The Development and Pilot Testing of the Meaning-Based Group Counselling Intervention for Bereavement

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DEDICATION

For my family, with love and affection…

Gwendolyn Alice Reid Nugent Robinson
(1921-1996)

Patricia McKenzie MacLennan MacKinnon
(1912-2003)

Elizabeth (Betty) Logan MacKinnon
(1939-2006)

Wayne Edward Robinson
(1942-2008)
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ABSTRACT

While bereavement interventions have proved effective in reducing complicated/prolonged grief reactions, the scholarship over the past 10 years suggests that the effectiveness of bereavement interventions for uncomplicated grief is negligible. However, these past studies have been critiqued for numerous design flaws, making any definitive conclusions about effectiveness premature. What has emerged is a need for theoretically-based uncomplicated bereavement interventions for individuals actively seeking support, which are supported by sound design and methodology.

Correspondingly, the meaning-making paradigm offers a potentially potent conceptual lens to understand grief reactions and is garnering increased empirical support. However, no studies to date have examined the application of a meaning-based approach to inform interventions for support groups targeting uncomplicated bereavement. This study seeks to address these gaps in knowledge.

The first objective of this dissertation was to review existent theories of meaning and their empirical applications, with the goal of deriving clinical implications for counselling psychologists engaged in cancer-related bereavement psychotherapy (reported in manuscript 1). Second, the lack of use of meaning-based theories in bereavement support groups resulted in the creation of an original meaning-based group counselling (MBGC) intervention for uncomplicated grief (reported in manuscript 2).

The third objective was to conduct a pilot test of MBGC using a formative evaluation to assess feasibility and effect refinements to MBGC as needed (reported in manuscript 3). Findings of this feasibility trial \( n = 9 \) resulted in several modifications to MBGC based on participant

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1 Except for parts of this dissertation that were/will be published in United-States-based journals, Canadian spelling (e.g., counselling as opposed to the U.S. spelling of counseling) will be used throughout.
feedback. The majority of group members reported the meaning-based intervention as beneficial. Descriptive statistical examination of outcome measures assessing depression and grief suggested small improvements from baseline.

Following successful completion of the pilot study, it was decided to proceed with a pilot randomized controlled trial (RCT), which constituted the final objective of this dissertation (reported in manuscript 4). The pilot RCT was registered with ClinicalTrials.gov (identifier NCT01384942). Recruitment resulted in 26 individuals randomly assigned to either MBGC or a control (treatment-as-usual) bereavement support group. A total of 20 participants (n = 11 in the experimental arm; n = 9 in the control arm) completed all aspects of the study including pre, post, and 3-month follow-up measures of meaning, anxiety, depression, and grief.

Final analyses suggest MBGC continued to be a feasible intervention in the pilot RCT phase. Overall results encourage proceeding with a full RCT to assess the efficacy of MBGC. However, relatively low recruitment rates suggest that a full trial will need to be conducted in multiple sites. A general discussion finalizes the dissertation.
RÉSUMÉ

Tandis qu’il a été prouvé que les interventions faites suite à un deuil réussissent à réduire l’incidence de réactions de deuil compliqué/prolongé, les travaux de recherche des dix dernières années semblent suggérer que l’efficacité de ces interventions reste négligeable dans les cas de deuil non compliqué. Toutefois, beaucoup critiquent ces études en raison de nombreux défauts de conception qui rendent prématurée toute conclusion catégorique. Il convient maintenant de trouver des interventions pensées à partir d’une base conceptuelle, théorique et méthodologique solide, et qui pourraient servir dans les cas de deuil non compliqué pour les personnes qui recherchent activement un soutien.

Par ailleurs, le paradigme de construction du sens offre une lentille conceptuelle qui pourrait nous aider à comprendre les réactions de souffrance liée au deuil et jouit d’un support empirique accru. Aucune étude ne s’est, toutefois, encore penchée sur ce que pourrait apporter la méthode de construction de sens pour informer les interventions des groupes de soutien qui ciblent le deuil non compliqué. Cette étude se propose d’examiner ces lacunes.

Le premier objectif de cette thèse a été de revoir les théories du sens existantes ainsi que leurs applications empiriques dans le but d’en tirer des implications pertinentes pour le travail de counselling des psychologues appelés à intervenir dans une psychothérapie pour deuil lié au cancer (rapporté dans le manuscrit 1). Ensuite, du fait de l’absence de prise en compte des théories de construction de sens dans les interventions des groupes de soutien, le second objectif a été d’élaborer une intervention de counselling de groupe fondée sur la construction de sens (MBGC) pour le deuil non compliqué (rapporté dans le manuscrit 2).

2 À l’exception des parties de cette thèse qui ont été ou seront publiées dans des revues des États-Unis l’orthographe canadien est utilisé partout (par ex. counselling au lieu de l’orthographe américain counseling).
Le troisième objectif a été de réaliser une étude pilote de l’approche basée sur la construction de sens (MBGC) à l’aide d’une évaluation formative qui permettrait d’en juger la faisabilité et d’y apporter les raffinements éventuels nécessaires (rapporté dans le manuscrit 3). Les observations faites dans le cadre de cette étude de faisabilité \( n = 9 \) ont entraîné plusieurs modifications au modèle MBGC à partir des commentaires des participants. La majorité des membres du groupe ont jugé bénéfique l’intervention basée sur la construction de sens.

L’examen descriptif statistique des critères mesurés pour la dépression et la souffrance liée au deuil a indiqué de légères améliorations par rapport aux valeurs de départ.

L’étude pilote ayant été menée à bien, il a été décidé de procéder à un essai randomisé contrôlé (ERC), ce qui a constitué l’objectif final de cette thèse (rapporté dans le manuscrit 4). L’ERC pilote a été enregistré sur ClinicalTrials.gov (identifiant NCT01384942). Le recrutement a produit 26 personnes réparties de manière aléatoire entre le groupe de soutien au deuil basé sur la construction de sens (MBGC) et le groupe témoin de soutien au deuil (traitement classique). Un total de 20 participants \( n = 11 \) dans le bras expérimental; \( n = 9 \) dans le bras témoin) ont participé à toutes les étapes de l’étude, incluant les mesures pré, post et de suivi à 3 mois pour le sens, l’angoisse, la dépression et la souffrance liée au deuil.

Les analyses finales semblent montrer que l’approche basée sur la construction de sens (MBGC) est restée une intervention réalisable dans la phase ERC. L’ensemble des résultats plaide en faveur d’une pleine étude randomisée contrôlée pour évaluer l’efficacité des interventions basées sur la construction de sens (MBGC). Cependant, les taux de recrutement relativement bas laissent penser qu’une telle étude devra se faire sur plusieurs sites. La thèse se termine sur une présentation des conclusions générales.
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Contributions of Manuscript Co-Authors

All four manuscripts, as well as all other written material contained in the dissertation, were originally composed by the doctoral candidate (Christopher J. MacKinnon) except where noted through appropriate referencing.

MacKinnon developed the initial protocol for this clinical research study, outlining the methodology and developing the initial version of the MBGC intervention manual. He co-facilitated all three MBGC groups and was primarily responsible for the qualitative (research reports, exit interview, and session transcripts) and quantitative (descriptive) analysis. He was also in charge of the research ethics application and renewals. He drafted all components of the dissertation, and was entirely responsible for integrating all feedback from supervisors, committee members, and co-authors in revising the written material. MacKinnon was the primary author on all four manuscripts, responsible for drafting, integrating co-author feedback, and submitting to peer-reviewed journals for publication. The contributions of various collaborators associated with the study are recognized below.

Co-supervisors Drs. S. Robin Cohen and Nathan Grant Smith have provided significant intellectual, methodological, statistical, analytical, and editorial contributions to the project. They evaluated the initial literature review that was a part of the candidate’s comprehensive examination. They were also heavily implicated in the development of the research protocol, interventional manual, and subsequent application and continuing reviews to the Research Ethics Committee of the Jewish General Hospital. During feasibility testing, Cohen and Smith reviewed audio recordings of the sessions, analyzed weekly research reports, as well as participated in a weekly research meeting to develop and adapt the intervention. They were highly involved in
reviewing all written material presented in the dissertation, as well as resultant refereed conference presentations.

Committee member Dr. Melissa Henry provided considerable clinical expertise as co-facilitator of two of the bereavement groups, as well as substantial intellectual, methodological, statistical, and editorial input at various stages of the study from protocol development to completion. Similarly Drs. Annett Körner and Dr. Harvey Max Chochinov have added noteworthy scholarly feedback in the development and analysis phase of the study, as well as editorial and intellectual contributions to the manuscripts. Dr. Körner also served as the second reviewer for the candidate’s comprehensive examination.

Five research assistants were engaged in this study for various lengths of time. Mel Berish served in the capacity of group observer, exit-interviewer, and co-facilitator for one of the experimental groups, conducted data entry, as well as furnished intellectual and editorial contributions to the project. Evgenia (Jane) Milman served as group observer, exit-interviewer, and transcriber, conducted data entry, and provided intellectual and editorial contributions, particularly in the development of manuscript one. Laura S. Copeland provided transcription and conducted literature searches. Amanda Farrace provided transcription, literature searches, as well as data entry services. Nancy Gair provided transcription services for data used in composing manuscript three.

Nikoleta Liarikos served as co-facilitator of two of the control groups. She also assisted with a substantial portion of the screening interviews for the pilot RCT.

The expert opinions of the co-investigators were sought during the development of various abstracts and presentations (i.e., posters, oral) associated with the study for various scholarly conferences and for peer-reviewed journal publications. The doctoral candidate
Christopher J. MacKinnon assumes principal responsibility for the originality, authenticity, methodological rigor, and accuracy of the findings presented in this study.

**Statement of Originality**

I (Christopher J. MacKinnon) confirm that this dissertation is an original work and contribution to the advancement of knowledge. Other scholarly works are fully acknowledged in accordance with standard referencing practices of the American Psychological Association. I attest that this dissertation does not infringe upon copyright except where noted. The dissertation has been approved by a doctoral thesis committee. It has not been submitted for another educational degree at any other institution.
CHAPTER 1: INTRODUCTION

The central paradox of our current feel-good culture is that we grow progressively more and more uncertain and less and less persuaded that our lives really mean something. Feeling good is a poor measure of life, but living meaningfully is a good one, for then we are living a developmental rather than a regressive agenda.

-James Hollis, 2006, p. 232-233

The first chapter of this dissertation introduces the background and rationale for the development and pilot testing of a novel meaning-based group counselling (MBGC) intervention for individuals in uncomplicated bereavement. Theories of bereavement and accompanying psychological factors associated with grief are then demarcated, followed by factors distinguishing normal/uncomplicated from complicated/prolonged grief. The first chapter concludes by examining the current trends in bereavement-intervention research, outlining the overall research objectives of the study, as well as specifying ethical considerations and implications for the field of counselling psychology.

1.1 Rationale for the Study

The rationale for this study rests in part on the need to develop more effective bereavement interventions for individuals in uncomplicated grief. Recent reviews have suggested interventions directed at uncomplicated bereavement are largely unsuccessful in ameliorating psychological distress (Currier, Neimeyer, & Berman, 2008; Forte, Hill, Pazder, & Feudtner, 2004). Those recently bereft and seeking formal psychological support are ethically entitled to more effective services grounded in rigorous scholarship in the spirit of relieving their psychological distress.

1.2 Theories of Bereavement

Early stage and attachment models of grief are giving way to integrated theories that seek to synthesize a complex variety of scholarship (Archer, 2008). Commensurately, the process of
meaning-making offers a preeminent conceptual lens to understand stressful life events, including bereavement. Meaning-making is a paradigm that is beginning to profit from increased empirical investigation (Park, 2010). A significant body of the meaning-making scholarship draws on postmodern narrative-constructivist paradigms (Neimeyer & Bridges, 2003; Neimeyer & Raskin, 2000a) to understand symptoms of psychological distress and suggests ways to guide treatment delivery to facilitate adaptation (Nadeau, 2008; Neimeyer, 2001a; Neimeyer & Anderson, 2002; Neimeyer, Keesee, & Fortner, 1998).

**1.3 Uncomplicated and Complicated/Prolonged Grief**

Current scholarship has dichotomized the reactions to bereavement as either normal/uncomplicated or complicated/prolonged. The majority of individuals experience variable degrees of emotional, physical, cognitive, and behavioural distress in the first 24 months following a death-related loss; however, these symptoms do not normally impair overall functioning (i.e., uncomplicated bereavement) (Prigerson & Maciejewski, 2008a; Shear et al., 2011; Worden, 2009). Conversely, complicated/prolonged grief refers to a clinical profile of heightened psychological distress that is fixed and requires professional intervention (Horowitz et al., 1997; Horowitz, Wilner, Marmar, & Krupnick, 1980; Worden, 2009). Several researchers are pursuing parallel paths in identifying key factors for a diagnosis of complicated (or prolonged) grief disorder for possible inclusion in future editions of the *Diagnostic and Statistical Manual (DSM) of Mental Disorders* (American Psychiatric Association, 2000; Prigerson et al., 2009; Shear et al., 2011). Within the recently released DSM-V (American Psychiatric Association, 2013), *persistent complex bereavement disorder* has been added as a possible future diagnosable psychiatric condition, though the proposed criteria have been critiqued for not being empirically validated (Boelen & Prigerson, 2012).

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3 The following terms are used interchangeably: meaning-making; meaning-reconstruction; the search for meaning.
1.4 Current Trends in Bereavement-Intervention Research

While bereavement interventions have been proven effective for the treatment of complicated grief (Piper, Ogrodniczuk, Joyce, & Weideman, 2011; Schut, Stroebe, van den Bout, & Terheggen, 2001), there remains a degree of controversy regarding the efficacy of bereavement interventions for individuals whose grief follows an uncomplicated trajectory (Jordan & Neimeyer, 2003). The controversy is in part due to past studies with numerous research design flaws, including lack of randomized controlled trials (RCTs), recruitment faults, use of un-validated outcome measures, lack of replicability, problematic control groups, and unclear therapeutic procedures (Forte et al., 2004). Furthermore, meta-analyses of bereavement interventions have been critiqued for using questionable statistical techniques to make unfounded generalizations of ineffectiveness (Larson & Hoyt, 2007). Finally, there is an appreciable shortfall of studies specifically assessing support groups for uncomplicated bereavement (see Stroebe, Schut, & Stroebe, 2007), despite the fact that groups are often used by the bereft. This dissertation attempts to address these concerns.

