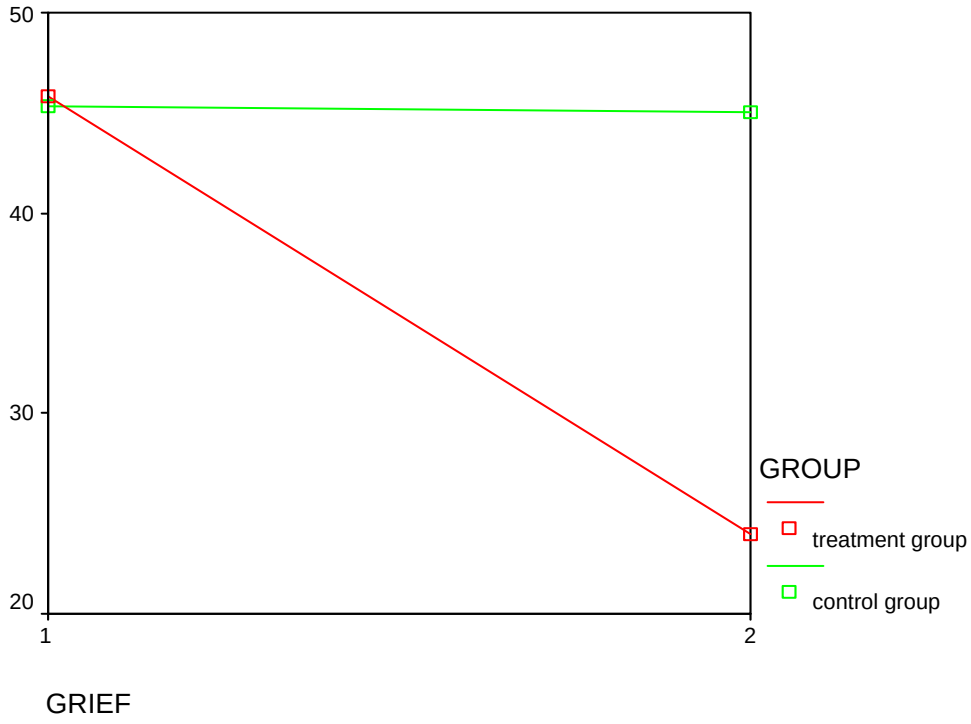

Figure 3 Profile of Changes in Complicated Grief over Time

The third test was to establish whether the treatment group differed across treatment conditions. A significant difference was observed ($F = 31.98$; $df = 1,10$; $p < .05$). Thus the intervention had a positive impact upon complicated grief levels The final test of simple effects demonstrated that there was no change between times of testing for the control group ($F = .737$; $df = 1,10$; $p > .05$). See Table11 for mean and standard deviation differences in ICG measures across time.

This concludes the findings of Design 1 of this intervention.

Table 11 Changes in Mean and Standard Deviation Scores for Complicated Grief Across 2 Time Periods

Group		Mean	Std. Deviation	N
ICG time 1	treatment group	45.83	12.057	6
	control group	45.33	7.146	6
	Total	45.58	9.453	12
ICG time 2	treatment group	24.00	3.225	6
	control group	45.00	5.514	6
	Total	34.50	11.782	12

5.5 Design 2

The waiting list control group were treated for complicated grief as per treatment group(T1). A 2X3 repeated measures ANOVA was then conducted to assess the impact of the intervention upon this group (T2) and to compare the results of the intervention with those of the first treatment group across three time periods (Pre, Post and Follow up).

5.5.1 Variable 1: Depression

The first variable to be analysed was depression (see Appendix D). The results from the 2X3 repeated ANOVA which tested for treatment and time effects found no significant interaction between the independent variables of time and group ($F = 0.733$; $df = 2,20$; $p > .05$). Figure 4 presents a profile of changes across time for both groups, T1 and T2. A significant change in depression over time was observed ($F = 9.99$; $df = 2.20$; $p < .05$).

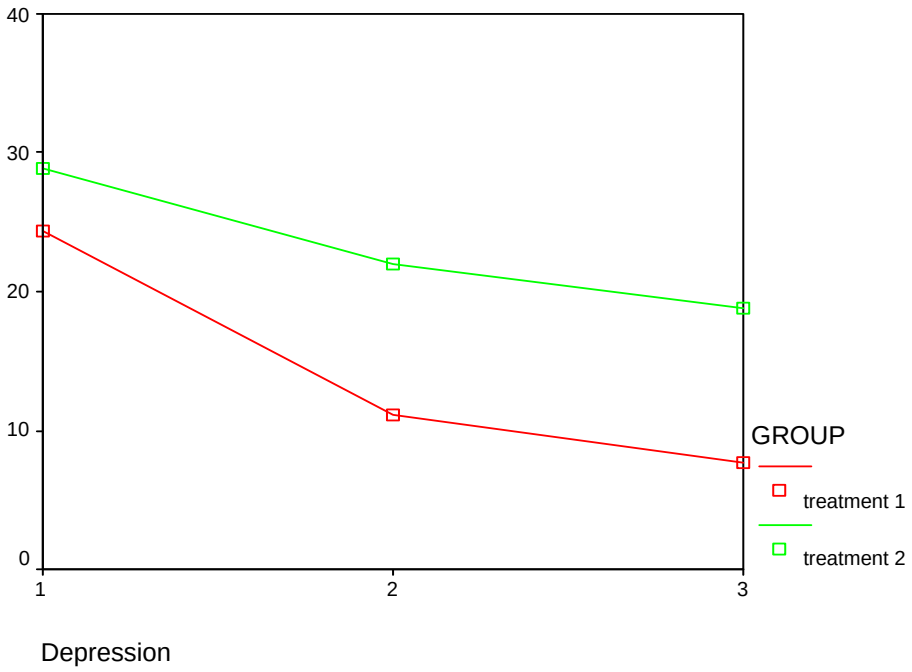

Figure 4 Changes in Depression Across Time

It can be observed from Figure 4 that the linear change observed can be seen for both treated groups (F = 11.923; df = 1,10; p = >.05). Thus the impact of the intervention is parallel over time. This demonstrates the positive impact of the intervention. Overall, the two treatment groups were not found to differ (F = 2.261; df = 1,10; p > .05). Table 12 presents mean and standard deviation scores across three treatment conditions.

Table 12 Changes Across 3 Time Periods in Mean and Standard Deviation Scores for Depression

Group		Mean	Std. Deviation	N
BDI time 1	treatment 1	24.33	14.431	6
	treatment 2	28.83	11.143	6
	Total	26.58	12.515	12
BDI time 2	treatment 1	11.17	9.411	6
	treatment 2	22.00	13.609	6
	Total	16.58	12.508	12
BDI time 3	treatment 1	7.67	7.421	6
	treatment 2	18.83	13.819	6
	Total	13.25	12.076	12

5.5.2 Variable 2: Anxiety

Analysis of results for the variable of anxiety demonstrated no interaction between group and time of testing (F = 1.884; df = 2,20; p = > .05). There was no change in anxiety levels across the times of testing (F = .446; df = 2,20; p= >.05).
(See Appendix E).
There was however a significant effect noted for group (F = 8.107; df =1, 10; p< .05) indicating that anxiety levels for T2 were significantly higher than for T1. Mean and standard deviation across three time periods are outlined in Table 13.

Table 13 Changes Across 3 Time Periods in Mean and Standard Deviation Scores for Anxiety

Group		Mean	Std. Deviation	N
BAI time 1	treatment 1	9.00	4.147	6
	treatment 2	19.17	12.024	6
	Total	14.08	10.086	12
BAI time 2	treatment 1	3.33	3.077	6
	treatment 2	21.17	11.923	6
	Total	12.25	12.476	12
BAI time 3	treatment 1	4.83	4.622	6
	treatment 2	20.50	15.333	6
	Total	12.67	13.547	12

5.5.3 Variable 3: Complicated Grief

The third variable to be analysed was complicated grief. Figure 5 contains a profile plot of estimated marginal means for both groups across three treatment conditions.

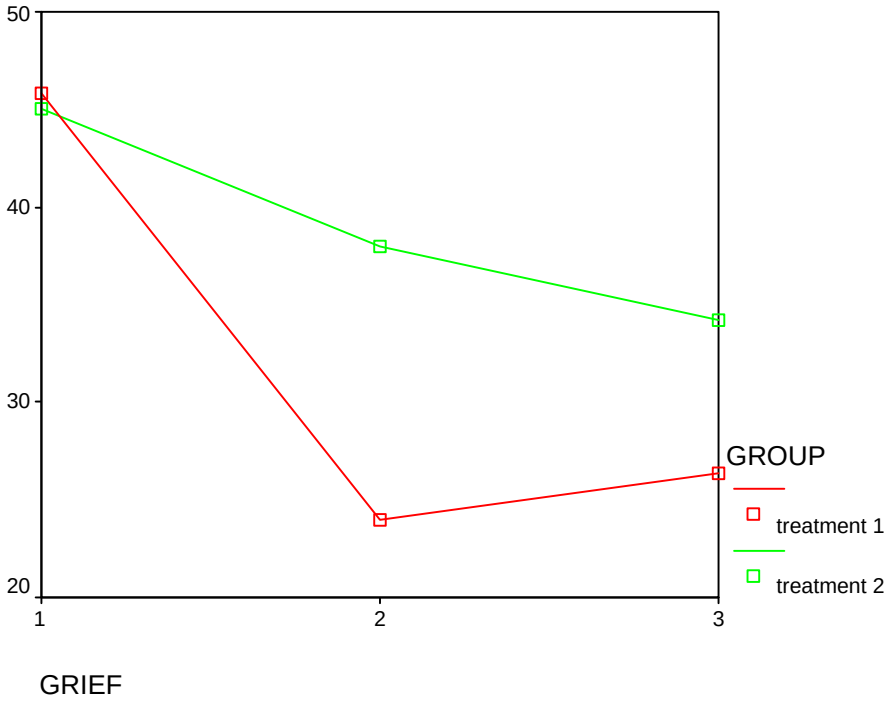

Figure 5 Changes in Complicated Grief across Time

Here a significant interaction was observed between treatment type and time of testing (F = 3.790; df = 2,20; p< .05). See Appendix F for results of the 2x3 repeated ANOVA. In order to locate the source of the interaction, tests of simple effects were carried out. The first test was to establish whether the groups T1 and T2 differed prior to commencement of treatment. The groups were not found to differ significantly (F = .048; df = 1,10; p = > .05) which result was again in line with the result of the t-test carried out prior to intervention. The second test was to establish whether the groups differed post treatment. A significant difference between the groups was observed at time of post testing (F = 13.377; df = 1,10; p = < .05), indicating that the intervention did not effect the groups similarly (T2 > T1). The third test was to establish whether the groups differed at time of follow up. Again, the groups were found to differ significantly (F = 4.555; df = 1,10; p = < .05), with (T2 > T1). The fourth test was to assess the degree to which T1 had changed across treatment conditions. This group was found to have changed significantly (F = 19.874; df = 2,20; p = < .05), thus affirming the positive impact of the intervention upon this group. The final test was to assess the impact of the intervention upon treatment group T2. Here, whilst changes occurred between pre, post and follow up, the change was not found to be significant (F = 4.134; df = 2,20; p = > .05), as the F score observed

failed to exceed the critical value of (F = 4.461) required for statistical significance**.** Table 14 contains the mean scores for both treatment groups, showing changes across three treatment conditions.

Table 14 Changes Across 3 Time Periods in Mean and Standard Deviation Scores for Complicated grief

Group		Mean	Std.Deviation	N
ICG time 1	treatment 1	45.83	12.056	6
	treatment 2	45.00	5.514	6
	Total	45.42	8.949	12
ICG time 2	treatment 1	24.00	3.225	6
	treatment 2	38.00	10.545	6
	Total	31.00	10.427	12
ICG time 3	treatment 1	26.33	4.590	6
	treatment 2	34.17	9.600	6
	Total	30.25	8.259	12

Thus, whilst the intervention was shown to have a significant effect for treatment group (T1) in terms of reducing scores of complicated grief, it did not show a similar impact upon treatment group (T2).

5.6 Summary

In conclusion, the results of the 2X3 ANOVA demonstrate that the intervention had a positive impact upon depression levels, showing a significant reduction for both treatment groups. It failed to make an impact upon anxiety levels for either group. However, the groups were found to differ in terms of their anxiety levels, with low anxiety levels measured for treatment group (T1) throughout all three treatment conditions, whilst anxiety levels for treatment group (T2) measured at a higher level from commencement to cessation of the intervention. The impact of the intervention upon measures of complicated grief differed for both groups. A statistically significant effect across treatment conditions was observed in the case of treatment group (T1), indicating the positive impact of the intervention. However, the changes observed in treatment group (T2) did not achieve statistical significance. The impact

of higher anxiety levels upon the success of treatment for treatment group (T2) will be addressed in the discussion section.

5.7 Results of Qualitative Analysis

Participants were asked to complete an evaluation form, following participation in the treatment program. Core elements of the program were identified and participants were asked to rate their views on a number of items, including personal experience and learning. A copy of the evaluation questionnaire is contained in Appendix K.