1.5 Research Objectives

Given the above trends, concerns, and gaps in knowledge, the overall research objectives of the dissertation were:

1. To develop a MBGC intervention for individuals in uncomplicated bereavement.

2. To assess whether MBGC was a feasible intervention within a pilot randomized controlled design.

To accomplish these two objectives, a comprehensive review of meaning and bereavement scholarship was necessary to highlight theoretical trends, recent empirical findings, and clinical implications for counselling psychologists. Particular focus was given to cancer-
related bereavement, as this particular form of bereavement has received only scant attention in the literature. This review was followed by the development of MBGC for uncomplicated bereavement, built on the recommendations and critiques expressed in the scholarship.

A feasibility trial was carried out to assess practicality, as well as to effect adaptations to MBGC informed largely by participant feedback. A total of nine participants completed all aspects of the feasibility study. Refinements were made to the interventions, and qualitative data suggested MBGC was useful in alleviating bereavement-related psychological distress. Descriptive statistical findings for the outcomes of depression and grief suggested small improvements from baseline. No counter-indications were identified and it was decided to proceed with a pilot randomized controlled trial (RCT).

The pilot RCT was registered with ClinicalTrials.gov (identifier NCT01384942). The research questions were:

1. Does MBGC remain a feasible intervention in a pilot RCT design?
2. Was the RCT methodology feasible, including treatment arm randomization and minimal participant attrition?
3. What further adaptations and changes to MBGC are needed based on participant feedback?
4. Do the outcome measures remain acceptable to participants?
5. Do the results support proceeding with a fully-powered RCT?

1.6 Implications for Counselling Psychology

It is regrettable that the field of counselling psychology has tended to largely marginalize inquiries into bereavement, a phenomenon that is universally human with clear psychological ramifications. It is also curious that a discipline interested in cultural variation, as well as
multiculturally-sensitive research and practice, has ignored a sphere of human life so deeply influenced by culture (Klass & Chow, 2011; Rosenblatt, 2008).

This dissertation is aligned with counselling psychology’s focus on promoting client resilience in the face of adversity (see Brown & Lent, 2008; Toporek, Gerstein, Fouad, Roysicar, & Israel, 2006). While not integrating an explicit theoretical model of prevention or development, MBGC assumes a personal-growth and wellness approach to grief adaptation (Wong, Ussher, & Perz, 2009). MBGC also treats bereavement as a non-pathological experience and champions the individual’s capacity to deal with adversity and assist others in a collaborative fashion. Lastly, the intervention’s constructivist underpinnings (Neimeyer & Raskin, 2000b) ensure attending to diverse understandings of reality (e.g., grief narratives), thus facilitating culturally-sensitive counselling and psychotherapy. The constructivist approach of MBGC allows it to be tailored to meet individuals “where they are,” co-constructing an experience that is appropriate to address their particular grief needs. Lastly, the dissertation is an attempt to raise awareness in the field of counselling psychology of the necessity for conducting future bereavement studies as well as associated clinical trials.
CHAPTER 2: BRIDGING THEORIES OF MEANING AND BEREAVEMENT

Though much is taken, much abides; and though
We are not now that strength which in old days
Moved earth and heaven; that which we are, we are;
One equal temper of heroic hearts,
Made weak by time and fate, but strong in will
To strive, to seek, to find, and not to yield.

-Alfred, Lord Tennyson, 2003

2.1 Preface

Over a decade ago, Neimeyer (2001b) remarked that research in the diverse fields of death studies (thanatology, grief counselling, suicidology, and traumatology) have historically been constrained by adherence to outdated theories, few sophisticated conceptual models, and a resulting failure to provide new insights into clinical practice. However, recent novel research designs guided by emerging theoretical models have resulted in an increasing number of scientific studies and interventions.

Specifically, the role of meaning as an important factor in the experience of grief is receiving increased attention. The process and derivation of meaning in adapting to stressful life events (including death-related loss) have been identified as intrinsic human responses (Park, 2010). Grounded in part on postmodern narrative-constructivist and trauma theoretical frameworks (Neimeyer & Anderson, 2002; Neimeyer et al., 2002; Neimeyer et al., 1998; Romanoff, 2001) with influence from existential (Frankl, 1981), stress (Park & Folkman, 1997), and spiritual theories (Golsworthy & Coyle, 1999), meaning-making is a process whereby the bereft rebuild and reinterpret their ongoing life stories following death (Neimeyer, 2001a).

Nonetheless, there remain significant gaps in our knowledge for applying meaning-making
frameworks to guide bereavement interventions. In particular, studies are needed to ensure that future interventions are grounded in rigorous methodology and scholarship.

To this end, Chapter 2 begins with definitions of essential constructs that appear throughout the dissertation. A sketch of theoretical trends in bereavement, followed by the particularities of grieving a cancer death, serves as a backdrop to the first manuscript of the dissertation. The opening article is an evaluation of emerging meaning-making premises and empirical trends, with clinical implications in cancer-related bereavement psychotherapy.

2.2 Definition of Key Constructs

To contextualize this treatise, it is important to first define the following terminology frequently employed in the literature: *loss, bereavement, grief,* and *mourning.* Often these terms are used somewhat interchangeably; however, subtle and important distinctions exist. The most comprehensive definitions that reflect the general consensus of scholars in the field (Parkes, 1996; Stroebe, Hansen, Schut, & Stroebe, 2008) are used to guide the discussion that follows.

*Loss* is a construct that tends not to be defined. It is a term that can apply to various domains of life (vocation, marriage, possessions) and suggests that people no longer have someone or something they used to have (Miller & Omarzu, 1998; Neimeyer, 2006).

*Bereavement* is defined as the objective situation of having lost someone significant through death. While no definition of bereavement includes temporal considerations, it seems important to note that bereavement is often assumed to be limited to a specific timeframe. The term *grief* is defined as an affective reaction to loss with accompanying psychological, cognitive, behavioural, and physical manifestations (Stroebe, Hansson, Stroebe, & Schut, 2001). *Mourning* is defined as the diverse social expressions of grief that are mediated by socio-cultural factors (Stroebe et al., 2001).
In addition to the above loss constructs, there is also a diverse vocabulary related to meaning found in the scholarship. Definitions of these various meaning constructs are found in manuscript 1.

**2.3 Current Trends in Theories and Models of Bereavement**

With the integration of diverse theories from an increasing number of disciplines focusing on bereavement, the resolution of grief has become one of the central theoretical issues in contemporary scholarship (Archer, 1999, 2008). The following sub-section follows Stroebe and Schut’s (2001b) framework, outlining a number of significant theoretical models: (a) general grief-related theories; (b) intra-personal and interpersonal models of bereavement; and (c) integrative models of grief.

**2.3.1 General grief-related theories.** General theories of grief continue to be dominated by the early efforts of Sigmund Freud, who is often cited for laying the foundation for the grief work hypothesis. The hypothesis suggests that grief is an active process that serves a specific intra-psychic function of separating from the deceased so that the bereft can adapt (Archer, 2008; Freud, 1957). The framework was later adapted by attachment theorists, in particular by John Bowlby, who postulated a biological framework for grief similar to psychoanalytic theory but with a more relational perspective. Bowlby (1961, 1980) argued that bereavement is a process whereby individuals re-invest their energy in new relationships, but do not entirely relinquish bonds with the deceased (Bonanno & Kaltman, 1999). Bowlby’s framework has been strongly endorsed, in particular his notions of pathological grief (Parkes, 2001).

Closely linked to attachment models are stage or phase models of grief, which theorize that individuals go through intra-psychic non-sequential stages in the bereavement process. Elizabeth Kübler-Ross (1969) proposed her illustrious five-stage model of grief. Specifically,
individuals go through the stages of denial, anger, bargaining, depression, and acceptance. This theory specified individuals do not necessarily go through the stages in a sequential order, but revisit certain states throughout the grieving process. Originally intended for understanding the experiences of individuals with terminal illness, the five-stage model of grief formed the basis for other stage models of grief, as well as theories of *anticipatory grief*. Anticipatory grief itself refers to psychological distress experienced in the present but influenced by previous losses in tandem with anticipated future losses (Rando, 2000).

The supremacy of psychodynamic theories, the grief work hypothesis, and stage models began to change in the late 1980s when unproven myths of bereavement began to be challenged (Wortman & Silver, 1989). For example, in a pioneering article, Stroebe and Stroebe (1991) reported an over-simplification and overgeneralization of the grief work hypothesis. Other articles followed that challenged traditional definitions and processes of grief (Corr, 1993; Stroebe, 1992-1993). These innovative contributions resulted in a growing awareness that studies in bereavement needed to be better grounded in sound empirical research (Stroebe, Hansson, Schut, & Stroebe, 2008).

In response, two recent empirical investigations of the stage model of grief have been conducted. Maciejewski, Zhang, Block, and Prigerson (2007) employed a longitudinal cohort design to examine the relative patterns of five grief indicators over three years post-death. Following the analysis of a series of questionnaires to assess participant’s patterns of grief, the authors reported that the five grief indicators achieved their respective maximum values in the following sequence: disbelief, yearning, anger, depression, and acceptance. Several letters to the editor of the specific journal in which Maciejewski, Zhang, Block, and Prigerson (2007) published have taken issue with the particulars of this study. For instance, Silver and Wortman
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(2007) argued that selective exclusion of nearly 40% of participants undermined the generalizability and validity of the study. In addition, Weiner (2007) commented that the study failed to take into account cultural diversity.

The most current attempt to investigate stage theory was made by Holland and Neimeyer (2010) who examined the relationship between time since loss, the five grief indicators, as well as sense making (often referred to as a feature of meaning-making) in a large sample of individuals bereft due to natural \((n = 441)\) or violent \((n = 173)\) means. The authors reported the findings largely failed to corroborate the stage model, though some evidence suggested disbelief, yearning, anger, and depression tended to be relevant for those earlier in the bereavement trajectory. Intriguingly, sense-making was consistently a more robust predictor of grief, accounting for more variability in the five grief indicators when compared to time since loss.

Taken as a whole, attachment and stage models continue to strongly influence current practice and scholarship (Lindstrøm, 2002; Mikulincer & Shaver, 2008). This trend is no more true than in the historical dominance of the stage model in training medical professionals on issues surrounding bereavement (see Downe-Wamboldt & Tamlyn, 1997). Overall, future research is needed to explore the validity and clinical implications of using the stage model (Holland & Neimeyer, 2010).

2.3.2 Intra-personal and interpersonal models of bereavement. Stroebe and Schut (2001b) commented that recent research has championed two broad theoretical categories specific to bereavement: intra-personal and interpersonal models. First, task models of bereavement tend to fall within the intrapersonal coping theme. Worden (2002, 2009) specified four tasks of mourning that underpin a typical grief-counselling intervention. These tasks comprise accepting the reality of the loss, processing the pain of grief, adjusting to a world
without the deceased, and finding an enduring connection with the deceased in the midst of embarking on a new life. Worden (2009) further identified ten principles and procedures of grief counselling, such as assisting the bereft to actualize the reality of the loss, to identify as well as process difficult emotions, and to find meaning in the loss.

Another prominent task model of bereavement by Rando (1993) specified six tasks of grief, which include recognizing the loss, reacting to the separation, remembering the deceased, relinquishing attachments, adapting to a new world while not forgetting the past, and reinvesting in new relationships. There are similarities between Rando’s (1993) and Worden’s (2002, 2009) task models in that they share the following: an emphasis on intrapsychic processes, a basis in attachment theory, the common task of relocating the deceased in one’s present life, and the development of new relationships with the deceased (DeSpelder & Stricklander, 2008).

Stroebe and Schut (2001b) have also specified interpersonal models of coping that include systemic considerations of bereavement. Specifically, Walsh and McGoldrick (2004) argued that death poses a challenge for families necessitating changes to, and reorganizations of, the family’s purpose and identity. They proposed four major family tasks (reminiscent of an intrapersonal model) that, if undertaken, will assist in positive adaptation: shared acknowledgement of the reality of death, shared experience of loss, reorganization of the family system, and reinvestment in other relationships and life pursuits. Family systems theories also extended the discussion to include meaning during bereavement, in particular the interplay between culture and spirituality (Walsh, 2004).

Another example of an interpersonal theory is the model of incremental grief. Cook and Oltjenbruns (1998) contend that individuals experience grief within a broader context, namely their experiences of continuous loss over the lifespan. The adjective “continuous” suggests an
additive feature of grief. With each new loss, there is a magnification of grief, which, if not properly dealt with, can result in additional distress for the individual. Overall, task models and intra/interpersonal models continue to exert a strong influence on bereavement scholarship.

2.3.3 Integrative models of bereavement. The following models have been identified by Stroebe and Schut (2001b) as attempting to integrate general models of adaptive coping with bereavement-specific outcomes. First, an example of a systematic integration of cognitive stress theory with bereavement is the Dual Process Model (DPM) of grief by Stroebe and Schut (1999, 2001a, 2001b, 2010). The authors identified two distinct types of coping tendencies a bereaved individual will experience. The first is loss-orientation coping. *Loss-orientation* is the tendency of the bereft to focus his or her energies on processing the aspects of the loss itself with the usual focus being on the deceased. Second, *restoration-orientation* coping refers to learning new skills so as to adapt to the changes resulting from the loss. What distinguishes the DPM from traditional stress and coping theory is an alternation between loss and restoration coping; this alternation is termed *oscillation*. Stroebe and Schut (1999) commented that “at times the bereaved will be confronted by their loss, at other times they will avoid memories, be distracted, or seek relief by concentration on other things” (p. 216).