5.7.1 Evaluation of Programme

All participants rated the program highly, giving it an average satisfaction rating of 96.67%. The features which were most frequently identified and given the highest evaluation were group sharing, trust and universality. Some dissatisfaction was expressed with the time allocated to the group sessions, with all wishing that this could have been extended. Regarding duration of the program, 75% expressed a preference for more sessions to be provided, whilst one participant stated that she wished the group could go on forever.

5.7.2 Perception of Change in Grief Experience

When asked to rate grief scores prior to participation in the group, 8 respondents rated their grief as measuring 100%. Table 15 presents self- ratings of perceived grief levels at time of commencement and following participation in the treatment program. As is demonstrated, nine of the twelve participants perceived a positive reduction in their level of grief experience as a consequence of participation in the program. Four individuals perceived their grief to have halved in intensity, and four perceived it to have reduced by one third. One respondent failed to give a numerical value to her grief experience at post treatment time, but commented that she was now more at ease with her grief. When this response is compared with measures of grief, as presented in Section 5.5, this participant had reduced her ICG by 10 points, from (Pre ICG = 44) to (Post ICG = 34), whilst her BDI score reduced significantly from (Pre BDI = 44) to (Post BDI = 10). The duration of this respondent's bereavement was in excess of 10

years. Respondent 9 reversed the trend by measuring her experience of grief as 0% prior to participation and by measuring it as 60% by the end of the program. She noted that her grief experience was blocked prior to participation. At time of follow up, this individual's ICG score had reduced from (Pre ICG = 39) to (Post ICG = 19).

Respondent 12 noted no change in her grief response, and this was an accurate representation of response as measured by the ICG post intervention (Pre ICG = 48; Post ICG = 55). At time of follow up, this score had only marginally improved (FU ICG = 33). This participant failed to participate fully in the program.

Table 15 Perceived strength of grief

Rate each answer from 0-100, where 0= no grief feelings; 100 = Grief as strong as you have ever experienced it)

N	Pre	Post	Perceived change
1	100%	40%	-60%
2	100%	60%	-40%
3	80%	50%	-30%
4	100%	80%	-20%
5	100%	40%	-60%
6	75%	40%	-30%
7	90%	60%	-30%
8	100%	-	-
9	0%	60%	+ 60%
10	100%	50%	-50%
11	100%	50%	-30%
12	100%	50%	-50%

5.7.3 Degree and Quality of Perceived Progress

Question 6 asked respondents to rate their perceived progress following participation in the program. Seven respondents perceived themselves as having made much progress and five perceived some progress.

Responses to question 7 which sought to establish what learning had occurred for participants suggests that the program provided an experience in which insights were gained into obstacles to moving on, grief response was normalised and new coping skills were developed. For example, one participant noted " You can't keep holding

on to grief because it does you more harm." Other responses made reference to the resolution of anger and the gaining of new understanding into their own process and that of others connected to them.

The extent to which participants had gained specific skills as a consequence of participation in the program are summarised in Table 16. Skills learned are ranked according to degree of perceived progress. Results suggest that all participants perceived themselves to have made progress in those areas targeted in the treatment program. Of the six components rated highest by participants, four relate to increased awareness or understanding, whilst two relate to learning in relation to grief management. Those features ranked lowest in terms of perceived progress, relate to belief in the ability to change and to actual behavioural change.

Table 16 Rating of Skills Gained on Program

Rate each answer from 0 to 2 where 0= none, 1 = some, 2= much more than previously

New ways of dealing with grief	Much progress (n = 9) Some progress (n = 3)
Greater ability to cope with the painful feelings of grief	Much progress (n = 9) Some progress (n = 3)
Greater awareness of how my thoughts affect my mood	Much progress (n = 9) Some progress (n = 3)
Greater awareness of those ways of behaving which can hold m e in my grief	Much progress (n = 8) Some progress (n = 4)
Greater awareness of issues that have prevented me from moving forward in my grief journey.	Much progress (n = 8) Some progress (n = 4)
Better understanding of grief	Much progress (n = 7) Some progress (n = 5)
Confidence in myself and my ability to cope with my difficulties	Much progress (n = 6) Some progress (n = 6)
New behaviours which help me deal with my grief	Much progress (n = 6) Some progress (n = 4) None (n = 2)
Greater ability to correct unreasonable, negative or unhelpful thoughts	Much progress (n = 6) Some progress (n = 5) None (n = 1)

Question 11 sought to evaluate those aspects of the program found to be of most assistance to participants and these are outlined in rank order in Table 17. Of the four factors ranked highest, three relate to the value placed upon group experience. This would seem to indicate a relationship between the use of a group treatment modality and observed reductions in grief and depression levels. Whilst other aspects of the program were also rated highly by some, there was a greater variation noted with respect to the helpfulness of features designed to motivate participants to change their own behaviour, such as the use of gaoling, homework assignments and journaling.

Table 17 Evaluation of Features of Program in terms of Helpfulness

	Mean	Standard Deviation
Being in a group with other bereaved people	95.83	14.434
Group discussion and sharing	95.83	14.434
Help sheets	87.50	20.944
Developing coping strategies in the group sessions	80.83	20.207
Planning new behaviours and setting goals	78.33	27.589
Homework exercises	77.50	24.861
Visualisation exercises	74.58	27.589
Using the journal	73.64	32.023

Rate each answer from 0-100, where 0=not helpful and 100=most helpful)

5.7.4 Change in Attitude

All participants acknowledged that they have gained a greater sense of hope in the future, though the degree to which this was experienced showed variation, with three respondents acknowledging a slight increase in hope, and the remainder of respondents stating that through attendance in the program they had gained much more hope for the future. Again, an association emerged between those who

experienced greater hopefulness in the future and those who had shown greatest improvement in measures of grief.

Change in attitude as a consequence of group participation reflected an increased awareness of aspects of grief experience acting as obstacles to resolution, and reflected some letting go of unfinished business, a desire to move on with life and for some, a decreased sense of isolation in wake of a shared experience of loss.

Whilst the overall evaluation demonstrates a high degree of satisfaction with the group program, there was a difference in perception of satisfaction with progress between the treatment (T1) and treatment group (T2) at time of follow up. These differences will be addressed along with quantitative results in the discussion that follows. This concludes the results section of this study.

Chapter 6
Discussion

6.1 Introduction

The aim of this study was to develop a group psychotherapeutic intervention to address the problems of complicated grief through the use of a cognitive behavioural treatment approach aimed at reducing grief symptoms and facilitating the grieving process.

The study tested the hypothesis that cognitive group psychotherapy can reduce symptoms of complicated grief. The core feature of cognitive therapy is an emphasis upon exploration and reconstruction of meaning. In effect therefore, the hypothesis was that a group psychotherapeutic intervention taking meaning reconstruction as a focus, can effectively reduce the symptoms of complicated grief. As depression and anxiety represent frequently encountered features of both normal and complicated grief reactions, these were chosen as additional dependent variables for analysis.

The principal finding of the study is that there has been a significant reduction in depression for both groups arising out of participation in the treatment program. The findings in relation to complicated grief however are less clear, with the statistically significant effect for participation in the treatment program observed for one treatment group (T1) failing to be replicated for the second group (T2). Such findings suggest that whilst cognitive group psychotherapy may successfully treat the depression associated with bereavement, the statistically significant reduction in symptoms of complicated grief for one group should be interpreted with caution.

The reasons for the differential impact of the program in relation to complicated grief symptoms raises a number of questions. What factors contributed to successful outcome with T1? Were these same factors present in the treatment approach adopted with T2 and if so, why was it not similarly successful? Equally, why did the approach achieve a statistically significant result for reduction of depression with T2, whilst failing to significantly reduce grief symptoms?

In seeking to clarify whether cognitive therapy can offer any solutions to the complex field of human grief experience, difficulty is acknowledged in inferring a direct causal association between quantifiable changes documented and specific elements of the treatment program. Indeed, in exploring reasons for the efficacy of the program in terms of reduction in depression, and the reduction in measures of complicated grief for one group (T1), it is acknowledged that this success might also relate to factors other than the treatment approach adopted, such as for example, specific group or individual characteristics, the power of group process or to factors suggestive of normal grief processing. It is also possible that the failure to produce a statistically significant effect upon complicated grief symptom levels for T2 may well be explained in the light of some of these factors. It will be necessary in an analysis such as this to use clinical and participant evaluation of the treatment process in order to support inferences made concerning changes noted, some of which were not quantifiable in nature. The discussion therefore will include clinical observations of group process as it unfolded and was recorded, as well as the self reported experience of group members, as outlined in their evaluation (see Chapter 5). Observations and comments will relate to the progress of both treatment groups, unless otherwise specified.

6.2 Differential impact of intervention

In keeping with the findings of literature, anxiety was not found to be a universally shared feature in both groups (Jacobs & Prigerson, 2000). Indeed, in T1, anxiety was measured at a normal level and predictably did not appear to impact upon the group dynamic or the behaviour of participants in any significant way, although the use of avoidance was noted as a feature and will be discussed later. However, it would appear that what primarily differentiated the two treatment groups in terms of treatment response was a higher degree of anxiety both measured and observable in T2. Whereas both groups were deemed to be similar in terms of anxiety prior to commencement of the intervention, this assessment of measures of anxiety was not supported by clinical observation at time of treatment of T2, or by the tests of simple effects implemented following the intervention. Indeed, anxiety appeared to act as a major defining feature of T2 in inhibiting the development of trust at an early stage and in inhibiting the processing of grief and the experimentation with new behaviours

even at a late stage in the life of the group. Horowitz (1986, 1997) has commented that enforced assimilation of threatening material, such as the reality of loss, demands change at the level of schemas, to which resistance is a natural response. Where present, anxiety responses in the case of some of the participants in this group, appeared directly related to trauma preceding or relating to the death, and elements characteristic of PTSD could be identified. Research findings indicate that where such symptoms are the primary, clinical problem, these require processing prior to the treatment of grief (Pynoos & Nader, 1990; Raphael et al, 1993; Stroebe et al 1998). In this case, whilst complicated grief symptoms appeared to predominate at time of assessment, a more complicated clinical picture emerged during treatment, with anxiety appearing to prevail and act as an obstacle to the processing of grief. In some cases, the anxiety and intense distress normally associated with trauma was expressed in the process of re-experiencing events surrounding the death. Implications for the replication of a treatment program are obvious therefore, when two groups differ in terms of a significant variable such as anxiety, which is capable of changing the focus and dynamic significantly. Such a difference created a problem in terms of replication of a specific focussed short-term treatment program operating a planned strategy. Given the treatment model adopted successfully with T1, replication with a more anxious group in which the features of traumatic distress were predominant, meant that study demands, individual demands and group demands conflicted. On the basis of this study, it is suggested therefore that where the predominant theme within a group is one of anxiety, a focussed attempt to address this element would require a program of longer duration which could address this element prior to treatment of complicated grief symptoms. It is noted that in the pilot study reported by Shear et al (2001), the results of which have yet to be established, subjects were treated individually and included those with both major depression and PTSD. However, complicated grief was considered the primary problem and the treatment protocol was of approximately 16 weeks duration.

Although it is commonly recognised that avoidance of bereavement related cues is manifestly ineffective in protecting the individual from the pain of grief, it's prevalence is frequently evident among the bereaved and was a noted feature of behaviour in both groups, despite the low levels of anxiety measured for T1 (Gauthier & Marshall, 1977; Kavanagh, 1990). Kavanagh(1990) has argued that such

avoidance, which has traditionally been treated as reflective of anxiety, might equally be regarded as reflective of depressive withdrawal. In support of this formulation, what did emerge from this study was the impact of avoidant and withdrawal behaviours upon participants, in the creation of self imposed social isolation wherein dysfunctional appraisals of loss could become the core cognitive focus, and negative ruminations could take hold. Such ruminations appeared to confirm negative assumptions leading to avoidance of the implications and challenges inherent in facing life without the deceased. In other words, for some, avoidant behaviours appeared to reflect a depressive rather than a specific anxiety response, and appeared to be maintained by a refusal to let go, arguably borne out of a fear of a future without the deceased.

Indeed, the negative impact of a ruminative style of cognitive behavioural response was clearly evident within the patterned responses of some participants during early group sessions. In order to facilitate change therefore, the corrective process commenced with the clear setting of goals. This process forced participants to look forward to the future instead of remaining focussed upon their unrequited loss and provided the challenge to begin reformulating a life without the deceased, through taking planned steps towards concrete goals. In the light of previous comments relating to T2, such an approach was clearly less effective, given the high anxiety levels present. However, the cognitive focus upon reconstruction of meaning and ensuing behavioural change was evident across both groups, and is supported by the significant reduction in depression noted in the study. This process was supported by the use of a guided mourning element, consisting of imaginal exposure to feared or distressing aspects of memory relating to the deceased and the death experience and included the added element of mood induction through the visualisation of positive memory related to the deceased. This was aimed at encouraging reconnection with a positive internal representation of the deceased and at reconnection with a supportive positive memory store, such as has been recommended in literature (Shear et al, 2001, 2002; Kavanagh, 1990). The use of visualisation as a method of accessing avoided material and of creating shift through revisiting painful memories appeared instrumental for some in facilitating the task of letting go of some of the pain of loss. Imagery provided the opportunity to imaginatively construct the desire of the deceased to allow life for the survivor to move on, unbound by the shackles of the

past. Such a finding is consistent with literature supporting the use of guided mourning as a means of facilitating grief processing (Melges and De Maso, 1980; Mawson et al, 1981). Evidence from participant evaluation of the program (Table 29, Chapter 5) and as discussed also in the context of therapy, suggests that this element was not found equally helpful by all participants and that those who were most anxious had predictable difficulty in participating fully in the imagery exercises. Difficulty with participation in such exercises can indicate reluctance to face traumatic experience and as such can lend validity to the use of such an approach. However, this might have implications for the treatment modality adopted in that group therapy for some may be more threatening and less effective than individual therapy.