Stroebe and Schut (2001) have further refined the DPM by examining its corresponding intersections with meaning reconstruction in the Pathways model. They suggest that embedded within the loss-orientation and restoration-orientation arms of the DPM are both positive and negative meaning-reconstruction pathways. These pathways can be used to conceptualize the narratives of the bereft, in part identifying positive or adaptive attempts at meaning reconstruction in a given orientation arm. It also calls attention to negative interpretations of events that may impede meaning making, and hence adjustment to the loss.
Next, the *four component model of grief* (Bonanno & Kaltman, 1999) synthesizes a diversity of theoretical approaches into four inherent themes of bereavement. First, the *context of the loss* frames the bereavement experience in terms of factors such as socioeconomic status, cultural diversity, age, gender identity, social support, and type of death. Second, the *continuum of subjective meanings* refers to the diversity of appraisals and interpretations individuals in bereavement bring to the experience, ranging from pragmatic concerns to profound existential questions about meaning in life. Third, *changing representations of the lost relationship* involves the bereft engaging in a re-organization of his or her relational worldview so as to be able to function and adapt to the loss. Finally, *coping and emotion regulation*, identified as the unique aspect of the fourth component model of grief (Stroebe & Schut, 2001b), refers to diminishment of negative affect and the increase of positive emotional states. This regulation of emotions enhances longer-term functioning by helping the individual to view the loss as manageable.

Lastly, the meaning-making paradigm is increasingly being explored in the emerging scholarship of dying, death, and bereavement (Reker & Chamberlain, 2000; Strack, 1997; Tomer, Eliason, & Wong, 2008; Wong & Fry, 1998). Attempts to integrate the meaning-making literature into a coherent amalgamated theoretical paradigm amenable to empirical evaluation have been spearheaded by Park (2008, 2010). This tendency towards integration, however, undermines one of the strengths of meaning-based approaches, in particular its derivation by scholars from multiple disciplines permitting distinctly creative and unique models.

Meaning-making theories of bereavement are one of the primary foci of the dissertation. It is a topic covered extensively in manuscript one, which attempts to re-centralize diverse meaning approaches (e.g., constructivist), enabling the development of richer and more effective bereavement counselling interventions. Given the increasing number of cancer deaths
internationally, and the lack of theories that specifically address bereavement following cancer, an important gap in knowledge remains concerning the intersections of meaning and cancer-related bereavement.

**2.4 Bereavement in the Context of Cancer**

Cancer death rates are on the rise globally (World Health Organization, 2008). A cancer death can provoke considerable psychological distress. Indeed, informal caregivers (i.e., family and friends) report decreased quality of life, as well as lower self-reported physical and mental health following a cancer death (Wright, Zhang, Ray, Mack, Trice, et al. 2008). Some studies report that as much as 34% of family caregivers experience clinically-significant depressive symptoms three months after the loss (Holtslander & McMillan, 2011). The trajectory of bereavement in the aftermath of death is often shaped by the mixed experiences of having cared for a significant one with cancer. For instance, in an interpretive qualitative study, family members of cancer patients in palliative home care reported negative as well as largely positive impacts of the caregiving experience on their bereavement (Koop & Strang, 2003). To better understand the diverse experiences of bereft individuals with the goal of informing the development of more effective psychosocial interventions, researchers are beginning to more thoroughly investigate the intersections between the cancer experience and resulting bereavement.

Specifically, Gilbar and Ben-Zur (2002) examined the responses of 69 cancer-bereft spouses using various measures of grief distress. They reported that older widowers with a history of past losses tended to be at risk for higher levels of grief-related distress. More recently, Dumont, Dumont, and Mongeau (2008) interviewed 18 recently bereft family caregivers with the aim of detecting elements of the cancer caregiving experience that appreciably influence
bereavement. Using a qualitative content analysis, six principal dimensions emerged including characteristics of the family caregiver and of the patient, symptoms of the illness, the relational context, social and professional support, and circumstances surrounding the death. Each of these six dimensions contained both positive and negative aspects that could be either facilitative of adaptation (e.g., being present at the time of death) or had detrimental effects (e.g., uncontrollable pain) on the bereavement experience.

The effects of a cancer patient’s suffering, including psychological pain, on bereavement outcome have been corroborated in other studies. Specifically, women bereft of their male spouse have been identified as having increased levels of depression and anxiety in bereavement, particularly when the cancer patient was perceived to be very anxious during the last three months of his illness (Valdimarsdóttir, Helgason, Furst, Adolfsson, & Steinbeck, 2002).

While these initial efforts have yielded a greater understanding of the bereavement experience following a cancer death, significant gaps in knowledge remain. Specifically, there is a need for the development of theories and clinical guidelines that better contextualize the experience of bereavement following cancer, as well as the development of psychosocial interventions tailored to address this particular type of loss.

As such, bereavement studies situated within the domain of palliative cancer care are warranted. Palliative care services are often involved in providing service and support to patients and their families negotiating advanced cancer and death (Foley & Gelband, 2001). Past studies have prospectively examined predictors of bereavement outcome in palliative care, including a larger number of adverse life events, the caregivers’ coping responses, past bereavement, the relationship with the cancer patient, as well as the severity of the patient’s illness (Kelly et al., 1999). There is increasing awareness within palliative care of the importance of addressing and
supporting the needs of family caregivers prior to the death and into bereavement (Holtslander, 2008; Hudson et al., 2012).

To fulfil this mandate, there is a perspicuous need for professional psychologists (Haley, Larson, Kasl-Godley, Neimeyer, & Kwilosz, 2003; MacKinnon & Vachon, 2010; Werth & Blevins, 2006), including counselling psychologists, to be prepared to offer bereavement counselling following a cancer death to those seeking support. It is more likely that a growing number of individuals will be forced to grieve a cancer death and some may choose to consult a counselling psychologist. As such, counselling psychologists need a strong conceptual framework (e.g., meaning making) to address cancer-related bereavement. These issues are addressed in manuscript one.
2.5 Manuscript One

Means to Meaning in Cancer-Related Bereavement: Identifying Clinical Implications for Counseling Psychologists

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Reference

Abstract

The search for meaning in bereavement is a topic of increasing scholarly interest. Nonetheless, literature has not yet appeared that examines the intersections of diverse theories of meaning, corresponding empirical findings, and clinical implications for counseling psychologists engaged in cancer-related bereavement psychotherapy. Meaning theories drawn from several domains of scholarship including existential, spirituality, stress, and bereavement are surveyed followed by a review of related empirical trends in the scholarship. A hypothetical case vignette is then presented to highlight potential strategies for counseling psychologists to integrate a broadened meaning-based approach to bereavement psychotherapy related to the loss of a loved one from cancer. The article concludes by identifying limitations of a meaning-based approach, as well as directions for future research.
Means to Meaning in Cancer-Related Bereavement: Identifying Clinical Implications for Counseling Psychologists

Statistics reported by the World Health Organization (2008) indicate that cancer-related death is likely to increase from 7.9 million in 2007 to 11.3 million by 2030. Emotional, cognitive, behavioral, and physical distress following a cancer death has been well documented in surviving friends and family (Stajduhar, Martin, & Cairns, 2010). While the majority of individuals demonstrate remarkable resilience in coping with grief (i.e., uncomplicated bereavement, see Stroebe, Hansson, Schut, & Stroebe, 2008), some bereft individuals struggle with excessive emotional pain, and impaired social and occupational functioning (i.e., prolonged/complicated bereavement, see Prigerson et al., 2009; Shear et al., 2011). Regardless of grief trajectory, counseling psychologists will likely be increasingly implicated in providing bereavement psychotherapy to assist individuals in coping and adjusting following the death of a family member or friend due to cancer (e.g., Schnider, Elhai, & Gray, 2007).

Regrettably, counseling psychology appears to have largely neglected bereavement (Servaty-Seib & Taub, 2010), and in particular cancer-related bereavement. This marginalization of bereavement may in part be due to the illusory perception that bereavement therapy is a relatively simple affair that involves some form of active listening, straightforward normalization of client’s responses, and the delivery of some generic psycho-education on bereavement stages (Neimeyer, 2012d).

However, bereavement therapy can be highly complex and there has been a powerful response to the historical critique of bereavement scholarship being constrained by outdated models, little empirical support, and inadequate clinical guidelines (Archer, 2008). New bodies of scientific research and evidence-based interventions guided by promising theoretical models
have recently emerged. Within this new wave, the search for meaning, or *meaning-making*\(^4\), has been identified as one of the principal tasks in adaptation to death-related loss (Neimeyer, Burke, Mackay, & Stringer, 2010), including cancer-related bereavement (Holland, Currier, & Neimeyer, 2006). An analogous construct, *meaning-reconstruction*, is grounded in part on constructivist and post-modern theories of psychology (Neimeyer & Raskin, 2000) that tend towards championing multiple understandings and expressions of bereavement and its resolution. Mental health professionals, including those working with cancer-bereft populations, are increasingly integrating meaning-based strategies in their clinical work (Currier, Holland, & Neimeyer, 2008).

Of late, the empirical scholarship associated with meaning-making was comprehensively critiqued using an integrated model of meaning-making by Park (2010). Judiciously, she differentiated between meaning-making as a process (i.e., to engage in meaning-making) and as an outcome (i.e., meanings made as a result of meaning-making). Furthermore, she highlighted the significant gaps between the rich theoretical literature of meaning and corresponding empirical evidence, demonstrating support for certain aspects of meaning-making and limited support for others. Specifically, studies she reviewed generally indicate individuals often engage in meaning-making efforts following stressful events, and violations of previously-held meanings contribute to psychological distress. Furthermore, the quality and quantity of meaning-making attempts are both important; for example, negative efforts (e.g., blaming someone for causing a death) predict poor adjustment. The same author argued that theories which predicted that global meanings are shattered in response to stressful events are somewhat exaggerated.

Finally, Park (2010) noted a number of ambiguities, discrepancies and important directions for

\(^4\) The following terms for the process and outcome of meaning-making have been used by other scholars: meaning-centered; meaning-reconstruction; meaning-based; meaning-focused; search for meaning. The present article adopts the term meaning-making to represent all these constructs.
future research, urging caution in implementing meaning-making approaches given our gaps in knowledge. However, this pioneering work was limited to interpretation of quantitative results using a single model largely based in the stress and coping literature (Park & Folkman, 1997). In addition, Park (2010) did not address cancer-related bereavement specifically, nor did she extensively discuss clinical implications of meaning-making to guide psychotherapeutic bereavement practice.

The objective of this article is to build on Park’s (2010) pioneering efforts by examining the intersections of fundamental meaning-making theories, identifying some of the emerging empirical research, and delineating the resulting clinical implications for counseling psychologists. To begin, we briefly outline some of the particularities of cancer-related grief. We then collate meaning-making theories from diverse schools of thought, highlighting the unique contributions of each meaning theory. We then review corresponding empirical research dilemmas outlined by Park (2010) in order to assess the clinical pertinence of meaning-making theories to inform bereavement psychotherapy. Finally, in order to emphasize how knowledge of meaning theories and evolving research can be used to guide counseling psychology practice, we present a hypothetical case vignette. Limitations, as well as directions for future research, conclude the article.

Specificities of Grieving a Cancer-Related Death

There is an increasing recognition of the importance of bereavement in the field of oncology (Kacel, Gao, & Prigerson, 2011). However, theories of grief and analogous psychotherapeutic practices appear to largely fail to distinguish the particularities of cancer bereavement from other types of loss. This omission is curious, as research suggests that caregivers of cancer patients tend to experience certain challenges distinct from other causes of
death that likely impact the bereavement experience (Kastenbaum, 2008; Stajduhar, Martin, Barwich, & Fyles, 2008). Gauthier and Gagliese (2012) recently identified several studies that highlight the psychological distress associated with cancer caregiving that can contribute to negative bereavement outcomes. For example, surviving spouses tend to report high levels of anxiety, depression, and sleep disturbance during bereavement in cases where the deceased partner had experienced unrelieved anxiety and pain prior to death from cancer (Jonasson et al., 2009; Valdimarsdóttir, Helgason, Furst, Adolfsson, & Steinbeck, 2002). Congruently, Lichtenthal, Prigerson, and Kissane (2010) identified several risk factors for complicated grief reactions due to cancer, including a lack of perceived preparedness of the bereft for death, as well as exposure to potentially traumatizing cancer-related events. Those bereaved from a cancer death may have witnessed traumatizing events such as acute pain crisis, cachexia, carotid arterial bleeds, delirium, dyspnea, emergency hospitalizations, fungating cancer wounds, paranoia and aggressive outbursts, severe psychomotor agitation, and spinal cord compression (see Holland et al., 2010).

In summary, bereavement theories remain largely a-contextual when it comes to death caused specifically from cancer. This omission is problematic as circumstances of cancer can embody numerous and sometime sudden traumatic events that can play a particularly important role during the grieving process.

**Theoretical Trends in Meaning-Making**

Unique conceptualizations of meaning-making exist across various fields of scholarship. Collapsing diverse meaning-making constructs into a single framework (i.e., Park, 2010) has the advantage of facilitating the synthesis and analysis of quantitative empirical research. However, a reductionistic approach risks neglecting subtle aspects of meaning-making suggested by unique
aspects found in the prolific theoretical literature that can resultantly inform more comprehensive clinical care. The present article attempts to re-centralize these fundamental meaning-making theories, using original constructs and terminology in the existential, stress, spirituality, and finally bereavement literature.

**Theories of meaning and meaninglessness in existential psychology.** Existential conceptualizations have been brought to bear on both the domains of cancer (Lee, 2008) and bereavement (Yalom & Lieberman, 1991). Existential theory provides a strong counterpoint to the traditional supremacy of essentialist approaches to knowledge that emphasize immutable principles and logical laws, probing deep questions about the nature of despair, grief, meaning, and death (May & Yalom, 2005). Frankl (1981) proposed three specific categories of meaning-making processes that are unique to each individual: *creative, experiential,* and *attitudinal.* First, the accomplishments, actions, and creations that individuals contribute to the world provide meaning. Second, meaning is drawn from individuals’ experiences and ways by which they interact with and adapt to the world. Finally, meaning is derived from how individuals negotiate and respond attitudinally to difficult experiences that are beyond one’s control. On the opposite end of the continuum, meaninglessness as an outcome has been identified as encompassing estrangement, hopelessness, a lack of authenticity, a failure to cope, and emptiness (Orbach, 2008). Frankl (1981) coined the construct *noogenic origin* to refer to the significant amount of psychological distress that can result from a loss of meaning.

Overall, existential meaning theories distinctively emphasize that the process of, and the derivation of, meaning serves to buffer against the anxieties that accompany existence (May & Yalom, 2005). Individuals are also held responsible for their responses in the existential meaning-making paradigm (Yalom, 1980). Moreover, meaning outcomes tend to be arrived at
experientially in relation with self and others. Finally, the paradigm distinctively embeds the notion that meaninglessness poses a serious threat to overall well-being regardless of circumstance.

**Meaning and stress: The integration of coping and trauma.** A large body of theoretical scholarship explores the significance of meaning for individuals coping with stressful events in their lives, including cancer-related death (Kauffman, 2002). This literature incorporates diverse theoretical frameworks including cognitive behavioral, complementary medicine, supportive-expressive, and post-traumatic growth theories (LeMay & Wilson, 2008).

Park and Folkman (1997) developed an integrated theoretical model of coping with stressful events, including bereavement and cancer, that combines aspects of meaning-making. They distinguished between two categories of meaning that dynamically influence each other. First, *global meaning* connotes abstract and generalized beliefs of individual meaning about the world that develop throughout the lifespan. Second, *situational meaning* refers to an interactive process between an individual’s global meanings and a given environmental event. It has three discrete temporal components: first, an appraisal of the given event; second, a search for meaning; and third, a retrospective appraisal of the outcome. In this framework, the process of meaning-making is defined as a process of adaptation to a stressful life event (e.g., cancer bereavement) aimed at reducing any discrepancy between the appraised meaning of an event (e.g., a world in which a given cancer death occurred) and the individual’s pre-existing global meanings (e.g., a world in which cancer does not touch one’s life or family). Recent attempts have been made by Stroebe, Folkman, Hansson, and Schut (2006) as well as Milman and MacKinnon (2012) to develop novel risk-factor frameworks to predict bereavement outcomes that draw in part on stress theory.
Theories of trauma can be thought of as sub-theories of stress that place particular emphasis on understanding how individuals respond to and cope with life events that are particularly sudden, shocking, and difficult (Stroebe & Schut, 2001; Stroebe, Schut, & Stroebe, 1998). For example, the experience of cancer can precipitate symptoms of trauma for bereft family members (Lichtenthal, Cruess, & Prigerson, 2004). Relatedly, Janoff-Bulman (1992) argued that a number of fundamental assumptions that individuals maintain about the world are destroyed when traumatic events such as death occur. These assumptions include the belief that one is worthy, that the world is a benevolent place, and that one can always find a way to make sense of events (Janoff-Bulman & Berg, 1998). The *assumptive world* framework unifies these ideas and goes further by specifying that these three fundamental assumptions orient individuals, provide a basis for understanding reality, and facilitate finding meaning and purpose in life (Kauffman, 2002). The framework presupposes that if death is a traumatic event that shatters previous assumptions, then a search for meaning becomes a process by which individuals adapt and reconstruct their cognitive schemas to make sense of the event (Landsman, 2002). Empirical studies have questioned the rigidity of this theory, suggesting that shattering may be too strong a word when describing changes to global meaning constructions (see Park 2010).

Unlike other fields of scholarship, both the stress and trauma literature have forged coherent frameworks (e.g., Park & Folkman, 1997) that attempt to unify diverse meaning conceptualizations. Furthermore, meaning as it is derived in this body of work patently identifies the notion of an individual’s perceived discrepancy between general orienting systems and environmental encounters, often upset due to traumatic events, as the primary motivator for the meaning-making process.
Meaning and spirituality. Spiritual and religious systems are often means to make meaning of stressful life events (Hill & Pargament, 2008; Park, 2005) such as cancer-related bereavement. Spirituality has been defined as the experiences, beliefs, and phenomena that go beyond specific religious affiliations, pertaining to the transcendent and existential aspects of life, whereas religion has to do with theistic beliefs, values, practices, and feelings often associated with organizational denominations (Richards & Bergin, 2005). Specifically, Benore and Park (2004) suggest that death-specific religious beliefs (e.g., faith in an afterlife) are essential determinants of bereavement adaptation.

However, the integration of spiritual/religious factors in bereavement theory remains rare, with some exceptions that consider intersections with meaning theory (Park & Halifax, 2011; Wortmann, & Park, 2008). For example, the intersections of spirituality and stress and coping postulate that discrepancies between global (i.e., spiritual/religious) beliefs and situational appraisals provoked by difficult events lead to meaning-making (Wortmann and Park, 2009).

Overall, while spiritual/religious paradigms offer individuals vast resources (e.g., clergy, scriptures, communities of faith) upon which to draw support, considerable gaps in theoretical understandings of spirituality and bereavement persist in the Western scholarly literature.

Meaning-reconstruction and bereavement. The meaning-reconstruction model in bereavement integrates aspects of narrative, social constructivist, family systems, and trauma theories, postulating a process whereby bereft individuals rebuild, reinterpret, and make sense of their ongoing life stories following death (Neimeyer, Burke, et al., 2010).

Discrete sub-types of meaning-making have emerged, including sense-making, which refers to the bereft’s ability to find some explanation for the bereavement experience, often based in philosophical or religious terms (Keesee, Currier, & Neimeyer, 2008), as well as benefit-
finding, which refers to positive gains identified as a result of the loss (Holland et al., 2006). In addition, a movement towards emphasizing the continuing bond between survivor and deceased as a means to meaning-making highlights the subtle imprints made by the deceased on the survivor (Stroebe, Schut, & Boerner, 2010). In addition, Nadeau (2008) has extended the meaning and bereavement scholarship to include the family system. Her theory of family meaning-making refers to the process by which families co-construct meaning following death and is based on evidence from a rigorous qualitative study.

Meaning-reconstruction literature has arguably the broadest and most abundant theoretical base (Neimeyer, Prigerson, & Davies, 2002). It is also the body of work that has most strongly attempted to bridge the gap between theory and bereavement psychotherapy. Furthermore, given its constructivist roots, it is likely the most sensitive theory with regards to cultural diversity.

Empirical Trends in Meaning-Making

While cogent theories are critical to guide counseling psychologists in their practice, clinicians are urged to proceed with caution as the empirical basis underpinning the efficacy of meaning-making theories remains in the early stages. The initial part of this section concerns empirical evidence of existential and spiritual/religious theories. The latter portion reviews the stress and bereavement literature and is largely scaffolded on Park’s (2010) recent review.

To begin, contemporary reviews of the empirical literature consistently report inconclusive evidence concerning the relationship between spiritual factors and bereavement adjustment (Park & Halifax, 2011). Consistent with stress and coping theory, one study suggests that some spiritual beliefs in place prior to the loss may be challenged by the death, necessitating a re-construction of the individual’s spiritual framework if it is to continue to provide meaning
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(Wortmann & Park, 2009). Other studies suggest that it may be easier for some spiritually/religiously-oriented individuals to impress an agreeable meaning outcome onto their bereavement experience (Lichtenthal, Currier, Neimeyer, & Keesee, 2010; Meert, Thurston, & Briller, 2005). Correspondingly, bereavement interventions that integrate spiritual/religious factors have shown some promise to improve levels of spiritual well-being (Ando et al., 2011).

Though there is some evidence that integrating spiritual factors can be helpful in facilitating bereavement adaptation, cautionary notes have been sounded. Study designs have been critiqued for being methodologically problematic, tend to be limited to the inferences drawn from cross-sectional designs, are plagued by confounding variables (e.g., failure to differentiate spiritual from religious factors), and lack adequate control participants (Park & Halifax, 2011). More sophisticated empirical studies have been repeatedly called for in review articles (Hays & Hendrix, 2008).

In addition to spiritual conceptualizations, existential theories of bereavement appear to enjoy the least amount of empirical support to date. However, a promising direction is the development of a meaning-centered bereavement intervention for parents (Lichtenthal, 2010) based in part on meaning-centered group psychotherapy (Breitbart et al., 2010), an efficacious intervention for advanced cancer patients largely based on Frankl’s theory of existential meaning.

There are also numerous concerns and caveats noted in Park’s (2010) empirical review that bear special consideration. To begin, there appears to be sufficient scientific evidence to assert that individuals tend to both engage in meaning-making processes, as well as experience meanings made following stress experiences such as bereavement (Park, 2010). However, while those who find meaning appear to be better adjusted than those who do not, there is evidence that
a significant subset of bereft individuals do not search for meaning and appear to be coping well, and many have difficulty achieving any meaningful understanding in bereavement (Davis, Wortman, Lehman, & Silver, 2000, as cited by Park, 2010).

There is also some empirical evidence that certain aspects of Park and Folkman’s (1997) stress and coping model are more nuanced than originally perceived. For instance, there is some confirmatory support of psychological distress during the process of meanings reappraisal (Park, 2010). However, there is only modest support for the assumption that distress is linked to perceived violations of global meaning, and almost no evidence that distress acts as a driving force in the meaning-making process. Additionally, while there is some support for small changes in global meaning constructs prior to and following a stressful event, there is limited support that these changes are severe enough to be described as “shattering” as theoretically predicted (Poulin, 2007, as cited by Park, 2010).

In addition, the quality of the meaning-making process is very important. Studies have found that participants who engage in reflective and experiential searching for meaning (e.g., engaging in spiritual or creative activities that buffer distress) as opposed to evaluative processing of stressful situations (e.g., making judgmental attributions) show better adjustment (Kross, Ayduk, & Mischel, 2005; Watkins, 2008). Furthermore, making detrimental meanings (e.g., despairing that one’s life purpose is forever gone; blaming oneself for the death) has been shown to lead to negative outcomes, such as meanings that organize the life-narrative around the bereavement event (Keesee et al., 2008) or those that appear to be maladaptive in their content (Coleman & Neimeyer, 2010). Likewise, certain types of meaning-making processes and outcomes have been shown to be problematic in certain circumstances. For instance, studies indicate that individuals who ruminate or engage in a prolonged and anguished search for
Meaning show poor adjustment (Nolen-Hoeksema, Wisco, & Lyubomirsky, 2008; Wu et al., 2008; Updegraff, Silver, & Holman, 2008).

Lastly, some studies report that the continuing bond (CB) theme can be problematic at times. CB expressions characterized by internalization and acceptance of the reality of the death predict bereavement adaptation, whereas manifestations of the CB that fail to acknowledge the reality of the death often lead to maladaptation (Field, 2008). Another study found that those with an insecure attachment styled CB suffered from great distress than those with more securely attached fashioned CBs (Stroebe, Schut, & Boerner, 2010). Other examples include individuals with a persistent CB tending towards higher levels of separation distress when they are not able to “make sense” of their loss (Neimeyer, Baldwin, & Gillies, 2006). Additionally, higher levels of grief and depression have been reported in individuals when the death was unexpected and sudden, the loss was that of a young partner, and the CB was un-relinquished (Stroebe, Abakoumkin, Stroebe, Schut, 2011). Field (2008) has argued for more research which clearly identifies which aspects of the CB are adaptive and which are not.

**Meaning-based clinical implications for cancer bereavement therapy**

How can a broadened understanding of meaning theories, bracketed by emerging empirical findings, guide a counseling psychologist’s clinical practice with cancer-bereft individuals? A hypothetical case vignette is presented below in order to exemplify the implications of using diverse meaning theories to inform the specificities of cancer-related bereavement counseling. Following the case vignette, the implications for counseling practice are presented along the theoretical domains of meaning scholarship, highlighting empirical findings where appropriate.
**Hypothetical case vignette.** Joan is a 30-year-old heterosexually-oriented, White woman of Jewish heritage. She currently lives in a culturally-diverse urban center in Canada. Joan completed university and technical training and has held steady employment as a dental hygienist for the past 10 years. Last year, her husband of 5 years, Joe, died following 2 years of colorectal cancer. Joan has recently sold the house that she lived in with her husband and now resides in a smaller apartment. Following her husband’s death, Joan took 3 months off work but has since returned to her full-time position.

Meeting with a therapist in private practice 4 months after the loss, Joan presents cognitively well-oriented with affect appropriate to content. She is experiencing the transition to widowhood as stressful and at times overwhelming. She reports fluctuations in her mood, with alternating moments of happiness and despair. Joan reports having trouble re-engaging in life following her husband’s death; for example, she finds little enjoyment in activities that used to be pleasant. Moreover, she reports difficulty in making and maintaining connections with people and activities that feel significant. Joan reports being well supported by a network of family and friends, yet she still feels isolated and disconnected, reporting that “no one understands” her loss and the changes in her life. She also feels pressure from others to “move on,” though she finds herself resisting this advice. She has turned to her long-standing Jewish faith, attempting to make sense of her loss, but remains confused about the significance of her recent experiences and dissatisfied with how she is coping. Following the initial assessment, the clinician concludes in consultation with Joan that her presenting concerns are consistent with an uncomplicated grief response.