6.3 Group Therapy as Treatment Modality

It is difficult to separately evaluate the core cognitive approach adopted in this study from the use of the group approach, which medium appeared to act as a powerful contributor to changes observed. Yalom (1995) has argued that to be successful, group therapy must facilitate the creation of a cognitive map which can frame the experience and emotion evoked within the group. For this to happen, the group must feel safe and supportive, and there must be sufficient engagement and honest feedback for effective reality testing to take place. It would seem likely that the socially supportive environment observed within both groups in this study was instrumental in the creation of a climate wherein repetitive and affect laden cognitive themes of loss and pain could be acknowledged and in many cases replaced by more focussed attempts at reconstruction of new meanings. This inference is based upon both clinical observation and also upon the results of participant feedback, which suggests that interpersonal support and feedback appeared vital to the development of the climate of trust and safety wherein a dynamic spiral of risk taking and change could unfold.

Whilst acknowledging the difference in rates of symptom reduction between the two groups in this study, it is important nevertheless to state that all participants placed a high value upon the supportive group experience, a feature which, as is noted in literature highlights the importance of social support in times of vulnerability

(Neimeyer, 1997, 2000; Parkes,1973; Raphael, 1983; Stilianos & Vachon, 1993). Indeed, one participant noted that the group became her "anchor", enabling her to safely name and express her painful feelings and previously unspoken negative thoughts. In exploring the differential response to treatment however, the importance of group dynamics becomes evident, in that the experience of trust and ensuing open sharing of experience was noticeably slower to develop in treatment group (T2), which difference appeared reflective of the higher anxiety levels of the group. The consequence of this inhibitory dynamic was the evolution of a more ruminative and avoidant style of group behaviour, which made active reconstruction of meaning within a group context more difficult. This does raise the question as to whether individuals with a predominance of anxious symptoms might be more suitable for an individual rather than a group approach to treatment. Nevertheless, the socially supportive experience of being in a group of individuals all of whom had suffered the pain of loss appears to have been a highly valued component which lends support to the use of group therapy in the treatment of grief and grief related depression.

Yalom (1995) argues that change is related to motivation, the amount of personal discomfort with present modes of behaviour, involvement with the group, and an individual's character structure and interpersonal style. Whilst the personal discomfort of painful unresolved grief was doubtless the motivating factor which brought individuals to the group, clinical observation suggests that it was the support and trust achieved within the group which enabled those participants who made most gains to take the risks necessary in order to create possibilities for change. Witnessing the risk taking of others created a dynamic that encouraged a number of participants to follow suit. An example of such change was the behaviour of one participant who risked expressing anger in the group and discovered in so doing it that she could survive it. This encouraged others to follow suit, leading to greater honesty and opportunity for reality testing of appraisals. Another participant dropped her avoidance of the reality of her husband's death by finding the courage to bring an item of his belongings to the group. Realising that nothing bad happened as a consequence of this initial action, she was empowered with encouragement from the group to finally open the wardrobe after two years and to begin the task of letting go of the past. A further participant in a different group, upon hearing the painful struggle of others, gained the courage after

years of avoidance, to open her husband's wardrobe and to begin the painful task of dealing with his effects.

In these groups, individuals learned to listen, affirm and to feedback observations. Group challenging of distortions, and affirmation of change thereby increased motivation and encouraged experimentation with new behaviours, thus leading to increased self-esteem. "To the degree that the group focuses on the here-and now, it increases in power and effectiveness" (Yalom, p.27, 1995**).** For example, in T1, the energy wasted by a participant in being always angry was pointed out by another participant. This feedback proved pivotal in bringing about cognitive shift. Another powerful and effective observation occurred when one member spoke of her isolation, only to be reminded of how loved she was, and to be challenged as to whether she instigated her own social isolation.

The role of affective expression as facilitative of grief resolution has been referred to in the literature review. The cognitive model supports the view that evocation and expression of raw emotion are not sufficient in themselves to bring about change. Rather, in order for a corrective emotional experience to occur, some cognitive reconstruction must take place (Safran & Segal,1996; Neimeyer, 2000; Yalom1995). Observations and findings from this study support this view, and suggest that the significant reduction in both depression and complicated grief symptoms (in T1) would not have occurred without real cognitive change having taken place, and note that shift was invariably accompanied by deep emotional expression. In this regard, the lack of significant change noted for T2 in terms of complicated grief symptoms must not ignore the reduction that did occur, nor the significant reduction in depression for this group which was arguably related to features of the treatment approach adopted. Here too, cognitive shift and affective expression appeared inextricably linked.

In this study, the lack of control for duration and type of loss experienced was based upon a decision to create a heterogeneous group. Allumbaugh and Hoyt (1999) have found that such groups yield greater effect size. Here, the heterogeneous mix of loss type appeared to create awareness among participants of the relatively homogeneous nature of grief symptoms, despite the evident qualitative differences in experience. This factor appeared instrumental in normalising some of the more painful or anxiety

provoking aspects of bereavement reaction, thus arguably serving a function in terms of increasing a sense of support, universality and a normalisation of the grieving process. Selection of participants on the basis of fulfilment of criteria for complicated grief (as assessed by the ICG) does not control for duration of bereavement, and there was a wide variation in range of time span between losses experienced ($\overline{X}$ = 5 years; sd = 5 .03 yrs; range = I - 18 yrs). Given this range, the question arises as to whether those suffering from complicated grief reaction are impervious to the healing factor of time? Do those who suffer to this degree ever find true healing? Indeed, are some losses more likely to endure and is duration of grief ever useful as an indicator of response to treatment? In this study, three participants differed significantly from the remainder of the sample in terms of duration, with time since bereavement ranging from 12 to18 years. What this study found was that those whose bereavement was of longest duration manifested a noticeably strong motivation to move beyond the pain, which factor has been identified by Yalom as indicative of progress. Results for these individuals show a significant drop in depression levels for two of the three and with ICG levels reducing for all, although still remaining at a high level. Comments shared give an indication of the meaning of the process undertaken by these individuals; "Life ahead is more clear and time is not so long"; " I am more at ease with my grief" and "I never dream of him, but last night I dreamed that he was telling me to find my old self again, so I'm going to try to start living again." Such comments reveal the painful struggle to live with ongoing enduring grief and the recognition that for some, the task may simply be to learn to accept and accommodate to loss rather than to resolve that loss. It is worth noting that in such cases, such apparently small quantifiable gains may in fact reflect major psychological breakthrough for an individual, without such change reaching statistical significance. In summary, the findings of this study support the use of group as an appropriate modality for the treatment of complicated grief, whilst recognising limitations which the presence of anxiety might have upon the use of this approach for some individuals.

6.4 Clinical Observations: Grief Resolution through Reconstruction of Meaning

With the evolution of theoretical understandings of complicated grief, the critical place of meaning reconstruction in resolution has been recognised. However, to quantify meaning reconstruction would have been beyond the scope of this study. Nevertheless, detailed observations were made of participants and their attempts to reconstruct new meanings throughout the intervention process. The clinical observations and evaluation of process which are presented in this section lend support to the theoretical viewpoint outlined in research, which view provided the rationale for the approach adopted in the study.

As has been noted in the literature review, cognitive therapy has been demonstrably effective in the treatment of conditions such as depression, anxiety, and PTSD but has not yet developed as an established and proven approach to the treatment of complicated grief. Indeed, Moorey (1996) has identified potential theoretical dilemmas raised by the application of cognitive therapy to the treatment of a phenomenon that is essentially a normal, transitional life experience, albeit an inherently aversive one. Despite this, the thrust of recent theory has been towards the development of a flexible cognitive model wherein the core elements of the grief response can be formulated. Such core elements include the conceptualisation of loss as a trauma which can evoke a complex cycle of anxious or depressive cognitions reflecting appraisals of threat and /or loss, and can lead to behavioural reactions emanating from an attempt to control symptoms. It is suggested that such dysfunctional cognitions require identification, exploration and where necessary, reconstruction, so as to enable assimilation and adaptation to take place. In effect, literature suggests that without meaning reconstruction, resolution of complicated grief may not take place.

In this study, despite the obvious adverse nature of the loss event and the presumption of functionality of grief response, cognitive distortion and associated distress were manifest as features within both groups, appearing to perform a maintenance function in the prevention of processing and in the prolongation of grief response which

measured well above that considered functional (ICG = > 25). In both treatment groups, cognitive appraisals of loss and it's meaning in terms of future life possibilities without the deceased were almost universally described in the black and white terms characteristic of depressed or anxious thinking. Appraisals outlined included the loss of meaning and purpose, the loss of self or part of self and the loss of hope in the future. Universally described sequelae included social isolation, loss of role and self esteem, and loss of a sense of safety. All such features reflect commonly accepted components of grief response in addition to reflecting the core premise underlying the cognitive formulation of depression. The loss of a sense of safety expressed by some, reflects the core feature of anxiety and is also commonly found amongst the bereaved. The use of a conceptual framework incorporating these elements seems therefore to have been theoretically appropriate. The treatment approach adopted used the interpersonal process as a vehicle for creation of the dissonance necessary to enable some cognitive reconstruction to take place. In line with the recommendations of theorists, such reconstruction appeared to facilitate the development for some participants of a more realistic appraisal of the legacy of the deceased and of a more realistic evaluation of future life possibilities in the absence of the deceased. In addition to clinical observation, evidence for this was found in group recordings and in responses to the evaluation form completed at the end of the program,. The identification of unresolved issues or appraisals leading to anger, resentment, fear or guilt, and to an ensuing response cycle of negative cognitions, rumination and maladaptive behaviours, is consistent with the cognitive formulation of response to loss experience and trauma which been referred to in the literature review (Schut & Stroebe, 2001; Kavanagh, 1990; Clark & Ehlers, 2000).

The potentially negative impact of a conflictual relationship upon bereavement reaction has been identified (Rando, 1984; Raphael,1978; Parkes & Weiss,1983). There was evidence to support this finding in the case of two participants for whom such a history created particular difficulty in achieving some resolution of their grief. Such resolution required a letting go of painful memory and some re-evaluation of legacy as one of survivorship. It is possible that it was the experience of a supportive group environment which created the space necessary to permit negative appraisals relating to the deceased to be acknowledged, thereby enabling some reappraisal and

resolution to take place, and results indicate that for these individuals, some closure did occur.

By contrast, the majority of participants in the study struggled with the loss of a close relationship, where exploration of loss appraisals manifested assumptions of a shared future with the deceased and the meanings invested in these assumptions. The challenging of assumptions of invulnerability and of a benevolent world, as outlined by Janoff-Bulman (1992), were exemplified in the struggle to accept the loss of this promise of continuity and the sense of insecurity and loss of sense of self which ensued.

As has been noted by Davis et Al (2000), where the search for meaning is unsuccessful, increased levels of distress are likely. For all participants, this search appeared to have been embarked upon. Group recordings suggest that for those for whom positive meanings had been constructed to explain and make sense of the loss, such meanings tended to relate to pre existing frameworks into which the loss experience was at least partially assimilated. For others, as also found by Neimeyer (1997), attempts to assimilate the loss experience had led to the jettisoning of aspects or frameworks of belief. For example, beliefs in the existence of god or the presence of a loving creator were now questioned by some and no longer adhered to by others. Other attributions, which were of a dysfunctional nature, contained themes of self-blame or other blame, and resulted in feelings of anger, guilt and ruminative cognitions, which were laden with counterfactual themes. A focus on meaning reconstruction, as recommended in literature, was therefore an essential element of the therapeutic process. (Neimeyer, 2000; Fleming & Robinson, 1991).

The use of journaling and letter writing has been demonstrated as effective in the assimilation of trauma and the facilitation of closure (Pennebaker et al, 1998). As part of the therapeutic intervention, participants were encouraged to keep journals and to complete written homework assignments. Where unfinished business appeared to block progress, the technique of journaling and letter writing appeared effective in providing a powerful therapeutic tool, which enabled some participants to name negative aspects of the past, explore unresolved issues and consolidate positive features and gains consequent upon having shared a relationship with the deceased.

Those who fully participated in the journaling activities valued the activity highly and linked the use of writing to the commencement of their healing process. Those who failed to use their journals consistently reported little benefit from them and acknowledged difficulty in writing about their thoughts and feelings. Here, lack of education appeared an added inhibitor for some though not all of those who had difficulty in exploring experience through the medium of writing.

Finally, as recommended in literature and referred to in Appendix L which summarises treatment modules, the use of ritual to mark closure provided a symbolic focus for both groups, facilitating both the ending of the program and a ceremonial gesture of letting go (van der Hart, 1988; van Gennep, 1960). Indeed, this process appeared to act as a powerful motivator for all participants, who without exception participated meaningfully in the ritualised act of closure.

In summary, the process of meaning reconstruction appeared vital in assisting participants to re-evaluate their experience of loss so as to enable some processing of grief to occur. It seems possible therefore to attribute some of the reduction in symptoms of grief and depression to specific features of the cognitive treatment approach adopted. Arguably, without meaning reconstruction, the observed processing of cognitive and behavioural obstacles to grief which translated into a quantifiable reduction in symptoms, may not in fact have occurred.

6.5 Commitment to Treatment

The lack of success and high attrition rate noted in group psychotherapy treatments in general is worth noting (Marmar et al, 1988, Neimeyer, 2000). What was striking in this study was the close mutual identification between participants in both groups, though more especially in T1. Yalom and Vinogradov (1988) have noted similar findings. This close identification was reflected in a low attrition rate and in the completion of the program by all twelve participants. Of these, six had a full attendance rate whilst four missed one session each. The attendance rate for T1 was higher than for T2, where two participants missed three sessions each. The presence of concurrent stressors are acknowledged as risk factors for complicated grief and were noticeable by their ongoing pressure upon the lives of those participants with the

lowest attendance rate (Fleming & Robinson 1991; Lazarus & Folkman, 1984; Parkes, 1975a; Worden, 1991). Such factors are of relevance in the light of the higher anxiety levels in T2. It is possible, despite the serious nature of the ongoing stressors reported by those participants with the highest attrition rate, that what differentiated them from others was the impact of anxiety in the determination of appraisals of coping capacities and ensuing behavioural responses. This poorer attendance rate may also have contributed to the failure to demonstrate a statistical impact upon grief levels for the intervention with this group, given that these individuals did not have the same therapeutic experience. However, the reality of a statistical effect for depression levels confounds this picture somewhat. A further limitation upon the results for T2 may be related to the disruption in therapy due to the occurrence of Easter at a midway point in the group treatment. Despite these comments, attendance rates for these groups reflect a general commitment to the process, which contrasts with the findings for other bereavement interventions noted (Marmar et al, 1988, Neimeyer, 2000).

Was the observed commitment to the program just an idiosyncratic phenomenon? Whilst every group creates it's own dynamic and both of these groups appeared very different in character, a common shared feature was the high score obtained on the ICG for all participants, indicative of a high degree of bereavement related distress. Perhaps, the degree of discomfort experienced by participants contributed to their commitment to the group process. It is arguable that had this measure been used in other studies, perhaps a more accurate definition of complicated grief might have isolated those most suitable for treatment, and those who did avail of treatment might have completed the programs in question. The issue of appropriate selection and measurement therefore appears vital.

6.6 Measurement Issues

In attempting to identify those individuals who might benefit from participation in a treatment intervention as opposed to those for whom treatment might prove counterproductive, an essential first step in this study was the choice of a measure to validly isolate the key features of the construct under investigation. In choosing the

ICG, account was taken of its face value clinical relevance to the population under investigation. What did emerge from this study was that all those who were assessed as falling within the range of complicated reaction, (measuring >25) were manifestly struggling to function in their lives as a consequence of their appraisals of loss and all perceived the need for assistance with their grief. Coping research reminds us that bereavement occurs in a complex and ever changing context and thus response variation is inevitable (Lazarus & Folkman, 1984). Respondent expectation of desirability of response may also effect quality of response. A feature which may have further confounded response was evident where participants presented as mourning more than one loss. In these situations, grief response was not confined, and therefore response pattern was complicated. An example of this occurred in the case of one participant (N2). Here, the unresolved loss of a dependent and loving relationship was combined with the loss of a highly conflicted relationship. Responses to measures therefore could potentially yield different scores, depending upon whose loss was being most deeply experienced at the time of measurement. Despite these reservations, the use of the ICG appears to have provided a useful measure of complicated grief which was generally borne out by clinical assessment at the various times of retesting.

6.7 Findings at Follow up

As already noted, findings from the qualitative component of this study reflect the high value placed upon the group experience by all of the participants. Learning appeared to take place for all, though some appeared to gain more than others in terms of concrete strategies and new behaviours. Findings suggest that individuals differed in terms of their capacity to generalise learning beyond the immediacy of the group setting and in terms of the concrete goals achieved both during the program and subsequent to it's conclusion. This difficulty in pursuing goals following a major life event has been noted in literature (Emmons et al, cited in Davis et al, 2000). Despite this difficulty however, all acknowledged awareness of the need to move beyond their loss experience and to find new meaning in their life. Regarding content and process of treatment, all expressed satisfaction. All however expressed a preference for longer sessions. It is interesting to note that those who made the most progress were

satisfied with the duration of the program, but those who made least progress would have preferred more sessions. Those with a poor attendance record were among those who expressed a wish for more therapy.

A valid question arises as to the power of the group process to effect lasting change once the life of the group ceases. Is it possible that effect size might be reflective of a temporary feel-good factor arising from the experience of group support and encouragement rather than of real cognitive shift? Indeed, to what extent are the reductions in the dependent variables predictive of lasting change? As mentioned previously, availability of social support is noted as having a major influence in recovery from loss (Parkes, 1973; Raphael, 1983; Stilianos & Vachon,1993), and this raises the question of what emerges when the support of a group is withdrawn? It has furthermore been noted that sharing painful experience in a socially supportive context, can act to maintain and reinforce maladaptive patterns (Clayton et al, 1973; Kahn, 1975; Gauthier & Marshall 1977). If these perspectives are both valid, then what may emerge is that where change is maintained at time of follow up, this may reflect the presence of other factors influential in the resolution of grief, such as the prior existence of a socially supportive context wherein grief behaviours are not reinforced. It might also follow that those who lack social support might demonstrate greater difficulty in maintaining goal related behaviours, once outside the supportive context of the group. This factor might in turn lead to a reduction in gains.

In this study, at time of follow up, depression levels were continuing to decrease. In terms of reduction in symptoms of complicated grief, the group (T2) continued to make gains at follow up time but these gains did not achieve statistical significance. In the case of T1, where a significant reduction in complicated grief levels across three times of testing was achieved, there was a minimal increase in scores at time of follow up (Post: ($\overline{X}$ = 24.00; FU: ($\overline{X}$ = 26.33). A possible explanation for this slight increase may be that for one participant, an anniversary of the death occurred just two days prior to follow up measurement. In addition, of the three participants whose ICG scores showed a slight increase, all were living alone and as such, lacked a sense of outside social support. In the case of T2, those who made least progress also lived alone and experienced an ongoing sense of social isolation. An additional factor identified in literature which might explain the slight reduction in gains is the

influence of personality features, such as a tendency towards dependency (Parkes, 1979; Parkes & Weiss,1983). It is worth noting that two participants responded to the closure of the group with distress. Indeed, one reported her desire for the group to go on forever. Both of these participants also frequently expressed the need to talk about their grief on an ongoing basis. Did the loss of social support following the group experience increase an already heightened sense of loss, thus leading to the reestablishment of negative cognitive and behavioural response patterns, and thus to the erosion of gains achieved? Were this true, it would lead one to question the efficacy of group psychotherapy for some individuals who might have a tendency towards dependency or for whom any social reinforcement of their grief status may be counterproductive. Indeed, could the temporary provision of social support have a negative effect upon those who normally lack social support in their lives, given the inevitability of return to a contrasting social state? Whilst such questions are valid, the actual gains achieved by these same individuals and indeed, personal perception of progress made cannot be ignored. In summary, it seems reasonable to infer a possible association between the slight increase in ICG scores and lack of availability of social support, suggesting that living status may be a variable having significance not only in terms of bereavement response but also in terms of treatment response. Future research might incorporate a measure of perceived social support in order to assess the impact of this upon treatment outcome.

The difference between depression and grief has been highlighted by Prigerson et al, and has provided the rationale for the development of specific measures to isolate the features differentiating these factors. The findings of Pasternak et al (1993) that it is possible to see a remission in symptoms of depression without any change occurring in grief intensity are of relevance in the light of some of the findings of this study. The question arises as to why treatment was successful in reducing depression levels for both groups, but in the case of T2, a similar statistically significant reduction in grief levels was not obtained, despite the fact that the focus of treatment was upon complicated grief. The role of anxiety in blocking grief processing has already been discussed and it is interesting to note that anxiety did not appear to impede the reduction in depression levels. Is bereavement related pain more difficult to resolve than the pain of depression? Perhaps, as previously highlighted by Moorey (1996), the answer is in the question. If depression arises out of cognitive distortion or

misperception of reality, then restructuring of that reality may be sufficient to reduce it. Where the loss is real and irrefutable however, the challenge to let go or to achieve some resolution may prove insurmountable. Indeed, to 'let go' may be appraised as an invalidation of the loss experience. For bereaved individuals, cognitive reconstruction of meaning can resolve obstacles to processing, thereby enabling loss to be carried with greater ease. However, as now accepted in literature, the loss of a significant other may remain a source of sadness accompanying some individuals throughout their lives.

6.**8** Limitations of Study

As has been noted, the treatment program did achieve a significant reduction in depression for both groups, as well as a significant reduction in symptoms of complicated grief for one treatment group. Given the failure to replicate the findings in relation to complicated grief however, no conclusions can be drawn as to the value of the program as a treatment protocol for this condition. The requirement of this study was to replicate the treatment protocol for both groups and this led to difficulties. In an ordinary clinical setting, such difficulties could have been addressed through the renegotiation of contract so as to enable an extension of treatment and to adopt if necessary a different protocol, such as suggested above. This study did not allow for this flexibility of approach in terms of extension of time, duration or treatment approach.

The small number of participants in the study obviously reduces the power of findings of this study. Other factors which might confound results include the use of the ICG as an assessment tool which does not control for homogeneity in terms of duration of bereavement, age or social or living status. The failure of this study to use any measure of cognitive distortion can be seen as a limitation, in that the author was forced to rely upon clinical observation and upon recordings of group process.

The dual role of author as both researcher and therapist may be seen as a limitation, though this was partially addressed by the use of a co-facilitator, who acted primarily as recorder and observer. A further therapist related factor which needs recognition is that of the impact upon a clinician of running two groups back to back. Given college

requirements to complete this study within a relatively short period of time, the possible impact upon the therapist cannot be ignored.

A further obvious limitation of the study was the short follow up time involved. There is no way of assessing whether trends noted would continue, without replication of measures at a future period in time. Literature suggests that so far, therapeutic interventions with the bereaved have shown limited success (Kato & Mann,1999; Neimeyer, 2000). In support of these findings, this study has failed to produce a conclusive finding in relation to treatment of complicated grief, although it does suggest that those who are suffering with bereavement-associated depression can benefit from such a treatment protocol. In order for any conclusions to be drawn from the significant findings achieved for T1 in relation to complicated grief, this study would require further replication. In any such replication, it is suggested that the protocol be extended both in duration and in number of sessions.

6.9 Implications for Future Research

The deleterious effects of bereavement are by now clearly acknowledged. It is recognised that despite the distressing effects of this experience, most individuals adapt after a period of time, albeit painfully. However for some, adjustment fails to take place and it is upon these individuals that future research efforts should continue to be focussed. The failure of therapeutic interventions to produce conclusive results has been linked to a failure to use appropriate measures for the identification of those whose grief is traumatic or complicated. Future researchers now have measures such as the ICG to isolate this syndrome, and to develop treatment programs to specifically address the symptom constellations of which complicated or traumatic grief consists. There are obvious advantages in terms of cost benefits to treating individuals as part of a group and this study has highlighted the therapeutic benefits to this approach for many bereaved individuals. Limitations of this type of treatment approach have also been suggested, in the case of those for whom grief response manifests in a predominance of post-traumatic distress symptoms which can act as an obstacle to processing.

The results of this study suggest that appraisals of loss may be either predominantly depressive or predominantly anxious in nature, suggesting that failure to differentiate and separate individuals according to such a classification may make the use of short term group treatment for complicated grief unproductive. It is suggested therefore that future research might study the effects of separating individuals on the basis of their appraisal orientation. Research might then study the effects of a cognitive therapy intervention such as that used in this study for the treatment of those sufferers whose grief is assessed as predominantly loss oriented and reflective of separation distress. It is further suggested that research is needed to study the effects of a modified treatment program which focuses upon those whose symptoms are assessed as predominantly threat oriented and reflective of post traumatic distress.

6.10 Conclusions

What then can be said of the benefits of cognitive therapy for those afflicted with a complicated grief reaction? This study has demonstrated that for some, this approach has been successful, whilst for others for whom anxiety has been a dominant feature, the approach has been less successful. This finding might seem to indicate that this treatment intervention might only be appropriate for those whose grief manifests as emanating from an appraisal that is loss focussed rather than threat focussed. However, to adopt such a stance would be to ignore the fact that complicated grief syndrome encapsulates both the symptoms of traumatic distress and those of separation anxiety. Nevertheless, it has been evident in this study that whilst grief reaction is idiosyncratic, shared themes predominate which emanate from the manner in which loss and its circumstances are appraised. Implications for group treatment might be that those whose primary appraisal of loss is as a threat which leads to a predominance of symptoms of traumatic distress, might benefit from an approach which addresses these specific dimensions, prior to the treatment of underlying symptoms of separation distress. Equally, those whose primary appraisal of loss leads to a reaction that is predominantly one of separation distress and where avoidance is reflective of depressive withdrawal rather than of anxiety, should be treated accordingly, using a model of grief similar to the cognitive model of depression. To suggest this differentiation is not to suggest that grief cannot be formulated in a single model but it is to acknowledge the different types of appraisals made and the

necessity to adapt the model to suit the powerful medium of group therapy. In this approach, the place of meaning reconstruction in the resolution of complicated grief is acknowledged and supported by the findings of this study.