**Existential meaning:** A counseling psychologist can intervene using Frankl’s (1981) categories of meaning-making. Given the limited empirical support of these theories in
bereavement, caution is urged on the part of the counseling psychologists. To begin, Frankl’s category of attitudinal meaning suggests that meaning is derived from how one negotiates and responds to difficult experiences beyond one’s control such as the cancer diagnosis and consequent death of her husband. Therefore, Joan may benefit from exploring her sense of agency in the bereavement process. Such exploration might entail raising Joan’s awareness of the choices she makes as she adjusts to her loss, as well as examining the corresponding meanings that are attached to such choices. As a result of such an exploration, Joan may begin to recognize choices she is making, and can make, in her new identity as a widow (e.g., moving to a smaller apartment in order to maintain financial stability) and attach meanings to such choices (e.g., “I may not have had control over my husband’s death, but there may be some ways I have control in building my life”). In addition, Joan may become more aware of her choices not to act (e.g., avoidance of making and maintaining connections with people and activities that feel significant) and the meaning she may be attaching to such choices (e.g., “I am afraid that going out and enjoying myself is somehow not honoring my husband”). Frankl’s category of creative meaning, which posits that individuals derive meaning from their accomplishments and creations, may also be helpful with Joan. Specifically, Joan may find that creative activities or philanthropic pursuits tied to the loss of her husband buffer against the difficult aspects of the loss (e.g., completing a project that had to be put on hold due to her husband’s illness). Finally, an existential framework also suggests assessing Joan’s current sense of meaninglessness, hopelessness, and despair. A careful assessment for clinically-significant levels of depression and suicidal ideation is warranted.

**Stress and trauma: Reconciling schematic gaps.** Park and Folkman’s (1997) framework suggests that Joan may benefit from exploring and articulating (a) her appraisals of her loss
experience and the life-changes it has created (i.e., situational meanings) and (b) the challenges that her loss appraisals pose for previously-held beliefs (i.e., global meanings). For example, Joan may hold a global belief about what constitutes a “normal” lifestyle for her life-stage (e.g., financial security, having children). Such beliefs may be discrepant with her appraisals of her loss-related life changes (e.g., decreased financial security). If this is the case, this discrepancy may be addressed through re-visiting either her global normative beliefs regarding lifespan progression or her situation-specific appraisals regarding being widowed or both. Clinical prompts for the counseling psychologist that might facilitate a process of schematic reconciliation might include: (a) What expectations did you hold about the way your life would be before this experience of cancer? (b) What expectations do you hold now for yourself and the future? (c) How have you managed to negotiate and cope with these discrepancies?

Finally, trauma theory and science suggests that it will be important to assess if Joan is preoccupied with difficult memories of her husband’s cancer experience that may take the form, for example, of recurring and disturbing images. Assessing how she has coped with and made sense of them can be accomplished with the following example clinical prompts: (a) Are you experiencing any feelings of disorientation, bewilderment, or associated anxiety? (b) Do you have preoccupying and recurrent memories, images, or dreams associated with events? (c) How do you understand your response to these troubling experiences?

**Meaning and spirituality.** Theory and research suggest it may be important for the therapist to carefully assess Joan’s spiritual-religious orientation. Taking a history of Joan’s spiritual experiences may help highlight positive and negative aspects, as well as situate any broader meanings associated with her husband’s death (e.g., how does cancer and death fit with Joan’s relationship to the transcendent or understanding of the universe?). It may also be
important to assess negative and maladaptive spiritual attributions of the loss (e.g., does she report being punished by a higher power?). Exploring the nature of any past spiritual traumas, seeking to understand harmful spiritual conceptualizations for the loss, as well as exploring adaptive religious-spiritual conceptualizations could be important therapeutic activities. The counseling psychologist can explore any ways in which her faith helps her to make meaning, as well as explore if there are ways she may derive social support from her religious community.

**Meaning-reconstruction and bereavement.** Meaning-reconstruction theory and research suggests three themes that may facilitate bereavement adaptation (Neimeyer, 2006). The first of these, sense-making, refers to assisting Joan in finding some degree of clarity and sense and assessing her understanding of her bereavement behaviors, cognitions, and emotions. It may also be useful to explore pertinent events prior to her husband’s diagnosis and the experience of caregiving for her loved one with cancer, essentially. These memories may be particularly difficult, bewildering, or perplexing for Joan. Lastly, the counseling psychologist may wish to draw attention to Joan’s feelings of self-criticalness, exploring with her the following: (a) How do you understand your dissatisfaction with your present coping? (b) What changes (if any) to both your coping and your feelings about how you are coping are you eager to achieve?

Clinicians should keep in mind empirical findings suggesting the dangers of ruminative sense-making, and are encouraged to familiarize themselves with emerging therapeutic modalities that target de-escalation of intrusive and repetitive thoughts (see Papageorgiou, & Wells, 2008).

The second theme, benefit-finding, entails the counseling psychologist exercising tentativeness and delicateness, as well as striving for nuanced and balanced interventions to avoid potentially invalidating the experience of loss. Benefit-finding can involve highlighting the nostalgic, bittersweet, and mixed emotions that accompany grief. The goal here can also be to
facilitate the integration of any competing or contradictory thoughts and feelings Joan may be experiencing. For instance, Joan may be very grateful that her husband is no longer suffering from cancer, but simultaneously distraught that he has died. The counseling psychologist may therefore wish to explore some of the moments of grief that have been pleasant surprises for Joan (e.g., supportive and loving messages she has received from friends and family).

Third, highlighting the character of the continuing bond (Neimeyer, 2009c) with her husband can be accomplished by two therapeutic exercises. The Life Imprint Exercise (Neimeyer, 2012c; Vickio, 1999) invites Joan to make explicit, in the form of a written homework assignment, the subtle ways in which her relational attachment with her husband endures. In particular, it asks Joan to explore the positive traces her husband made, and continues to make, on her life (e.g., the impact Joan’s husband had on her values and beliefs). The exercise also invites her to reflect on imprints she would like to relinquish, highlighting any impression left by her husband that she does not wish to nurture. Initial research of this exercise when completed by participants in the context of a bereavement group indicates it facilitates adaptation and sense-making (MacKinnon, Smith, Henry, Berish, et al., 2012). Finally, consistent with empirical findings (Stroebe, Abakoumkin, Stroebe, Schut, 2011), maladaptive aspects of the continuing bond that prolong her bereavement distress (e.g., failure to relinquish ties that impair daily functioning) can be collaboratively challenged in therapy and reframed.

Lastly, Nadeau’s (2008) meaning-based framework suggests examining Joan’s familial patterns and strategies of dealing with the loss, promoting adaptive meaning-making and curbing non-adaptive meanings. Guided by some of Nadeau’s (2011) many clinical examples, while synchronously attending to systemic-cultural factors, the counseling psychologist may wish to explore some of the following areas. First, are there any shared rituals in the family, and how
have such rituals been affected by the loss? How has the family responded to loss in the past? In line with this, it may be important to assess what cultural values inform not only the expression of grief within the immediate family, but also within the broader social system. Along these lines, the counseling psychologist can assess Joan’s understanding of these cultural trends, how they mediate her experience, and how these may be sources of meaning and support. Second, how have the roles of family members changed as a result of the loss (e.g., if Joan’s husband kept track of financial matters, how is Joan reacting to adopting this role following his loss?)? Third, what family rules exist surrounding communication about the loss (e.g., are there particular individuals in her husband’s extended family that dictate norms surrounding expression of bereavement-related emotion?)?

**Summary of counseling implications.** The strategies highlighted above may result in a decrease of Joan’s reported mood fluctuations, as well as diminish her distressing grief symptomatology. A meaning-based approach may also intensify Joan’s ability to find joy in activities, feel more connected and understood in her social milieu, renew her sense of purpose, and highlight her agency. Counseling psychologists are urged to bear in mind the concerns and limitations articulated in the empirical scholarship, assuming a collaborative approach with clients that encourages continual monitoring of the usefulness of a meaning-based approach.

**Limitations**

There are several limitations of this meaning-based clinical method for counseling psychologists. First, while there is an emerging body of scholarship considering cultural variations at the end of life, there has been relatively limited research assessing the intersections of meaning-making and culture. This is somewhat curious given the existent scholarship considering how culture shapes the language used, behaviours, perceptions, understandings,
meanings, rituals, and practices surrounding bereavement (Neimeyer, Prigerson, & Davies, 2002; Rosenblatt, 2008). On the whole, further research is needed with culturally-diverse populations to further explore culturally-specific meaning processes and outcomes.

Second, the highly complex nature of the meaning-making scholarship contributes to a blurring of constructs, contradictory findings, and considerable methodological obstacles to the empirical study of meaning. Taken together, these limitations make the identification of clinical implications provisional at best. For example, qualitative studies attempting to explore the sense-making construct have asked participants to elaborate on their inner experience of having “made sense of the loss.” Such studies have shown that individuals’ conceptions of sense-making vary widely (Park, 2010). Furthermore, these conceptions of sense-making occasionally overlap with other types of meaning that have been proposed in the literature, including that of benefit-finding (Davis et al., 1998; Pakenham, 2007). Thus, given the difficulty in distinguishing and operationalizing meaning-making, clinicians may find it difficult to differentiate what a given meaning theme actually looks like therapeutically.

In addition, Park (2010) has reported a surprising lack of research that examines the relationship between meaning-making processes and resultant outcomes, with some studies demonstrating clear positive associations while others showing no relationship at all. The unknown relationship between process and outcome leaves clinical implications on uncertain grounds with insufficient research to definitely explain how or whether meaning-making attempts are useful in creating actual meaning outcomes. Clinicians are urged to proceed with caution when using these themes in clinical practice, as further research is needed to explore the outcomes of meaning-making interventions.
Third, the theoretical and empirical meaning literature largely fails to consider grief trajectories (e.g., uncomplicated/common versus complicated/prolonged). As such, the clinical implications described may need to be altered for prolonged grief. Counseling psychologists are encouraged to assess grief trajectory at the outset and during the course of therapy (see Bonanno, 2009; Prigerson et al., 2009), as prolonged grief tends to be comorbid with other psychological disturbances (e.g., clinical depression or suicide ideations), necessitating therapeutic interventions beyond just meaning-based ones.

Fourth, by and large there is a failure to assess the unique factors associated with a cancer death in terms of grief and meaning theory, as well as a lack of empirical studies concerning cancer bereavement outcomes. Related to the above discussion on risk factors, for example, there is very little literature that examines the contextual factors of cancer that may heighten the risk for prolonged/complicated grief. The arguments we make attempt to bridge this gap, though the arguments are speculative in that they draw inferences between multiple bodies of work, but lacks solid theoretical, empirical, and clinical foundations.

**Directions for Future Research**

There remain significant gaps concerning the intersections of meaning, cancer, and bereavement in the knowledge base, which provide ample directions for future research. First, a more thorough understanding of the particularities of cancer grief is sorely needed at both the conceptual level as well as in evidence-based practice. While inferences have been drawn above between the sometimes traumatic nature of cancer treatment and death, a more empirically-based understanding can help illuminate conceptualizations and clinical guidelines.

Second, the efficacy of bereavement interventions, in particular for individuals following an uncomplicated grief trajectory, remain largely insignificant with respect to effect size shifts
(Currier, Neimeyer, & Berman, 2008). Lack of clearly described atheoretical interventions, plagued by methodological design issues (e.g., problematic recruitment strategies, unspecified inclusion/exclusion criteria) may be addressed through the development of new meaning-based interventions for bereavement.

Third, there is a need to examine how culture informs the experience of cancer grief. It may be interesting to explore how meaning processes and outcomes vary across culturally-diverse populations. A more comprehensive understanding of which meaning processes are most effective with certain populations will increase the sensitivity and effectiveness of counseling psychologists’ interventions.

Lastly, Park (2010) notes several future directions in her review including the need for prospective longitudinal studies to better depict the active processes underpinning meaning-making. For example, research has yet to be done on the role that quality of meaning-making processes have in adjustment to cancer-related bereavement over time.

**Conclusion**

This article highlights diverse meaning-based theories and corresponding empirical findings with the goal of informing counseling psychologists in their practice with bereft individuals following a cancer death. Counseling psychologists are encouraged to assume a cautious and collaborative approach with clients when using this meaning-based approach, continually monitoring its usefulness in facilitating bereavement adaptation. Although the recommendations are tentative due to lack of empirical validation, meaning-making theories can clearly translate into bereavement counseling practice to contextualize the subtle, though often profound particularities, of grieving a cancer death.
CHAPTER 3: BEREAVEMENT TRAJECTORIES AND A NOVEL INTERVENTION

Then long-suffering noble Odysseus thought long and hard, and, deeply shaken, communed with his valiant spirit: ‘Oh, let this not be one of the deathless ones, weaving a net for me, telling me to abandon the raft. I will not obey her yet, since the land, she said I would escape to, was far away when I saw it. This I shall do, and this seems best, to wait here as long as the timbers hold, and endure in misery, then if the seas beat the raft to pieces, swim, for want of a better plan.’

-Homer, 2004, 5.313-387

3.1 Preface

Empirical studies have consistently reported that most bereft individuals accommodate bereavement into their life without significant disruption to their everyday functioning, a trajectory commonly referred to as uncomplicated/normal bereavement. Unfortunately, a smaller segment of the bereft population becomes immobilized in their loss and is unable to acclimate to the changes brought about by the death. This clinical profile is commonly referred to as complicated/prolonged bereavement. Chapter 3 begins by specifically detailing the literature concerning these two grief trajectories. With an eye towards developing future group interventions for uncomplicated bereavement, a meaning-based group intervention targeting uncomplicated bereavement is described in the second manuscript.

3.2 Clinical Profile of Normal/Uncomplicated Bereavement

Given that death is a natural part of life, the majority of individuals cope relatively well with the loss of a family member or friend. Stroebe et al. (2008) defined uncomplicated bereavement as “an emotional reaction to bereavement, falling within expected norms, given the circumstances and complications of death, with respect to time course and/or intensity of symptoms” (p. 6). While varying degrees of depressive symptoms, fatigue, social isolation, disturbed sleep, low self-esteem, changes in relationships, shock, and painful emotions are often
reported, taken as a whole these symptoms do not impair functioning (Stroebe et al., 2001). Shear and colleagues (2011) provided an extensive clinical profile of acute grief symptoms that can occur within the first 6 to 12 months consistent with an uncomplicated trajectory. These symptoms may include various combinations of yearning, profound sadness interspersed with moments of reprieve, vivid images and thoughts, strides to accept the death, low levels of anger and bitterness, diverse types of somatic distress, as well as social isolation and/or withdrawal.