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Appendices

Appendix A Inventory of Complicated Grief

Please fill in the circle *next to the answer* which *best describes* how you feel right now

1. I think about this person so much that it's hard for me to do the things I normally do…

0 never O rarely O sometimes O often O always

2. Memories of the person who died upset me…

O never O rarely O sometimes O often O always

3. I cannot accept the death of the person who died…

O never O rarely O sometimes O often O always

4. I feel myself longing for the person who died…

O never O rarely O sometimes O often O always

5. I feel drawn to places and things associated with the person who died…

O never O rarely O sometimes O often O always

6. I can't help feeling angry about his/her death…

O never O rarely O sometimes O often O always

7. I feel disbelief over what happened…

O never O rarely O sometimes O often O always

8. I feel stunned or dazed over what happened…

O never O rarely O sometimes O often O always

9. Ever since s/he died it is hard for me to trust people…

O never O rarely O sometimes O often O always

10. Ever since s/he died I feel like I have lost the ability to carte about other people or I feel distant from people I care about…

O never O rarely O sometimes O often O always

11. I have pain in the same area of my body or have some of the same symptoms as the person who died…

O never O rarely O sometimes O often O always

12. I go out of my way to avoid reminders of the person who died…

O never O rarely O sometimes O often O always

I feel that life is empty without the person who has died…

O never O rarely O sometimes O often O always

14. I hear the voice of the person who died speak to me…

O never O rarely O sometimes O often O always

15. I see the person who died stand before me…

O never O rarely O sometimes O often O always

16. I feel that it is unfair that I should live when this person died…

O never O rarely O sometimes O often O always

17. I feel bitter over this person's death…

O never O rarely O sometimes O often O always

18. I feel envious of others who have not lost somebody…

O never O rarely O sometimes O often O always

19. I feel lonely a great deal of the time ever since s/he died…

O never O rarely O sometimes O often O always

Scoring is as follows; never (less than once a month) = 0; rarely (once a month or more, less than once a week) = 1; sometimes (once a week or more, less than once a day) = 2; often (once every day) = 3; Always (more than once a day) = 4;

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Am. J. Psychiatry 154: 7, July 1997

Appendix B Beck depression Inventory (BDI)

Page 1

Appendix B Beck depression Inventory (BDI)

Appendix C BECK ANXIETY INVENTORY

Name Date

Below is a list of common symptoms of anxiety. Please read each item in the list carefully. Indicate **how much** have been bothered by each symptom during the PAST WEEK, INCLUDING TODAY by placing an X in the corresponding space in the column next to each symptom.

		Not at all.	Mildly It did not bother me much.	Moderately. It was very unpleasant but could stand it.	Severely. I Could barely stand it.
1	Numbness or tingling				
2	Feeling hot				
3	Wobbling in legs				
4	Unable to relax				
5	Fear of worst happening				
6	Dizzy or lightheaded				
7	Heart pounding or racing				
8	Unsteady				
9	Terrified				
10	Nervous				
11	Feelings of choking				
12	Hands trembling				
13	Shaky				
14	Fear of losing control				
15	Difficulty breathing				
16	Fear of dying				
17	Scared				
18	Indigestion or discomfort in abdomen				
19	Faint				
20	Face flushed				
21	Sweating (not due to heat)				

Appendix D

D.1 Results of Two- way repeated ANOVA for Depression (BDI)

Table D.1-1 Tests of Within-Subjects Effects

Source	Type 111 Sum of Squares	df	Mean Square	F	Sig
Depress	216.00	1	216.000	4.697	.055
Depress*Group	308.167	1	308.167	6.702	.027
Error(Depress)	459.833	10	45.983		

Table D.1-2 Tests of Between-Subjects Effects

Source	Type 111 Sum of Squares	df	Mean Square	F	Sig.
Group	661.500	1	661.500	2.800	.125
Error	2362.500	10	236.250		

D.2 Results of 2X3 Repeated Measures ANOVA for Depression

Table D. 2-1 Tests of Within Subjects effects

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Depress	1155.566	2	577.778	9.998	.001
Depress*Group	84.667	2	42.333	.733	.493
Error (Depress)	1155.778	20	57.789		

Table D.2-2 Tests of Between-Subjects Effects

Source	Type 111 Sum of Squares	df	Mean Square	F	Sig.
Group	702.250	1	702.250	2.261	.164
Error	3105.389	10	310.539		

Appendix E

E.1 Results of Two-Way Repeated ANOVA for Anxiety (BAI)

Table E.1-1 Tests of Within- Subjects Effects

Source	Type III Sum Of Squares	df	Mean Square	F	Sig.
Anxiety	5.042	1	5.042	.096	.76
Anxiety*Group	108.375	1	108.375	2.064	.18
Error (Anxiety)	525.083	10	52.508		

Table E.1-2 Tests of Between-Subjects Effects

Source	Type 111 sum of Squares	df	Mean Square	F	Sig.
Group	805.042	1	805.042	9.921	.010
Error	811.417	10	81.142		

E.2 Results of 2X3 Repeated Measures ANOVA for Anxiety

Table E.2-1 Tests of Within-Subject Effects

Source	Type III Sum Of Squares	df	Mean Square	F	Sig.
Anxiety	22.167	2	11.083	.446	.647
Anxiety*Group	93.722	2	11.083	1.884	.178
Error(Anxiety)	497.444	20	24.872		

Table E.2-2 Tests of Between-Subjects Effects

Source	Type 111 sum of Squares	df	Mean Square	F	**Sig.**
Group	1906.778	1	1906.778	8.107	.017
Error	2351.889	10	235.189		

Appendix F

F.1 Results of Two-Way Repeated ANOVA for Complicated Grief (ICG)

Table F.1-1 Tests of Within-Subjects Effects

Source	Type III Sum Of Squares	df	Mean Square	F	Sig.
Grief	737.042	1	737.042	16.486	.002
Grief * Group	693.375	1	693.375	15.509	.003
Error (Grief)	447.083	10	44.708		

Table F.1-2 Tests of Between-Subjects Effects

Source	Type 111 sum of Squares	df	Mean Square	F	Sig.
Group	630.375	1	630.375	8.529	.015
Error	739.083	10	73.908		

F.2 Results of 2X3 Repeated Measures ANOVA for Complicated Grief

Table F.2-1 Tests of Within Subjects Effects

Source	Type III Sum Of Squares	df	Mean Square	F	Sig.
Grief	1753.722	2	876.861	19.949	.000
Grief*Group	333.167	2	166.583	3.790	.040
Error(Grief)	879.111	20	43.956		

Table F.2-2 Tests of Between-Subjects Effects

Source	Type 111 sum of Squares	df	Mean Square	F	**Sig.**
Group	441.000	1	441.000	3.757	.081
Error	1173.889	10	117.389		

Appendix G
Permission to use ICG

20 March 2003
Ms. Angela Pugh
julian.pugh@ntlworld.ie

Dear Ms. Pugh:

PUBLICATION DETAILS: Inventory of complicated grief from PSYCHIATRY RESEARCH, V59(1-2): 65-79, Prigerson HG et al: "Inventory of complicated…" © 1995 Elsevier Ireland Ltd.

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Nicole McIntyre
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Appendix H
Ethical Approval

ST. VINCENT'S UNIVERSITY HOSPITAL
Elm Park, Dublin 4
ETHICS & MEDICAL RESEARCH COMMITTEE
Tel: 2094117 / Fax: 2838123
email: joan.mcdonnell@ucd.ie

3/10/02

Dr. L. O'Siorain,
Consultant in Palliative Medicine,
Our Lady's Hospice,
Harold's Cross,
D. 6 w.

Re: The cognitive formulation of loss can provide some resolution of complicated grief. An application of a brief cognitive therapy intervention to a group of bereaved individuals with unresolved grief.

Dear Dr. O'Siorain,

The above study was reviewed at the Ethics and Medical Research Committee meeting held on Wednesday 2nd October, 2002.

This study was approved. However, the committee were interested to know why this study is limited to females.

Yours sincerely,

Dr. T. Crotty, Chairman, Ethics and Medical Research Committee.

cc. Ms. A. Pugh

UNDER THE CARE OF THE RELIGIOUS SI.STE-RS OF CHARITY
AFFILIATED TO. UNIVERSITY COLLEGE DUBLIN

Appendix I
Patient Information Leaflet and Consent Form.

The death of a loved one can be a source of great pain and sadness. It is said that separation and death are normal parts of living and that in time, healing will take place. However, for some of us, these words are no comfort and we continue to feel the pain and distress long after the death has occurred. The program in which you have been invited to participate is a group psychotherapy treatment program for bereaved people who are suffering the pain of loss and for whom it is believed that participation in the program may be of assistance.

The group will run over an eight week period. You will be informed of all details regarding date of commencement, time and venue, once these have been finalised.
This program will form part of a research project and the findings will be recorded in a written document. The purpose of the research is to see if what we do in this group can form part of a future treatment program to help others. In order to ensure your privacy, a rule of confidentiality will be made with all members. In addition, I guarantee your anonymity in any written document which is produced.
In order for the group to be a success, everyone will be asked to commit to the full program and will be asked to sign a contract at the end of the first session, promising commitment, confidentiality and attendance.

Consent

I understand the purpose of this program and agree to take part in it. I am aware that it forms part of a research project and that a written document will be produced which will use material from the group sessions, I understand that my privacy will be respected in this.

Signature……

Appendix J
Help Sheets and Examples of Homework assignments

Help Sheet 1 Surviving grief.

Nobody but you can live through your grief. It belongs to you. It is the price you are paying for being attached to someone. It reflects the kind of relationship you experienced with the person you have lost and what this loss means to you now.
When death occurs, life changes forever. It will never be the same again. This can seem for some of us like an unbearable thought, a thought that can overwhelm us, a thought from which we want to hide. For some of us, what we have lost may seem like our whole world and everything that was important to us. For others of us, what has been lost by the death may have been a difficult or unhappy relationship, a bond we are relieved to be freed from. Yet, whatever the kind of loss we have experienced, we can all find ourselves grieving.

Change for all of us is stressful and at times very painful. Grief is like a journey over a seemingly endless ocean, which can ebb and flow like the tide, at times calm and predictable, and at times like a fierce storm. At times we feel buffeted by waves of harsh and distressing thoughts and feelings. Memories and images appear before us and our hearts can feel like breaking. Sometimes, we may recall when things were difficult and we can be filled with unpleasant feelings of anger, regret, shame or guilt. Often we find ourselves withdrawing from others so that we can be alone with our grief. We isolate ourselves from family or friends and stop doing the sorts of things we used to do, things which gave us pleasure. Sometimes, when we find a moments space from grief and begin to feel normal again, the realisation of our loss hits us and we feel guilty. Even when we try to act normal, we find that nothing is the same. Everything has changed, and so we must change. Yet we find that often we have lost the energy and confidence in ourselves to make the changes necessary. We don't feel like we have what it takes to cope, to survive and to pick up the threads of a new life. We feel stuck in our grief, preoccupied by our loss.

How can we survive grief? How can we help ourselves to move through this experience. Here are some suggestions which may help, but remember, we are all different and our paths through grief will also be different, so use what suggestions you feel may help you.

1. Be patient and gentle with yourself. It will take time to heal the pain of loss, and for every one, this time will be different. Some seem able to move on with life, and you may feel left behind. That is because what you grieve and how you grieve is different. Try not to compare yourself to others. This can lead to feelings of anger or resentment, or to the lowering of your self esteem.

2. Your feelings are your feelings, and whatever they are, they are neither right nor wrong. Sometimes we need to find a safe place in which to grieve alone and to allow our feelings to flow out. These feelings can be very raw and they need a voice, so expressing them will help us. If we try to avoid these feelings or to force them down inside us, we may find that they come out in other ways, such as in headaches, illness, tensions, etc.

3. Avoiding our feelings can sometimes help us through a difficult situation because we do need to be able to cope with the practical side of living while we grieve. By giving space to feelings and expressing them when we need to, we can help ourselves to find space to get on with the task of living when we need to do that too. When in difficult situations, practising steady breathing and talking to ourselves in a calm and reassuring voice can help.

4. Talking about loss is also important. If there is nobody to whom you can talk, try writing. It helps to tell your story and to work things out on paper. It releases some of the tension and the pain from within. It can also help to see things in a different light. Once is often not enough. Usually, in order to digest difficult experiences, we may need to go over and over the same ground, until we come to terms with what has happened, so writing about the same thing over and over can also help.

5. Take support from family or friends. Whilst we all need space to grieve, the support of others is very important. Isolating ourselves will not help us and may in fact hinder

our recovery. Remember, most people like to help and to feel needed, but often when in grief, we shut them out. Try asking for what you need.
6. Mind yourself. When feeling low, we tend to ignore the obvious. Look after your body as well as your mind. Exercise regularly, try not to neglect your diet, treat yourself with care, and don't use alcohol or medications to dull the pain of grief. It will still be there to greet you when you wake up.