Prigerson (2004) reported that approximately 80-90% of bereft individuals report symptoms corresponding to normal/uncomplicated grief. The majority of individuals tend to experience a decrease in yearnings, depressed mood, disbelief, and anger, with concurrent rise of acceptance and positive adaptation over a period of approximately 24 months (Prigerson, van der Werker, & Maciejewski, 2008). Uncomplicated bereavement typically has a duration of approximately 2 years (see Davidson, 1979, as reported by Neimeyer, 2006).

What is considered normal/uncomplicated varies considerably, not only with regard to ability to cope, but also in the modes of expression and duration of different grief reactions (Ringdal, Jordhoy, Ringdal, & Kaasa, 2001). It has been well established that variations in grief expression (i.e., mourning) are mediated by cultural factors, and what is considered to be normal or appropriate grieving behavior in one population will not necessarily be shared in another (Rosenblatt, 2008). Culture provides a basis for how people represent their bereavement and is arguably the foundation for their feelings and behaviours (Klass & Chow, 2011). There is a tricky balance to maintain between pathologizing a grief reaction that is merely different (and normal in a different cultural context) and neglecting to recognise and treat significant bereavement distress (see Shear et al., 2011)
Strongly linked to uncomplicated grief is literature that focuses on resilience in the face of loss. Bonanno (2004) postulated that resilience is the natural tendency for individuals who experience a death to maintain functioning comparable to their baseline. Moreover, the same author identifies several distinct factors that help individuals facing loss to promote their own resilience: hardiness, self-enhancement, positive emotions, and laughter. Of particular interest is the personality construct of hardiness, which includes a motivation to derive meaning in life, the belief that events are not beyond a person’s influence to control, and the conviction that learning and growth can occur from both positive and negative life events (Bonanno, 2004).

Overall, it is something of a paradox that while uncomplicated bereavement is so common, it is a sphere of scholarship with relatively little depth. With some minor exceptions noted above, the majority of scholarship on bereavement trajectory and corresponding interventions tends to be devoted to complicated/prolonged bereavement.

3.3 Clinical Profile of Complicated/Prolonged Bereavement

An early definition by Horowitz, Wilner, Marmar, and Krupnick (1980) defined complicated bereavement as the heightening of grief to such a degree that individuals become overwhelmed, engage in maladaptive behaviours, and/or that their level of distress becomes fixed. There is a great deal of overlap and redundancy between terms, including complicated, complex, abnormal, unresolved, traumatic, and pathological grief reactions and most recently prolonged grief (Neimeyer, Hogan, & Laurie, 2008) and persistent complex bereavement disorder (American Psychiatric Association, 2013). In an attempt to make clear distinctions, scholars have proposed clinical sub-diagnoses of complicated grief reactions including chronic grief, delayed grief, exaggerated grief, and masked grief (Worden, 2009). However, despite the objections of clinicians, some researchers have urged against the development of further
subcategories, supporting their scepticism with rigorous statistical studies that fail to confirm these variations of complicated grief (Bonanno & Kaltman, 2001; Bonanno et al., 2002; Enright & Marwit, 2002).

Burke and Neimeyer (2013) suggested that individuals’ responses to death-related loss can be thought of along a continuum. Looking at scholarly trends, one end of the continuum is characterized by resilience and fairly rapid return of psychological equilibrium in bereavement (i.e., uncomplicated grief). The middle range involves more significant psychological distress that requires more time for adjustment. The other end of the continuum encompasses the most functionally-impairing form of bereavement. A recent taxometric analysis of the underlying structure of grief (Holland, Neimeyer, Boelen, & Prigerson, 2009) supports the notion of a grief continuum, suggesting little rationale for categorical notions of normal and prolonged grief. Conversely, Boelen and van den Bout (2008) reported in a study with 242 mourners that bereavement trajectory is not necessarily a question of degree, but rather there are factors that distinguish complicated grief from its uncomplicated counterpart at high degrees of statistical significance.

In a comprehensive review of longitudinal, phenomenological, and diagnostic articles about grief reactions, Bonanno and Kaltman (2001) concluded that approximately 15% of individuals continue to report significant impairment in functioning between one to two years post death. Other reports show slightly higher numbers, ranging from 15 to 20% of individuals reporting impairment (Rubin, Malkinson, & Witztum, 2008). Risk factors for complicated grief confirmed across a wide review of empirical scholarship by Burke and Neimeyer (2013) include (a) low social support, (b) anxious/avoidant/insecure attachment styles, (c) discovering or
identifying the body (in cases of violent death), (d) being the spouse or parent of the deceased, (e) high pre-death marital dependence, and (f) high levels of neuroticism.

Current research is also attempting to identify key variables for a proposed complicated grief disorder diagnosis consistent with standards of the *Diagnostic and Statistical Manual of Mental Disorders-IV-TR (DSM-IV-TR)* (American Psychiatric Association, 2000; American Psychiatric Association, 2013; Boelen & Prigerson, 2012; Lichtenthal, Cruess, & Prigerson, 2004; Prigerson et al., 2009). Simon and colleagues (2007) have reported that sufficient evidence exists to support complicated grief as a distinct diagnosis from similar disorders such as major depression and post-traumatic stress disorder. In a recent review, Zhang, Areej, and Prigerson (2006) integrated a wide body of scholarship in proposing both descriptive and diagnostic criteria for complicated grief disorder.

Several diagnostic tools have been developed to assess for complicated prolonged bereavement. For example, Shear et al. (2011) developed the *Brief Dimension Complicated Grief Assessment* (BDGA). A second tool is the *Prolonged Grief Disorder-13 (PG-13)*, developed by Prigerson and Maciejewski (2008). The PG-13 was used in this dissertation to assist with screening participants in both the feasibility study and the pilot RCT. The reader is directed to manuscript 3 for a description of PG-13’s psychometric properties.

### 3.4 A New Intervention for Uncomplicated Bereavement

Numerous psychological interventions have been developed to support the bereft population across both the uncomplicated and the complicated/prolonged grief trajectory. In particular, interventions for complicated/prolonged bereavement have demonstrated efficacy in randomized controlled trial designs (see Piper et al., 2011). However, uncomplicated bereavement interventions remain rare, have been strongly critiqued in the scholarship for
numerous methodological biases, and have demonstrated minimal effectiveness in reducing psychological distress in bereavement.\(^5\) Manuscript 2 begins to address some of these concerns, building on the theoretical foundation of meaning making established in manuscript 1, and proposing a novel intervention for uncomplicated grievers based on previous recommendations.

\(^5\) The psychological distress associated with uncomplicated bereavement by definition does not impair functioning. Thus, corresponding uncomplicated bereavement interventions will likely have less impact than their complicated bereavement counterparts, given the absence of impairing psychological distress. As such, any changes that result from participating in an uncomplicated bereavement intervention will likely never approach the same degree for individuals participating in a complicated bereavement interventions.
3.5 Manuscript Two

_Bridging Theory with Emerging Trends in Intervention Research: Meaning-based Group Counseling for Bereavement_

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Reference

Abstract

A growing body of scholarship has evaluated the usefulness of meaning-based theories in the context of bereavement counseling. While scholars have discussed the application of meaning-based theories for individual practice, there is a lack of inquiry regarding its implications when conducting bereavement support groups. The objective of this article is to bridge meaning-based theories with bereavement group practice, leading to a novel intervention and laying the foundation for future efficacy studies. Building on recommendations specified in the literature, this article outlines the theoretical paradigms and structure of a short-term meaning-based group counseling intervention for uncomplicated bereavement.

Keywords: bereavement, grief, meaning, group, counseling, intervention
Meaning-based Group Counseling for Bereavement: Bridging Theory with Emerging Trends in Intervention Research

Research is needed to develop empirically-supported treatments that are effective and efficacious for bereft individuals, particularly for uncomplicated grief given the rather unimpressive results of corresponding interventions (Currier, Neimeyer, & Berman, 2008). Meaning-reconstruction theory has surfaced as a promising theoretical framework to inform bereavement counseling (Neimeyer & Sands, 2011). Meaning-reconstruction theory posits that therapy is a process of facilitating the bereft to re-author a life story challenged by loss into a more coherent and purposeful narrative (Neimeyer, Prigerson, & Davies, 2002). Although the scientific basis supporting meaning-reconstruction (also referred to as meaning-making) theory has evolved significantly in the past few years (Currier & Holland, 2008; Park, 2010), no scholarship explicitly considers the implications of diverse meaning-based theories for clinical practice in bereavement support group contexts. Consequently, we developed a novel meaning-based group counseling (MBGC) intervention to address the past critiques and gaps in knowledge outlined below.

Bereavement intervention meta-analyses and systematic reviews provided a number of insights that we implemented in developing the MBGC intervention. First, researchers have consistently reported effect sizes close to zero both immediately post-intervention and at follow-up for uncomplicated grief\(^6\) interventions (Forte, Hill, Pazder, & Feudtner, 2004; Neimeyer & Currier, 2009; Schut, Stroebe, van den Bout, & Terheggen, 2001). These findings have called into question the appropriateness of such interventions (Genevro, Marshall, & Miller, 2004).

Although varying degrees of distressing symptoms are reported, taken as a whole these

\(^6\) Uncomplicated grief is defined as “an emotional reaction to bereavement, falling within expected norms, given the circumstances and complications of death, with respect to time course and/or intensity of symptoms” (Stroebe, Hansson, Stroebe, & Schut, 2001, p. 6).
symptoms do not impair functioning. However, when individuals experiencing uncomplicated grief actively seek support services, it is argued that they are ethically entitled to more effective interventions than those currently being offered. Furthermore, some studies suggest that individual bereavement interventions are more effective than group interventions (Allumbaugh & Hoyt, 1999). However, because bereavement support groups frequently occur in clinical practice (Neimeyer & Currier, 2009), further research is needed to assess both their effectiveness and efficacy for treating uncomplicated grief.

Second, interventions may need to be theoretically driven to ensure consistency in delivery (Schut et al., 2001) (e.g., see Currier, Holland, & Neimeyer, 2010; Piper, Ogrodniczuk, Joyce, & Weideman, 2011). Third, Schut and colleagues (2001) encourage researchers to clearly describe interventions to permit future replication. This involves specifying training procedures for facilitators (Allumbaugh & Hoyt, 1999) and outlining a clear structure for delivery.

Fourth, interventions may be more effective when they account for the nature of the grief (i.e., uncomplicated/complicated), bereft characteristics, relationship to the deceased, and context of the death (Jordan & Neimeyer, 2003). While clear inclusion and exclusion criteria will promote a goodness-of-fit between the population and chosen intervention, participants should probably not be too dissimilar as to necessitate radically different treatment objectives.

Fifth, interventions tend to be most effective when individuals are themselves actively seeking support (Neimeyer & Currier, 2009; Zech, Ryckeboosh-Dayez, & Delespaux, 2010). Recruitment procedures should emphasize attracting participants who are motivated (Schut & Stroebe, 2005) and assess each individual’s expectations of participating in a bereavement group. Lastly, future interventions should attend to issues of diversity, in particular cultural variations in grief expression (see Klass & Chow, 2011).
Meaning-based Group Counseling (MBGC) for Bereavement

In addition to heeding the insights gained from the meta-analyses and systematic reviews noted above, the authors developed MBGC by a process of comprehensively reviewing and integrating several theories of bereavement, a model of grief group psychotherapy, and aspects of recent meaning-focused interventions in oncology. In addition, the authors integrated concepts from several scholarly conferences and continuing education workshops (Breitbart & Poppito, 2010; Neimeyer, 2009b, 2010a) as well as audiovisual material produced by the American Psychological Association (2008).

To begin, the intervention combines different meaning-making approaches including narrative-constructivist, bereavement, existential, coping and trauma, as well as spiritual/religious theories (for an extensive discussion, see MacKinnon, Milman, Smith, et al., 2013). MBGC also integrates the Dual Process Model of Grief (Stroebe & Schut, 1999), which identifies two distinct orientations a bereaved individual will experience: loss orientation, the tendency of the bereft to focus their energies on processing the aspects of the loss itself, and restoration orientation, the process of the bereft investing energy in re-constructive domains such as building new relationships or learning new skills to adapt to the changes stemming from loss. Oscillation is the process by which the bereft will at times confront the loss, while at other times invest their energy in rebuilding their life. Lastly, MBGC adapts a brief group therapy model as articulated by Yalom and Leszcz (2005). This model informs short-term (i.e., 12-20 sessions are suggested) interventions centered on recent problems and issues. Principles of brief group therapy include delivery of an intervention efficiently, with discrete tasks and objectives closely linked to participants’ therapeutic goals. Rigorous screening is vital to protecting the integrity of the group. This model also prioritizes interpersonal rather than intrapersonal issues.
MBGC also incorporates specific aspects of two distinct meaning-focused interventions developed for oncology patients. First, the *Meaning-Making intervention* (MMi) is a manualized treatment approach designed to assist patients newly diagnosed with cancer in adjusting to a life-threatening illness. Three studies have demonstrated the usefulness of the MMi, including an RCT and two pilot studies (Henry et al., 2010; Lee et al., 2006a, 2006b). MBGC integrates the MMi’s *Lifeline Exercise*, an activity that encourages participants to situate a current stressful event within the broader contexts of their lives. MBGC also integrates a modified version of Janoff-Bulman’s (1992) theory of shattered assumptions, similar to that used in the MMi.

Second, Meaning-centered Group Psychotherapy is a manualized and efficacious treatment for individuals with cancer who want assistance finding a sense of meaning (Breitbart, Rosenfeld, et al., 2010). MBGC includes Frankl’s (1981) existential sources of meaning and a focus on prior meaningful life events as per Breitbart and Poppito (2010).

**Intervention Training and Facilitation**

It is recommended that facilitators be licensed mental health professionals (with expertise in the areas of bereavement and group counseling) and that two facilitators conduct MBGC. An advantage to co-facilitation includes being able to more comprehensively attend to material shared by participants. While conducting MBGC, it is recommended that co-facilitators attend to counter-transferential issues (Yalom & Leszcz, 2005) such as: (a) anxiety inherent to the role of group facilitator; (b) fear of public scrutiny and exposure; (c) experiencing a loss of control during the group’s evolution; (d) fear that excessive content and emotional material will overwhelm; (e) a large volume of clinical material to synthesize; and (f) unpleasant memories of earlier group experiences.
Facilitator training can involve the observation of experienced group clinicians, regular individual clinical supervision (Bemak & Epp, 2001), participation in an interpersonal learning group (e.g., Hemenway, 1996), and personal psychotherapy. Group co-facilitators might also explicitly attend to their relationship, negotiating their mutual expectations and anxieties before and during the group. In order to achieve these training goals, facilitators can have regular meetings (e.g., 15 minutes in duration) prior to each group to negotiate the expectations and goals of a given session. A debriefing session at the conclusion of each meeting (e.g., 30 minutes) permits reviewing clinical impressions.

**Intended Population and Screening**

MBGC is appropriate for a culturally-diverse adult population. However, the literature underpinning the intervention mostly addresses bereavement due to advanced illness (i.e., cancer) and therefore the intervention may be most appropriate for this particular circumstance of death.

Only those individuals who are actively seeking bereavement group services and are experiencing an uncomplicated grief response are appropriate for participation. The death should have occurred no less than 6 weeks and no more than 2 years from the first meeting of the group, as per Neimeyer’s (2006) proposed timeframe of uncomplicated grief. MBGC is intended for participants grieving the loss of a parent, spouse, friend, or adult child. Participants must be over the age of 18 at the time of the first session and grieving the death of someone older than 18 years. MBGC does not account for issues of parental grief. Thus the screening interview should exclude parents grieving the death of a young child (less than 18 years old). The exclusion criteria also apply when the death was the result of suicide, suspected suicide, or homicide as MBGC does not sufficiently address these concerns. Furthermore, no two members of the same
family of origin should participate in the same group as this will likely lead to sub-grouping. Finally, individuals are not appropriate for MBGC if excessively angry, are unable to give and receive support from others, and/or are reporting severe suicidal, psychotic, or homicidal ideations.

It is recommended that individuals participating in MBGC undergo thorough screening to assess the match between participants and the intervention. Screening can involve an empirically-validated psychosocial assessment guide to evaluate current psychological functioning, as well as severity, intensity, and duration of past and current mental health concerns (e.g., Kefler, 2005). As participation in MBGC is inappropriate if an individual is experiencing a complicated/prolonged grief response, the screening interview can use the *Prolonged Grief Disorder-13* (PG-13; Prigerson & Maciejewski, 2008b) if the death has occurred more than 6 months ago. The PG-13 is a 13-item diagnostic tool for assessing prolonged grief. As psychometric validation of the PG-13 is still in early stages, use of the instrument in conjunction with a clinical interview is indicated. An alternative to the PG-13 is the recently developed *Brief Dimensional Complicated Grief Assessment* as reported by Shear and colleagues (2011).

Finally, it is recommended that screening follow Piper and colleagues’ (2011) strategies for assessing the appropriateness of individuals for short-term group therapy (e.g., self-reflective capacity; frustration tolerance) and techniques for preparing selected individuals for group participation (e.g., emphasizing commitment). Moreover, the sometimes intensely emotional context of grief may dictate smaller group sizes (six to eight participants), permitting sufficient opportunity for sharing and intergroup communication. Attrition in the early stages of the group
is possible and thus, facilitators may wish to aim for eight participants to assure minimum numbers.

**Structure and Delivery of MBGC**

MBGC comprises 12 weekly sessions of 90 minutes each. Fixed session times and lengths are an important aspect of the therapeutic frame and provide consistency, stability, and reassurance to participants about the boundaries, limits, and opportunities within treatment (Pipes & Davenport, 1999). Occasionally, facilitators may have to lengthen the space between sessions (e.g., holidays), and it is thus recommended to plan ahead to attenuate irregularity (e.g., permitting no more than one 2-week period between sessions per intervention).

MBGC contains themes embedded over three temporal phases (beginning, middle, and termination). Themes typically overlap at different times depending on the needs of participants, the group’s developmental level, and facilitators’ clinical judgment. The tasks facilitate a collective and collaborative exploration of both intrapersonal and interpersonal meaning reconstruction. Facilitators will periodically provide handouts to help anchor sessions in specific tasks. Participants may at times refuse to explore certain themes or partake in certain tasks. In these instances, exploring and discussing resistance in a respectful way can provide rich therapeutic material concerning participants’ grief.

The beginning phase spans sessions 1 to 3. Session 1 consists of a brief welcome and introduction, followed by group facilitators and members communally establishing norms. Norms can include confidentiality, regular attendance, punctuality, the importance of monitoring and being responsible for one’s own behavior, giving sufficient time for each member to share, the importance of self-disclosure, the significance of the group to its members, and the necessary
balance between support and confrontation (Yalom & Lesczc, 2005). In addition, the facilitators can briefly present and discuss the concept of meaning making in bereavement to facilitate understanding. Lastly, the leaders can intentionally introduce a colloquial vocabulary of meaning making when commenting on individual and group process.

Facilitators invite participants to share the story of their recent loss, identifying common and divergent themes in their bereavement narratives. Particular attention is given to contextual aspects of the loss, such as the nature of the relationship being grieved. Facilitators can ask participants to identify any expectations they have of the group, as well as their personal therapeutic goals.

The framework of session 2 follows conventional bereavement support group principles (Worden, 2009; Yalom & Vinogradov, 1988). Tasks include actualizing the loss, identifying difficult emotions, normalizing responses, and examining current coping styles. Facilitators aid exploration by encouraging participants not only to identify their feelings but also to articulate their understanding of their current emotions (Neimeyer, 2006). In addition, facilitators can encourage participants to contrast the current death with any previous deaths, perhaps situating the loss within the narrative of the family history (Nadeau, 2008).

Participants are invited (at the end of Session 1) to bring in meaningful objects (e.g., pictures, clothes) associated with the deceased to share with other group members in Session 2. This exercise is intended to be a springboard in permitting a more comprehensive characterization of the deceased.

Session three focuses on participants’ sharing of significant/meaningful events shared with the deceased (adapted from Breitbart & Poppito, 2010; Breitbart, Rosenfeld, et al., 2010). This may or may not be linked to the significant object from the previous session. Also, session 3
introduces the *Griefline Exercise* (adapted from Lee, 2006a, 2006b). Facilitators place a ribbon in a straight line in the center of the group, inviting participants to symbolize the ribbon as their life with one end representing the beginning of their life and the other its end. The goal of the exercise is to contextualize the death in participants’ life story, identify other significant stressful events (especially previous losses), and ascertain ways in which previous difficulties were addressed.

The middle phase spans sessions 4 to 10. In session 4, participants are encouraged to begin reflecting and identifying implicit or explicit assumptions they have about themselves and the world, with the goal of beginning to facilitate a process of re-establishing a sense of coherence in their lives. The goal is to identify with, and speculate on, strategies to rebuild assumptions shaken by the loss (e.g., of a benevolent and meaningful world, and the worthiness of the self; Janoff-Bulman, 1992). The group’s dialogue could focus on how the loss has validated or invalidated specific personal meanings and assumptions they previously held. This collective reflection process can generate alternative, more malleable, and adaptive constructions of the world and self that reflect a new reality.

The fifth session introduces participants to the Dual Process Model of Grief (Stroebe & Schut, 1999) to help frame their experience of loss, stimulating the creation of links between the model and their current experience. Members can identify specific loss-oriented activities, restoration-oriented activities, and any effects of oscillation between these two orientations.

The first broad task in the three mid-point sessions (Sessions 6 through 8) is to encourage participants to reflect on any changes they have experienced about their sense of self, identity, and family (Neimeyer, 2006; Riches & Dawson, 1996). Highlighting transformations in values, roles, and relationships can facilitate participants’ ability to orient themselves as well as identify
changes they wish to make. Facilitators can attend to the family system, inviting comments on the ways in which the family has changed, communicates about the loss, shares rituals to acknowledge the deceased, is influenced by pertinent social cultural factors, or has negotiated difficulties emerging from the loss (Nadeau, 2001).

The second task encourages members to explore the meanings of direct or indirect dreams of the deceased. Drawing on aspects of Hill and colleagues’ (2000) work on dreaming and loss, participants can identify beliefs about dreaming, the comforting or disquieting aspects of dreaming, or the lack of dreaming. For example, some participants may believe that a failure to dream is a commentary on the nature of their relationship with the deceased. Facilitators can probe for alternative explanations for a lack of dreaming directly about the deceased. Participants awaiting a dream often assign its meaning as a reunion with the deceased, and they can realize through other members’ sharing that dreaming about the deceased is not always pleasant.

The final task of the middle sessions, introduced at the conclusion of session 7 and completed in session 8, emphasizes the continuing bond as a means to meaning via a written therapeutic homework exercise called the Hello Again Letter (Neimeyer, 2012a). A handout containing prompts guides participants in composing a one-page letter written at home between sessions. Prompts include “What I have always wanted to tell you is…,” “What you never understood was…,” “What I want you to know about me is …,” etc. Participants can respond to as many of these prompts as they desire and bring to session 8 their letters to share with others in the group. Facilitators can highlight the convergent and divergent themes in letters as well as new insights gained in the course of writing.

By sessions 9 and 10, participants may feel safer and more connected with the group, triggering more profound and intimate sharing. Participants may also anticipate the end of the
group, and feel the need to use the remaining time beneficially. The final sessions of the middle phase introduce Frankl’s (1981) notion of attitudinal responses to events that are beyond one’s control. Facilitators can gently encourage participants to identify ways of regaining power, as well as emphasize personal agency and responsibility in negotiating loss. The objective is to stimulate a discussion on creative responses to loss, as well as past and present sources of meaning, similar to Breitbart and colleagues’ (2010) intervention. For instance, co-facilitators may ask what past activities have always been meaningful for the dyad (e.g., art, music, nature), how these activities can be continued, and/or brainstorm new meaningful activities.

Finally, session nine revisits the theme of the continuing bond through a second written homework, the Life Imprint Exercise, for sharing in session 10. Modeled on the work of Vickio (1999) with modifications by Neimeyer (2012b), the Life Imprint Exercise asks members to author a one-page excerpt about the subtle and implicit ways in which the deceased influenced and continues to exert sway on them (i.e., imprints). This exercise endeavors to encourage participants to underscore both positive imprints they wish to nurture as well as negative ones they wish to abandon.

The termination phase spans sessions 11 and 12. In the final two sessions, there is an attempt to integrate the therapeutic efforts of previous sessions. One of the objectives of the termination phase is to explore members’ impressions of the group’s impending conclusion, which tends to bring about diverse feelings (Yalom & Vinogradov, 1988). Participants can revisit goals expressed at the outset of the group and ascertain their level of accomplishment. Members may also discuss their lives after the group ends, related anxieties, and what plans they wish to make to further their adaptation to loss.
Epston and White (1995) challenge traditional psychotherapeutic conceptualizations of termination as loss of the expert therapist for the client. Rather, termination of psychotherapy (i.e., the group) can be seen as a rite of passage and the gains experienced by participants drawn out and explored in a series of interrelated questions. Drawing on Epston and White’s (1995) framework, *orientation questions* call attention to the steps participants have made, the knowledge they have gained, their achieved personal developments in constructing a coherent narrative, and any lessons learned. Second, *unique account questions* examine the process by which members have made distinctive gains in the course of treatment. Participants can trace their grief narrative in the context of the group and the inimitable advances achieved. Third, *unique re-description questions* encourage group members to consider alternative knowledge created and discovered throughout the course of the group. Fourth, *unique possibility questions* concern the future in the context of the past. These future-oriented/backward-looking questions invite members to imagine arriving at some valued destination in life, and then looking back to identify the steps needed to arrive there and the steps still needed to achieve the desired end. Finally, *circulation questions* encourage participants to begin thinking about making links with a broader social network for purposes of sharing their gains, and also for future support. These questions can provoke a discussion of the bereavement group’s own story (i.e., the meta-narrative).

Some participants may not be able to readily identify any significant gains, alternative reconstructed narratives, or positive impact of this meaning-based intervention. In this instance, exploring any barriers members perceived during the course of the group is indicated, as well as touching on more challenging aspects of the meaning-based group experience.

**Initial Empirical Results**
Qualitative and exploratory quantitative analysis from both a feasibility ($N = 11$) and a pilot randomized controlled trial (RCT) ($N = 20$) study indicate that MBGC is a practical and potentially useful intervention in facilitating psychological adjustment for uncomplicated grief (MacKinnon et al., 2011; MacKinnon, Smith, Henry, Milman, et al., 2012). Participants found MBGC beneficial in several regards. Specifically, the written exercises tended to promote adaptation and insight. Participants often reported many benefits from being with others in grief, such as bearing witness to the diverse grief experiences of others. Perhaps the most interesting finding was that MBGC acted as a learning environment with several promising outcomes: (a) group members learned about the nature of grief; (b) group members learned how to express their grief with others; and c) group members learned how to reconstruct with others a meaningful sense of identity following loss. These initial studies attempted to address several critiques outlined in the previous literature including the rigorous development of an intervention grounded in several theoretical models. MBGC was also constructed in collaboration with participants and is well described, thus permitting replication. The study also properly randomized participants into treatment and control arms, had clear inclusion and exclusion criteria, and targeted only those individuals seeking support. However, MacKinnon and colleagues’ (2011, 2012) early efforts were hindered by a small sample size that precluded the use of inferential statistics. There was also an inconsistent control arm in the pilot RCT (i.e., the control groups varied in their duration and tasks/themes).