7. Start planning new positive moves. The rest of your life is ahead and you do have choices about how you plan to live it. Your life still holds the possibility for peace and contentment, even if at present, these times are absent, limited or unimaginable. Build on what is positive and on what holds promise. Start with the smallest steps and gradually take on new more difficult challenges, until you reach your goal.

8. Remember, grief cannot be avoided, but it can be survived and conquered. Try to carry the memory forward with you, rather than holding on and standing still with what has past. You will get through this and find life again. Trust yourself.

Homework / Help Sheet 2

1. Those who haven't worked out their steps to goal, write them in your journal, in order of easiest to most difficult. It can help to grade them on a scale of one to ten, ten being the most difficult and one being the easiest.
Remember, you know best what holds you where you are in the pain, so you know best where you want to go and what steps you need to take. Ask yourself the question. "What needs to change, or what do I need to do different, if I am to start letting go of pain and finding new meaning in my life?

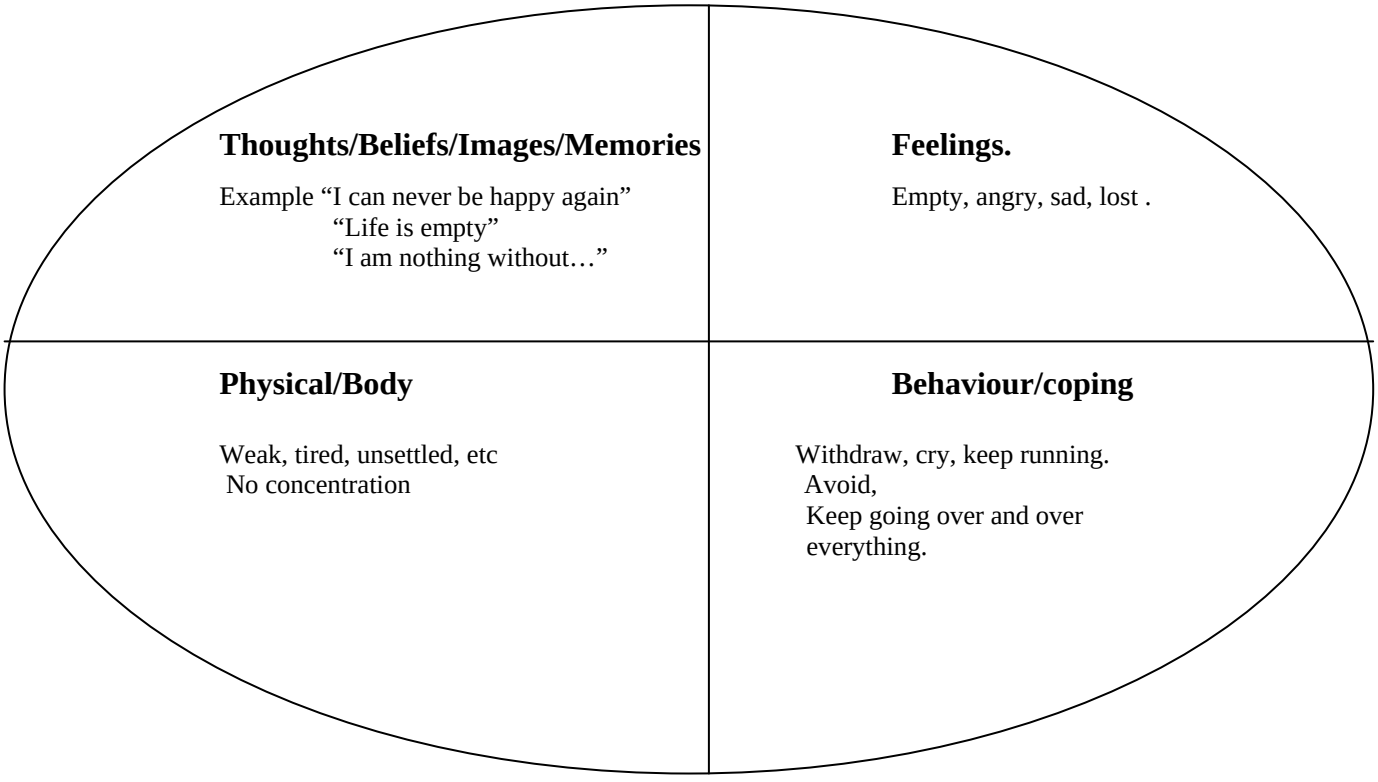
2. Everyone take a step towards goal.

3. See if you can work out for yourself what happens to you when you grieve, using the map I have shown you of the hot cross bun. To remind yourself, look at the four parts of the circle and see if you can fill it in for your self. Remember, what we are

trying to do is to understand how everything that is happening to us is connected and is influenced by the way we look at things. Thoughts are very powerful and if we can become aware of how our thinking is at the root of much of our pain, we may begin to challenge some of our more negative or unhelpful thoughts.

Hot cross bun model.

Death/ Loss



Home work / Help sheet 3 Challenging our thoughts and being our own best friend

At any time, if we tune in to our minds, we can become aware that there is an ongoing stream of thoughts and images that never stops flowing. We take this stream of consciousness for granted. It just seems to happen automatically. WE can call these thoughts and images in our mind **"Automatic Thoughts".** We are all used to thinking about things in our own particular way and sometimes, our thoughts reflect deep beliefs we have about ourselves, our lives or our future.

In fact, we get used to assuming that **whatever we are thinking is a fact**. However, just because I think something, it doesn't mean that it is necessarily true.
If I have grown up with the belief that I am not a very bright person, or that other people are better than me, just because I think this, it doesn't make it true. We sometimes need to look at the evidence for our thoughts, especially if the thoughts we are having are causing us to feel unhappy.

What thoughts or beliefs stand in the way of your healing?
When we are grieving, it is normal to have negative thoughts, and painful feelings. This is something we can usually work our way through and is part of the grieving process. However, if we are finding that our thoughts are holding us back from healing, then we need to start examining them to see if in fact they are true.
When you think about your loss, what thoughts go through your mind about yourself, your life or your future?
Do you find your self thinking thoughts such as
(a) I'm nothing without him/her.
(b) Life has no purpose
(c) There is no future.
(d) If I think about what frightens me or causes me pain, I won't be able to cope.
(e) I must not show my feelings to others.

Do you have images in your mind, such as a picture of the future as always unhappy or lonely?

Do you find that your thoughts are always about the past, and that you get into the pattern of thinking "if only…such and such had (or hadn't) happened .. …..". or "I should /shouldn't have said/ done…..".

Such thoughts seek to control the past, but the past cannot be controlled. It is over.
We do have some control over how we deal with the present and future however.

If we are to manage our grief and begin to move forward with less pain, we need to start answering back the negative thoughts and challenging the negative images in our minds because they can hold us in our pain. Try finding answers to challenge these thoughts.

Example:

(1) Thought: --------"My life is over now."

Answer: ---------". I am alive today and I have a choice about how I live it. I am here, with a future filled with possibility. I do have good things in my life, things I enjoy, people I care about, places I like to visit etc. Life is different now, but it is not over. I can be happy again."

(2) **Thought: ---------"I should have done…."**

Answer: ----------" I did the best I could at the time and in the circumstances, and with the knowledge I had……Or------"Maybe I did do some things wrong, or did make some mistakes. I am human after all! However, The picture is not all black. I also did many things that were good, such as……. So now I will forgive myself. Telling myself over and over that what I did was wrong or that I am to blame, does not help me now.

(3) Thought: ---------" Why did this happen to him/her/me? He/she/I did not deserve this".

Answer: --------" Sadly, life isn't fair. What happened cannot be changed. At least…..it could have been worse in a number of ways…….. Now I have to make the most of it. When I think about how hard this has been for me, I am proud of the fact that I have survived and can now start fighting back for myself."

Such answers are just examples of how you can start to challenge those thoughts that hold you in your pain. You alone know your own private thoughts. If they are troubling you, keep challenging them and eventually they will become much quieter.

Remember, thoughts are not facts! To challenge a thought which troubles you:
(1) Write it down. (2) Write out the evidence you have for believing it. Try rating it on a scale of (1-10), for how much you believe it. (3)Write down any possible reasons why this thought may not be true. Imagine your friend is answering you. Gather as much evidence against the thought as you can find. Give this evidence a rating from (1-10). Compare the evidence for and against the thought. You may be surprised with the result.

Remember, our thoughts , feelings and our behaviour are all connected. Think of the hot cross bun. If you can change the thoughts and challenge the beliefs which harm you, your feelings will change. If you change the behaviours also which don't work for you, you will feel better, grow in confidence and begin to enjoy life again.

Appendix K
Group Feedback Form

1. On a scale of 0 to 100, rate your satisfaction with the group programme (where zero represents no satisfaction and 100 represents complete satisfaction).

Answer:

2. What, if anything, did you like about the program?

Answer:

3.What, if anything, did you dislike about the program?

Answer:

4. Before you came to the group, on a scale of 0 to 100, how strong do you estimate your grief feelings to have been? (0 = no grief feelings, and 100= grief which is the strongest that you have ever experienced).

Answer:

5. At the completion of the program, how do you rate the strength of your grief feelings, on a scale of 0-100, (where 0 =no grief feelings and 100 = grief as strong as you have ever experienced it).

Answer:

6. Since coming to the program, how much, if any progress do you think you have made?

Please circle your response to this question:

Much progress Some progress No progress

7.What, if anything, did you learn from the program ?

Answer:

8. **Rate the extent to which you have gained the following skills on this Program**

For each of the following questions, **circle** a mark from 0 to 2, where (0 = none), (1= some) or (2 = much more than previously).

(1) Better understanding of my grief 0 1 2

(2) New ways of dealing with my grief 0 1 2

(**3)**Confidence in myself and my ability to cope with my difficulties 0 1 2

(4) Greater ability to cope with the painful feelings of grief 0 1 2

(5) Greater awareness of how my thoughts effect my mood 0 1 2

(**6)**Greater ability to correct unreasonable, negative or unhelpful thoughts 0 1 2

(**7)**New behaviours which help me deal with my grief 0 1 2

(8) Greater awareness of ways of behaving which can hold me in my grief 0 1 2

(9) Greater awareness of the issues which have been blocking me from moving forward in my grief journey 0 1 2

9. Has attending the group helped you to look more hopefully at your future life?

Circle answer:

Not at all Not much Slightly more Much more

10.If you have noticed some change in how you look at things now, can you name what has changed?

Answer:

11.What was most helpful to you in this program? Rate each answer from 0-100, where 0= not helpful, and 100= most useful)

a. Being in a group with other bereaved people Rate----------

b. Group discussion /sharing Rate----------

c. Using the Journal. Rate----------

d. Help sheets . Rate ----------

e. Homework exercises Rate----------

f. Teaching of strategies for coping during the group sessions Rate----------

g. Visualisation exercises Rate----------

h. Planning new behaviours/ goals Rate----------

i. Anything else which you found helped you?

12. Are there any changes to the program which you would like to suggest ?

(1) Would you change the way it was run? Yes / No If yes, what would you change?

(2) Would you change the number of sessions? Fewer? Or More?

(3) Would you change the length of the session? Shorter? Longer?

Appendix L Treatment intervention

L.1 Treatment Intervention for Group 1

Session 1 Content

Session 1 commenced with introductions, using the round robin technique. This was followed by agenda setting, an outline of group purpose and the rationale for addressing the problem of complicated grief within a group setting. The aim of the group was expressed positively as an opportunity to share the experience of loss in a socially supportive atmosphere and as an opportunity to explore new ways of coping and of moving forward with less pain. This was followed by a pairing exercise and some group sharing of agreed content. A group contract was then formulated.

Group members then took time to express how the death of the deceased had impacted upon their lives and named what they hoped to achieve by coming to the group. Impact was variously described as devastation, aloneness, loss of purpose, emptiness, loss of friendship and support, and feelings of anger, guilt, envy and disappointment in family. Withdrawal behaviours and behaviours motivated by a desire to hold on to the deceased were described by all. Goals described included dealing with unresolved issues, such as family conflict arising out of circumstances related to the death, and unresolved issues relating to the deceased. In addition, all members identified a desire to "move on" with life and to let go of pain. These impacts and goals were written on white board. Following a summary of group process, members unanimously responded by expressing delight with the first session. Homework was assigned in which members were asked to write down their goal and to complete mood logs in their journals.

Group Process

The objective of the first session was to orientate members to the group experience and to develop an atmosphere of trust, safety and cooperation so as to enable the group to begin the therapeutic task through the development of a cohesive working unit. In this, the objectives were met. Group anxiety was speedily replaced by a sense of trust, as the sense of shared experience of suffering appeared to unite the group.

Interaction occurred freely and communication appeared honest and forthright. Good listening was demonstrated by all but one group member, who showed resistance to

the agreed group rule regarding one person speaking at one time. The group unanimously expressed a common primary goal of pain relief and getting on with life, and the norms of support, affirmation of one another's experience and honest sharing quickly established. Affect was expressed openly and covert themes relating to unresolved issues were alluded to. Given that this was a first session, the leader's role was to offer safety and support to members, and to mirror appropriate group norms of behaviour. This was done by establishing an agenda, and sticking to it, and by ensuring that space was given to all members equally. Given the nature of a brief intervention group, it was necessary to maintain the group focus upon the task in hand. However, members were permitted space for expression. Throughout the session, the leader focussed on the here and now of group experience, which had the effect of encouraging affective response and increasing awareness of members.
The role of the co-leader was to observe, support and to act as scribe for the group.

Session 2.

Objectives: (1) Building of group cohesion
(2) Review of impact of first session
(3) Introduction to cognitive strategy of mood tracking
(4) Commencement of goal operationalisation.

Content.

The group began with a review of the first meeting. Reactions ranged from a renewal of affective expression of grief to an increased awareness of the isolation and loneliness normally experienced. Homework journaling was discussed and some individuals chose to share from these. The tracking of moods revealed primarily negative feelings, with members finding it difficult to acknowledge any positive mood shifts. All members shared elements of their personal stories, including an admission by two members of a family history of suicide and all but one of the group members shared histories of ongoing family conflict arising out of the circumstances of the death. One member (ML) described her father's abusive behaviour towards herself and her deceased mother and named her ambivalence and sense of guilt in the wake of his death. MS spoke of the bullying which she has experienced at the hands of her sister throughout life, which escalated into serious conflict at the time of her mothers death, leaving her unable to grieve. ML spoke of her awareness of being alone in the world and of the 'sinking feelings' she experienced when group members referred to

members of their families. 'I have nobody.' One member responded by saying that though she had a family, she still felt completely alone. This sense of isolation was affirmed by the group. The final 30 minutes of the session was spent on the operationalisation of goals with two members. They were asked by the leader to express how they might begin the process in the group and how the group might support them in this. Social isolation and grief resolution, including the need for forgiveness of self and the deceased were noted as goals for one member. The second member agreed to begin the task of letting go of some of her husbands belongings which she had been afraid to touch since the death two years previously. She agreed to bring a pair of his shoes (never worn) to the next group meeting and also agreed to plan out how she might continue this process subsequently. She additionally named some steps she might take to begin the healing of family conflict. The group meeting ended with a summary of group process, which included affirmation of group risk taking, honesty and hard work and with an agreement regarding homework.

Group Process.

The group started more quietly than the first meeting, and members needed some encouragement to engage. The review of the process of the last meeting however quickly removed barriers to deep sharing. Content was expressed with deep affect, and group members continued to identify themes of their own experience which were reflected in the stories of others. Here and now processing proved powerful for members, and feedback was sought and given to challenge assumptions and to create awareness of difference. The group is still in a formative stage, with some members still testing the waters. However, the process was a powerful one, with the norms of openness, honest sharing and support of members evident, engendering a real sense of cohesion.

Session 3.

Objectives: (1) Completion of goal operationalisation

(2)Group formulation of grief experience

Content

Following a mood check, members divided into pairs for 10 minutes, to share what they had written in their journals, concerning a painful memory of the deceased.

The leader then developed a cognitive model of loss using the hot cross bun figure. Members contributed to this exercise from their own experience, and seemed to

absorb the interconnections between the different components. Feelings of anger, sadness, loneliness and guilt were expressed by members. Meaning questions were prominent in response to questions about thoughts relating to the loss. Physical feelings noted were of tiredness, restlessness, and loss of appetite. Behaviours noted were of seeking distraction, withdrawal, repetitious visits to places evocative of the past, holding on to items belonging to the deceased, etc. Members agreed to write their own formulations at home. The group then moved on to the completion of the process of goal operationalisation and strategies for goal achievement within the group context. The session ended with a mood check, summary of process and homework agreement.

Group Process

The group process was open and cohesive, with trust and support expressed with regularity. Content was deep and expressed affect raw. Themes relating to conflict and a sense of injustice arose, as different members questioned the meaning of the death. Humour was expressed, as well as positive affirmation of the validity of both individual and group experience. Group motivation to change appeared mixed, with some members appearing to actively embrace the process, whilst others expressed a lack of motivation or confidence to make change. The use of journaling and homework exercises appeared to facilitate process and expression in the group. The use of here and now processing continued to create a sense of surprise, increasing sense of awareness of self and process. All members engaged and interacted in the process, with only two members requiring leadership invitation to join in.

Session 4

Objectives: (1) To explore maladaptive behavioural strategies for coping

(2) To use the interpersonal group process to explore idiosyncratic appraisals of loss and to facilitate functional behaviours

(3) Training in affect modulation.

Content

The topic of behavioural strategies for coping with loss was addressed in the context of the Hot Cross Bun. The discussion of avoidance was followed by a short thought suppression exercise and members talked of their awareness of how efforts to avoid can result in breakthrough pain. A short visualisation followed, to demonstrate affect

modulation. Rumination was then explored and the group identified a universal tendency to hold on to and to repetitively churn over painful memories. The need both to confront and avoid grief was explored. Members spoke of how difficult it is to let go of anger and to resolve unfinished business. The fear blocking such a process was explored and the empty chair technique used to assist expression of anger. The desire to resolve conflict led on to a discussion of goal directed action by members. Amid great affirmation from the group, one member produced a bag of clothes from her husband's wardrobe which had remained closed for two years following the death. The session ended with a brief summary of process and a help sheet and homework assignment was provided.

Group Process

This was another powerful session, with quiet listening and reflection evident and with greater engagement of more reticent members. The group appeared to have established itself as a cohesive entity with strong group norms of trust, loyalty and respect. Where deep affect was expressed, it had a positive quality and there was a sense of the group involved in a united struggle to deal with the pain of their loss in an honest and real way. Risk taking continued and feedback was positive and affirming. Themes of unresolved anger continue to emerge with comparisons between experience noted, which process appeared to effect those who perceived their experience as more negative or intractable than that of others. The use of journals by members has continued to positively support the therapeutic process. The ongoing theme of isolation and loneliness of members temporarily addressed within the group will have implications for dissolution.

Session 5

Objectives: (1) Facing the reality of loss

(2) Challenging appraisals of loss and pain

(3) Progress check.

Content

The session opened with a mood check and review of the previous weeks theme. Members spoke of changes taking place and most acknowledged progress in dealing with unfinished business. A visualisation followed which guided members to the deathbed scene, where they were instructed to acknowledge the reality of the death, say goodbye to the deceased and then return to a safer memory. In the discussion

which followed, Ml spoke of the anniversary of her mother's death ten years ago and of her struggle cope on her own. She compared her state of social isolation to that of others more supported than herself. This perception was challenged by MB who pointed out that despite being a loved person, ML seemed to have cut herself off from people. This led to an acknowledgement by all of the tendency to withdraw when depressed and members were reminded by MB of the Hot Cross Bun Model.

The theme of guilt and a sense of disloyalty when enjoying momentary reprieves from grieving was then explored. Members acknowledged this common feeling but some stated their conviction that the deceased would not want them to be unhappy. Making change was acknowledged as difficult, and the technique of thought challenging was then explored. Examples of negative automatic thoughts were gathered, and two examples chosen and evidence against such thoughts gathered. The group was given a help sheet to assist them in understanding and continuing this work at home.

Group Process

The group worked to a common purpose, with a sense of support and acceptance evident between members. Climate was relaxed and whilst painful affect continued to be frequently expressed, there appeared to be a greater sense of hope among some. Group problem solving was concrete, with members freely commenting and challenging others to risk change. Themes explored included the value of the group, their sense of acceptance and freedom to express what had previously been unexpressed, and their struggle to cope with the consequences of loss in their lives. Unspoken themes such as the impact of the interpersonal dynamic were also evident, with members comparing and contrasting themselves with one another, in terms of perceived advantage, disadvantage, positioning, etc. In all, this was another positive session, with both group and individual members showing positive shift.

Session six

Objectives: (1) Review of progress

(2) Modification of goals

Content

Following a mood check which revealed that two members were feeling very low due to the occurrence of anniversaries**,** the group took some time to discuss the

inevitability of triggers to grief and how best to deal with these events. This was followed by a review of progress for individual members. The goals initially set by members were reviewed and where necessary modified. Most members admitted to feeling freer to express grief, to drop masks and to explore conflict areas. All agreed that whilst the pain was still intense, life appeared more manageable. One member stated that she no longer felt in danger of 'falling down the black hole.' ML acknowledged how anger was still blocking her goal of moving on and this led to a discussion of whether forgiveness (either of the self or of others, including the deceased) is needed in order to move on. The effectiveness of exercises already used by group members to discharge anger were referred to by group members in an effort to assist ML to resolve her struggle and some re appraisal of legacy was found to be a difficult but helpful step in this process. A discussion of thinking errors followed and this led to an acknowledgement by MA of her sense of self as 'nothing'. Reasons for this belief were explored and solidly rebutted by the group on the basis of here and now experience. Goals to build self esteem were then generated and the progress achieved was noted. Group summary followed and homework set.

Group Process

This was an energetic meeting with interaction at times noisy and forceful. Members actively responded to one another, supporting one another by challenging negative beliefs and assumptions expressed. Feedback and affirmation of changes made and progress noted was ongoing. Affect expressed was more muted than previously. Leadership actions were used to bring members out of history and into here and now experience. The effect of feedback upon individuals was checked out against assumptions, and difficulties in absorbing positive feedback or discordant suggestions noted. Some cognitive resistance to change was evident for some, with a difficulty in acknowledging personal progress or in persisting with goal–directed action plans noted.

Session 7

Objectives: (1) Celebrate the legacy of the deceased
(2) Letting go of unfinished business

The session used ritual as a tool for accessing the legacy of the deceased. A white candle was lit to symbolise celebration of the life of the deceased, and a guided

imagery followed, focussing on the theme of appreciation and upon the need to move on. For those whose relationship was of a negative or ambivalent quality, focus was upon lessons learned in the struggle to survive. The personal meaning of holding on to the past and the requirement to face the future was acknowledged, with members instructed to ask the deceased their wish for them.

Following this exercise, each member in turn lit a small candle to represent their gratitude, showed a photo of the deceased to the group. They then shared memories and thoughts on this theme. Lessons learned and strengths developed in order to survive loss were reflected upon. Members discussed their perceptions of what the deceased would want for them. This was followed by the lighting of a red candle symbolising the pain, fear, and anger associated with elements of the loss experience, and unfinished business. Each member placed an object symbolising this element, and gave moving accounts of why they wished to leave these objects behind. Objects included a mouth organ, a half used bottle of after shave, a pen, a plant, and a photo.

Group Process

This session was marked by a quiet and reflective atmosphere. Members participated fully in the ritual, and listened respectfully to one another. Communication was open and trusting, with negative affect freely expressed. Group feedback was positive and freely given, with all members interacting with one another. There was a sense of members working hard to support one another and to challenge negative cognitions. The choice of objects to represent what was being left behind was meaningfully related to factors representing obstacles to growth, and signified real cognitive shift.

Session Eight

Objective: To build resilience and emphasise choice in relation to the future

The session opened with members being asked to reflect upon their learning in the group, in relation to themselves and their process. Each reflected back to the group the changes made and identified high points and moments of learning. Each spoke of how the journey embarked upon had changed them and of their desire not to return to their previous painful state. MA stated that this day, she was feeling especially sad as this session was occurring on the anniversary of her father' death. This led to a normalisation of these feelings by members, who reminded her of previous sessions

which had coincided with anniversaries, when they too had struggled. The ability to survive such occasions and to gain courage through surviving them was named. Throughout the session, members noted the strengths and attributes of one another, and the changes which they had observed in one another. Where individuals had difficulties in looking forward purposively, the leader used the lifeline technique to assist a solution focussed approach towards the future, emphasising choice and the resilience demonstrated within the group. At the closing of the meeting, anxiety in relation to the ending of the group was acknowledged, but somewhat forestalled by the agreement to return for a follow up appointment in one month. The group ended with members thanking one another, and exchanging phone numbers.

Group Process

The meeting was relaxed, with members communicating in an open and honest manner. Individuals addressed one another's issues with familiarity and understanding. Previously unspoken observations were made, particularly in relation to personal characteristics of members. Differences between members in terms of disposition and coping style were acknowledged with warmth and a degree of understanding and mutual acceptance. The tone and atmosphere appeared appropriate for a group facing closure, with themes of affirmation, gratitude, and of courage witnessed in the face of pain. Some muted affect was expressed at times, when themes touched on the losses experienced by members, but this had none of the raw quality of affect expressed in previous sessions. Here and now processing was used to facilitate reflection by members of feedback received. In all, this was a positive meeting marking closure for members both in terms of the life of the group and in terms of some of the painful aspects of grief which they had processed within the life time of the group.

L.2 Treatment Intervention for Group 2

Session 1

The structure of this session replicated that provided to the treatment group. Members shared basic elements of their loss experience with one another and identified

common elements in the stories of others. All acknowledged their pain and their struggle and expressed hope that the group would provide them with some resolution of their grief. Rule setting was clear and emphatic in terms of the need for confidentiality and the right to chose not to share sensitive information unless willing to do so. Impact of loss was described by individuals in terms of negative life changes, loss of control and trust, and the experience of painful feelings of guilt, loneliness and fear. There was some subtle acknowledgement of conflict themes, and of previous histories of troubled lives and relationships. Descriptions of response to death included words like final straw, shellshock, and loss of self, trust and hope. Goals in coming to the group were expressed in terms of resolution of trauma, return to self, achievement of peace, self-forgiveness, reengagement, and the lifting of depression and sadness. The concept of homework was explained and a help sheet and journal were given to all members.

Group process.

The session was slow to start, with members appearing tense and anxious and interaction appearing hesitant and guarded. The pairing exercise achieved some diffusion of this anxiety. Extra time was given to this exercise so as to enable some trust to develop. Feedback by members was communicated clearly and with compassion, though in some cases with a predictable blurring of experiences and stories. As feedback progressed, risk taking increased and there was some affective expression. This led to a shift in the dynamic and the achievement of greater openness of some members. Individuals appeared to listen carefully and watchfully to the contribution of others. Body language was controlled and guarded until towards the end of the session when there was a sense of the group relaxing somewhat. Humour was expressed by two members towards the close and this diffused anxiety somewhat.

Leadership took the form of normalisation of anxiety feelings and affirmation of the group's decision to pace their contributions so as to ensure safety. Group courage was also noted and affirmed as it was evident that the decision to attend had not been taken likely. Where deep affect was expressed and some opening up of stories began, the leadership task was to ensure containment. This first session was an anxious one, in which some members appeared to guard themselves from exposure.

Towards the end of the session, there was some sense of a fragile trust developing, and of the objective of the session tentatively progressing.

Session 2

Objectives (1) To reduce anxiety and facilitate the development of cohesion

(2) To commence the task of goal operationalisation

Agenda setting was followed by a review of homework. The use of a mood log revealed the prevalence of anxiety among group members. Emphasis was upon physiological symptoms suffered and upon catastrophic cognitions. The relationship between experience of trauma and resultant anxiety symptoms was explained and normalised by the leader.

The review opened up a discussion of belongingness within the group with two members questioning whether they should be in the group due to their additional ongoing emotional baggage (abusive relationships) one member noted that loss seems to bring with it other losses. Comparison between overt experience of trauma and grief arising from the breaking of close affectional bonds was explored. This led to the validation of everyone's personal experience of pain. The theme of negative memories surrounding the death experience developed and anger against the medical profession was expressed.

Noting that group affect and energy appeared low, the leader sought agreement to commence the task of goal operationalisation . One member's goal of letting go of the past was explored and operationalised as a desire to make sense of the past and a decision to progress towards this by commencing the task of writing about trauma experience. It was agreed that when ready, the story might be shared with the group, so that they too might assist in the task of meaning making. Fear of loss of control and the difficulty in approaching trauma memory was explored and the theme expanded by another individual. A goal of finding of finding forgiveness and relief from the pain of depression led to the elaboration by FM of events leading up to the death of her daughter 11 years ago. The group responded empathically to the content of the story and to the expression of deep affect. Homework was then agreed and a help sheet distributed.

Group process

The group appeared to gel somewhat, with more frequent cross-group interactions taking place. Members appeared less anxious, despite the discussion of shared anxiety experiences. Such identification appeared to increase a sense of trust, and group cohesion. Despite the growth in trust, avoidance was evident in the responses of some members. One member verbalised her lack of readiness to share, yet was noticeable by her compassionate response to others. Group norms of support, acceptance and affirmation of one another developed over the course of the session.

Affect expression appeared deep and raw at times and this had the effect of evoking an affective response from all group members which appeared to further encourage the bonding process, and by the end of the session, members appeared to have developed a greater sense of closeness. Trust nevertheless was an issue for this group despite expression by members of feelings of increased safety. This may well emanate from the common experience of trauma surrounding the loss experience of some members.

Leadership action was primarily directed towards facilitation of the interpersonal process and the use of the here and now provided opportunities to test out assumptions, as well as increasing interaction across the group.

Session 3

Objectives: (1) Group formulation of grief experience

(2) Completion of goal operationalisation

Content

The session commenced with a brief guided imagery designed to reduce anxiety. Members then broke into pairs to discuss homework tasks. The group then completed a cognitive formulation of grief. Common cognitions included 'It's not fair', 'If only' and 'life has no meaning'. Feelings of envy, sadness, fear and guilt were expressed. Discussion of anxiety, and feelings of helplessness and fear led on to a group formulation of anxiety. An over focussing upon physical symptoms was recognised as a feature of anxiety response, with fears surrounding the meaning of symptoms expressed by some. Common behaviours included withdrawal and avoidance.

The process moved to a continuation of goal operationalisation. RM spoke of her desire to resolve her conflicting feelings in relation to her dead husband, whose promise to haunt her still induced anxiety. A series of steps towards achievement of

resolution were agreed, using the format of journal writing and sharing within the group. BC then spoke of her progress in opening her husband's wardrobe after 11 years and removing and praying with his rosary beads. She disclosed how since the death she developed a phobia about going anywhere beyond a short distance from home and then was assisted to set practical goals to forgo avoidance. FM agreed to complete a written exercise aimed at resolving guilt feelings in relation to her daughters death. LM then spoke of her inability to accept the unfairness of her husband's death and of intrusive memories surrounding events connected with it. She agreed to track her feelings when experiencing her regular and intrusive cognitions. The group ended with an agreement about homework and a help sheet was distributed.

Group process.

This was a constructive session, in which both agenda and process needs were adhered to. The process commenced somewhat hesitantly, but atmosphere became less anxious following the small group activity. The group formulation exercise was thoughtfully addressed and generated honest sharing of experience. Trust was a group issue, with a distancing from people both a commonly shared behaviour outside the group, and manifesting itself at times within the group. However, bonds began to develop between members, and subgroup formation was evident. This development seemed to assist one previously reticent member to find her voice in the session. Little affect was expressed, and the climate was reflective, as the group worked to develop an understanding of their own process and formulation. Good listening and empathy were evident throughout.

Session 4

Objectives: (1) To explore maladaptive behavioural strategies for coping, by focussing upon avoidance and rumination

(2)To explore loss appraisals and to encourage adaptive behaviours

Content

The session started with a mood and homework check and led to an exploration of idiosyncratic dysfunctional cognitions blocking the processing of grief. The theme of physical pain associated with grief was widely acknowledged. Beliefs blocking grief

expression were then explored, and the view expressed that pain should be repressed, so as to protect others. Downward arrowing revealed a deeper fear that to cry might mean never stopping. The theme of avoidance led to a member confessing to avoidance of situations which might lead to feelings of disloyalty to the dead. This theme was developed and it was acknowledged that the wish of the dead would not be a continuance of the suffering of the living. Access to happy memories and the sharing of images led to a discussion of the mechanisms of confrontation and avoidance in grief management. The continued tendency to ruminate over the unfairness of death was raised by LM, who acknowledged a growing recognition that she had a lot to be grateful for. She was affirmed for the manner in which she was learning to challenge her thinking so as to find some positives in a difficult situation. This led FM to talk of her struggle to come to terms with her daughter's death. Exploration of her assumptions regarding her failure to give her daughter a happy life experience led to the evocation of forgotten memories of laughter and happiness and following this to a discussion of thinking errors. RM spoke of her struggle to deal with the conflict between her desire to forgive her dead husband and the need to name the damage he had inflicted upon her. DD then became profoundly anxious and distressed and spoke of her inability to talk about or to challenge her profoundly negative and distressing memories of her sister's death and it's aftermath. The leader then facilitated her re-experiencing of her trauma in the here and now. The group expressed shock, sadness and support for DD following this cathartic expression. Some time was given to grounding the group members prior to the cessation of the session.

Group process

This was a powerful session in which all members participated with respect and empathy. Affect was expressed openly and it had a raw and deep quality to it. There was a sense of an increasing group cohesion, as the expression of mutual trust deepened. Anxiety was both thematic and visible within the group. The leadership role was to facilitate the cognitive exploration of assumptions and to act as facilitator and container of deep affective expression.

Session 5

Objectives (1) Facing the reality of loss
(2) Challenging appraisals of loss

The session opened with a mood check, followed by a description by DD of the impact upon her of re experiencing of her trauma, and her recognition that she has dissociated from her experience due to it's traumatic effect upon her. The failure of avoidance to protect from the pain of grief was discussed.

Following this, a visualisation took place in which painful or frightening memories relating to the death were invited, explored and then replaced by positive memories. This led to an acknowledgment of difficulty in accessing positives for members whose relationships were associated with suffering. Loss of sense of self was expressed, and one member questioned whether others could understand her desire at times for the struggle of life to be over. Social isolation, alienation from others, feelings of lack of self worth and the destructive impact which control by others can have upon the self were all explored. This led to an explication of the strategy of challenging of negative automatic thoughts relating to the self, others and the world. The group concluded with some more goal setting relating to the issues discussed during the session.

Group process

The atmosphere in this group appeared noticeably more relaxed and there was a sense of increasing cohesion. Communication was open and honest and activity was constructive and goal orientated. Unlike previous sessions, there was a reduced sense of anxiety expressed either verbally or nonverbally, and body language was more open and relaxed. Humour was expressed on a number of occasions and personalities were revealed in a manner nor previously noted. There was a sense of empathy and understanding, with the group rushing to affirm strengths and to support the vulnerability of others. Whilst there was some advice given, the manner in which issues were explored was generally one of honest expression of similarity of struggle and of themes of survival, which were used sensitively in order to encourage others. In all, this was a constructive therapeutic encounter.

Session 6

Objectives (1)Progress check

(2)Continuation of cognitive exploration of obstacles to resolution

The session commenced with a review of homework. LM expressed distress leading up to the anniversary of her husband's death and an exploration of her ruminative thoughts followed. This led to further discussion about the negative effect of rumination and themes relating to losses and failures experienced around the time of the death were developed. Some reappraisal of experience followed.

The event of a burglary the previous day led RM to attribute meaning to this event in the context of a life of abuse, leading to a perception of the unfairness of life. This theme was taken up by BC, who stated an inability to discover anything positive in life. The power of negative thinking was then explored and thought challenging was facilitated by RM's statement that despite life's pain, positives can happen, which can restore hope. This reappraisal led BC to reappraise her negative generalisation about the unhappiness of life and she acknowledged that poor health was affecting her mood. When one member spontaneously handed BC a get well card, this was used to remind BC that some good can happen even in the midst of sorrow. The homework task of writing to the deceased was then discussed and one member stated that she would like to write a letter to the child who had once been her husband, a child who must have suffered abandonment in order to have treated her so abusively. The group agreed their tasks and the session closed.

Process:

Ongoing major life stressors provided the backdrop to this session. As a result, the climate was one of anxiety and loneliness in the face of life's struggle. Negative, selective and black and white thinking were in evidence and the task of cognitive restructuring through the use of interpersonal process proved difficult. There was a sense of individual members lost in their own struggle for survival and communication though honest, nevertheless appeared less fluid across the group. Towards the end of the session, affect shifted and became more positive and some humour was expressed. There was evidence of some behavioural changes taking place both outside and inside the group and of cognitive insights into the maladaptive effect

of certain kinds of cognitions. However, the underlying sense throughout the session was that the losses experienced by members continued to exert a painful influence upon lives and that individuals were guarding themselves against the threat of challenge.

Session 7

Objective

Reconnecting with the deceased, and completion of tasks

The group process commenced by LM crying as she described her continuing anxiety and distress leading up to the anniversary. This led to a discussion of the triggers to grief and of the ability to survive. Following this, a visualisation took place in which the death scene was faced and the wish of the deceased for the survivor was sought. This led RM to acknowledge that negative memory had blocked out good and positive memories of her husband, but that in connecting with the child he had once been she was beginning to be able to face more painful and abusive memories of him. DD then spoke of her ongoing difficulty in facing her traumatic memories or of writing about them. Trauma management and processing were again addressed. Anger against god was also proving an obstacle to find meaning and this led to a discussion which enabled some reconstruction of meaning to take place. Others spoke of also having gained strength through death and of new meanings acquired in the light of the experience and perceptions of group members. Progress towards goals was acknowledged and affirmed by all.

Group process

This was another painful session with members expressing themes of ongoing pain and struggle. Negative affect was expressed strongly and it was difficult for some members to progress beyond their pain. Some resistance to change was evident in some members, whilst most expressed hope and a sense of renewed optimism. Towards the end of the session mood lightened and those expressing greatest negativity appeared to become more encouraged as the group process became more other focussed, affirmatory and challenging of negative appraisals. There was a sense of a group sharing commonality and finding solace in this but also a recognition that each member has a way to travel and for some, a sense of anxiety and futility of struggle was evident as the journey of the group approached closure.

Session 8

Objectives

(1)Acknowledgement of group resilience in the face of ongoing adversity

(2)Ritual letting go of pain, acknowledgement of legacy and closure

Members shared their experience in the group, what learned and what steps remained to be tackled. The leader recognised the active ongoing difficulties and areas of struggle of members, which due to the time limits of the program, could not now be tackled. There followed a ritual in which, following a short visualisation, each member of the group used symbols to acknowledge the legacy of the dead and to let go of painful obstacles to resolution.

Process: Content was of a deep nature and expressed with affect. The use of ritual provided a powerful focus for the group. Despite the recognition of the ending of the group, some resistance was noted, as some members anxiously attempted to move content into deeper areas of personal struggle and resisted rules agreed for the closure ceremony. There was a sense that closure of the group was untimely and that for some individuals, therapy was just beginning. Leadership therefore demanded active containment in the face of the ongoing needs of some members. Follow up planning will be necessary for these members.