**Limitations of MBGC and Directions for Future Research**

MBGC draws mostly on Western conceptualization of grief and its resolution. Thus, the intervention is based on the assumption that grief can follow a well-defined trajectory (i.e., uncomplicated) with regards to course and timeframe, which is socially and culturally rooted
within Western scholarship. As such, the line between uncomplicated and complicated grief is not definitive; when screening participants it is important to attend to variations in grief expression that may fall outside the dominant socio-cultural norm. In addition, studies have only just begun to assess the cross-cultural validity of meaning-making theories (e.g., Hussein & Oyebode, 2009). As a result, MBGC may need to be altered to accommodate patients of diverse cultural background. Consequently, future clinician/researchers may wish to introduce a model of multicultural competence for conducting group therapy (e.g., see Chen, Kakkad, & Balzano, 2008). Moreover, the strict inclusion and exclusion criteria limit MBGC’s transferability. For example, in settings with small participant pools (e.g., rural), the use of the strict criteria may result in an insufficient number of participants.

There are several areas of potential future inquiry. First, clinician/researchers may wish to adapt MBGC to an individual modality, which may help broaden its applicability to diverse settings where the resources necessary for conducting a group are not present. Second, it will be necessary to investigate and empirically validate the training and competency requirements for clinicians to adequately facilitate MBGC. Third, a full RCT is appropriate given that the intervention is feasible and appears to facilitate bereavement adjustment (MacKinnon, Smith, Henry, Berish, et al., 2012). Fourth, the tasks and themes of MBGC might be re-engineered so as to be appropriate for bereft adolescents as well as other causes of death (e.g., accidental, suicide, etc.). Fifth, future researchers may also wish to use the Group Selection Questionnaire (GSQ) (MacNair-Semands, 2002), a 19-item self-report questionnaire designed to predict individuals most likely to improve during the course of group psychotherapy. Finally, a detailed intervention manual will facilitate replication efforts (available from the primary author upon request).
In conclusion, there is a palpable need for theoretically-based and scientifically-sound psychotherapeutic interventions for individuals seeking support in negotiating an uncomplicated bereavement trajectory. Meaning-based theories of bereavement offer novel and interesting possibilities for guiding bereavement psychotherapists in conducting support groups. A focus on meaning within a bereavement group opens the possibility for collective meaning-making through a process of interpersonal learning. However, MBGC is not intended to fully resolve the current difficulties of the bereaved individuals. Rather, in keeping with a truly constructivist approach, the intervention might most usefully be conceptualized as the creation of a single chapter in the ever-evolving narrative of participants’ lives and an opportunity to facilitate re-learning the world (Attig, 2001).
CHAPTER 4: PILOT TESTING PHASE

How do we go about re-establishing the plot structure of a life that has been disrupted by trauma or loss? We do so by telling and retelling our story in the context of listeners who care, each of whom contributes, in a unique way, to the further evolution of the narrative….In the public telling of our tales, we seek help in finding answers, or at least permission to share the burning questions.

-Robert Neimeyer, 2006, p. 54

4.1 Preface

The first half of the dissertation was largely concerned with establishing the fundamental theoretical framework of meaning making in bereavement, as well as outlining the structure of meaning-based group counselling (MBGC). The second half of the dissertation is devoted to preliminary empirical evaluation of this new intervention, first through pilot testing the intervention, and second with a pilot randomized controlled trial (RCT).

To situate the pilot testing of MBGC within the broader literature of bereavement interventions, Chapter 4 begins by outlining psychosocial bereavement service utilization trends. Methodological issues of conducting the pilot study of the intervention and ethical considerations are discussed as a prologue to the third manuscript of the dissertation.

4.2 Bereavement Service Utilization

Do individuals in bereavement regularly partake in formal and/or informal services to bolster their efforts at coping with the repercussions of loss? Indeed, segments of the bereft population do seek out professional psychosocial support (including support groups) to receive support and help them learn to adjust. However, the reported proportion of family and friends who make use of bereavement services varies considerably.

Currow and colleagues (2008) reported that 13% of a large sample of bereft individuals ($N = 1965$) sought help from various sources in coping with bereavement. Informal supports
were described, including friends and family members, as well as more formal services such as
grief counsellors, spiritual advisers, nurses, and doctors. Only 3.4% sought formal professional help (i.e., psychotherapy). In another study, Cherlin and colleagues (2007) reported that 30% \((n = 49/161)\) of individuals bereft following a death from cancer sought out bereavement services, mostly within the first six months of loss. The most commonly-used services were offered either through hospice support services or with an independent professional counsellor. A relatively large percentage of this subgroup \((n = 13, 26.5\%)\) participated in bereavement support groups.

Several barriers to, and predictors of, bereavement service utilization have been proposed. Early research suggests that participating in a bereavement support group may carry with it certain stigmatizing qualities (Levy & Derby, 1992) that discourage bereft individuals from seeking formal support. In another study, Johnson et al. (2009) found there was a statistically-significant relationship between bereft participants’ higher grief symptoms and greater perceived negative responses in their social entourage \((N = 135; \text{e.g., minimization of distress})\). This lack of informal support perhaps impels the need for more formal support.

Currow and colleagues (2008) reported that bereavement service utilization tended to be associated with (a) the family or friend providing more intensive care to the dying person at the end of life, (b) being less able to move on with one’s life following the death, and (c) being unemployed. In Cherlin et al. (2008), service utilizers tended to be spousal caregivers of younger age, met the diagnostic criteria for major depressive disorder, themselves witnessed events they perceived to be traumatic during the end-of-life period, were highly involved in supporting the patient with instrumental activities of daily living, and communicated with a physician prior to the death.
Relatedly, Lichtenthal and her colleagues (2011) specifically examined predictors of bereavement service utilization in a sample of bereft individuals ($N = 86$), 16% of whom screened positive for prolonged grief disorder. Similar to findings from Cherlin et al. (2008), having discussed psychological concerns with a health care professional when the patient was ill was the only significant predictor of a family member with prolonged grief disorder seeking mental health service.

Unfortunately, to date no studies have examined the relationship between uncomplicated bereavement and service utilization. It is likely that many uncomplicated grievers seek professional support while many others do not and appear to adjust relatively well; the exact percentages remain unknown.

4.3 Methodological Considerations in Pilot Phase

The following subsections go into more detail regarding the methods used in the pilot testing than are reported in the third manuscript, which was shortened due to space limitations dictated peer-reviewed journal submission requirements. In depth particulars of the recruitment process precedes details of the monitoring procedures adhered to during the pilot phase. The process by which MBGC was refined based on participants’ responses is then reported. A rationale for the outcome measures selected is provided with reference to detailed psychometric properties provided in Appendix B.

4.3.1 Recruitment, informed consent and screening procedures. During both the pilot and pilot RCT phases of MBGC, local allied mental health professionals frequently contacted MacKinnon. They had heard about the study either through email LISTSERV announcements or poster displays. They indicated that they wanted more information about the study to share with their client population. It was made clear by MacKinnon that individuals had to self-refer to the
study by contacting MacKinnon directly by telephone. MacKinnon returned voicemail messages promptly, usually within 48 hours.

When MacKinnon was successful in making telephone contact, he first expressed his condolences. He then briefly informed these individuals of the current study drawing on information from the Description of Participation in the Study in the Informed Consent form (see Appendices C/D). When individuals remained interested in the study, a mutually convenient time to conduct a screening interview was set. The interviews took place in the offices of Palliative Care Research at the Jewish General Hospital and included informed consent, pre-screening (Appendix E), and completion of baseline outcome measures and the demographic data form (Appendix F).

The results of the recruitment procedure are aligned with those of Caserta et al.’s (2010) study that identified four factors that led to individuals joining and remaining in a bereavement-intervention study. First, participants desired to obtain help and support; this was the primary motivation for the majority of individuals in the MBGC pilot and pilot RCT. MacKinnon emphasized during recruitment that one of the main goals of the study was to offer and develop more effective psychological support. There was an attempt to minimize the burden of research, clearly differentiating research (e.g., informed consent, completing questionnaires, exit interview) from the therapeutic aspects of the study (i.e., the goal of the group was to provide bereavement support). Second, participants in Caserta et al.’s (2010) study desired to help other bereaved individuals. This factor influenced a minority of participants in the MBGC pilot during the recruitment process. Some expressed their desire to support others in a group setting (n = 7; 58%), whereas others wished to share what they had already learned about grieving and coping (n = 2; 17%). Third, Caserta et al. (2010) found that individuals who wished to contribute to
research tended to participate in bereavement intervention research. In the MBGC studies, there was a high volume of university-educated participants who may have been more familiar with the general objectives and procedures of research. A minority of participants were very curious about the study and desired to be informed when the findings were disseminated. Others wanted to participate in research that could potentially assist the field of bereavement counselling. Lastly, Caserta et al. (2010) found that bereavement intervention participants tend to have constructive interactions with the research team. They reported appreciating a professional, empathic, and culturally-sensitive approach. In the dissertation study, it was a priority to establish a good rapport with potential participants upon first contact. Every member of the research team who had direct contact with participants strove to be respectful and mindful of participants’ losses throughout the study. Progress of participants through each step of both the pilot of the intervention and the pilot RCT was carefully tracked in each treatment arm, from recruitment to pre-screening interview, randomized allocation to treatment arm, and finally to follow-up interview for MBGC participants using the participant tracking form (Appendix G).

4.3.2 Recruitment challenges. Recruiting participants for this bereavement intervention research was challenging at times, mirroring the difficulties summarized by Caserta et al. (2010). Attempts to time the intervention with the particular bereavement needs of the individual were difficult, especially when a participant wanted immediate service and the group was only scheduled to begin several months later. During the screening procedure, individuals who were already psychologically vulnerable expressed some reticence about congregating with others they had never met before to share their emotionally-laden stories. There were also practical barriers to participation, including some reluctance to commit to a relatively long-term enterprise.

7 No alternative psychosocial treatment was recommended to individuals who screened positive for uncomplicated bereavement. A professional referral (i.e., medical, psychological) was made for those who screened positive for complicated bereavement.
on a regular basis, difficulties travelling (e.g., many older individuals did not wish to travel at night or in winter; one individual lived in a different province and could not travel the required distance to attend sessions). There were also scheduling conflicts (e.g., planning to go away on a holiday during the group; a prior weekly commitment) that prohibited some from participating.

Finally, a high number of individuals left a message with the research team indicating they were interested in the study. However, they frequently did not return follow-up voicemail messages from MacKinnon. This phenomenon remains unexplained.

4.3.3 Intervention monitoring and data collection. Multiple sources of qualitative data were collected during pilot testing. The sources were used to prompt refinements to the original version of MBGC. While these sources are identified in manuscript 3, more details are provided below with reference to corresponding documents found in the appendices.

To begin, detailed session notes were made by the co-facilitators following an established protocol (Appendix H) for each session. The notes assessed meaning-making themes, observations of group dynamics and the functioning of specific group members, as well as objectives for the next session based on development within the previous group session (e.g., negative response to a given exercise) and recommendations for refinements.

The observation protocol (Appendix I) was completed by a research assistant after each session. The research assistant noted implicit and explicit events in the course of the group. Particular attention was given to identifying themes of meaning making, observations of specific members and group dynamics, and suggestions for adaptations.

The treatment fidelity and integrity thematic checklist (Appendix A9) was completed by the research assistant and the facilitators for every session. The purpose of the checklist was to
ascertain the degree of consensus by the co-leaders and the research assistant regarding whether specific tasks and themes of MBGC were covered in each session.

At the conclusion of sessions 3, 6, 9 and 12, the co-leaders allocated 5-10 minutes per session to briefly invite participants to provide suggestions for intervention improvement. The interview guide for in-session feedback is found in Appendix J, with participants’ responses integrated into the observation protocol described above.

Furthermore, at the end of the intervention, MBGC participants were invited to participate in an individual audio-recorded exit interview following a semi-structured guide found in Appendix K. This was consistent with the recommendation of Forte (2004) that future interventions should be developed in consultation with participants to ensure that the needs of the bereaved are appropriately met. The interview assessed the participant’s experience of MBGC, aspects of the intervention that were more and less helpful, as well as suggestions for improvement. The interview took place within six weeks of completion of MBGC and the majority were approximately 30 minutes in duration (ranging from ~20 to ~35 minutes). A research assistant conducted the exit interview in an attempt to account for the potential for social desirability. Interviews were transcribed verbatim and analyzed by MacKinnon. The qualitative data contained in the exit interviews was reviewed to validate the initial refinements to MBGC based on the research reports, as well as to identify additional participant recommendations. No explicit qualitative methodology was used to review this material as it was beyond the scope of the doctoral dissertation.

4.3.4 Additional analytic details. Qualitative content analysis guided by the research questions was conducted systematically with the above data sources. The findings were summarized in a weekly report (Appendix L) prepared by MacKinnon. The research report
comparatively synthesized the co-facilitator notes, the observation protocol, fidelity checklists, and, where possible, participant feedback. Particular attention was given to convergent and divergent observations by members of the intervention team.

Each weekly research report \((N=12)\) was sent to the research team, which comprised the research supervisors (Cohen and Smith) and MacKinnon. The research report was thoroughly reviewed in a weekly one-hour meeting (12 meetings total) that occurred only during the pilot testing phase. Research reports are not included in the dissertation as they contained identifying details and sensitive material. The goals of the research meetings entailed reaching consensus on divergent themes identified in the research reports, determining changes to intervention strategies, making new additions to the observation protocol, delineating adaptations to the tasks and themes of the intervention, and identifying other issues of research and clinical significance. In order to effect refinement, the intervention team (comprised of both facilitators and the observer) met for 30 minutes (occasionally longer if required) before and after each session for the purposes of integrating any changes to MBGC.

Lastly, all MBGC sessions were audio-recorded on a digital recording device and transcribed verbatim to obtain a record of participants’ moment-by-moment response to MBGC. To ascertain within-session participant responses to MBGC, a mixed inductive/deductive qualitative content analysis (Fereday & Muir-Cochrane, 2006) was conducted on the session transcripts (approximately 225 pages). This methodology was used to identify dominant themes of participant responses using data charts with units of text (i.e., excerpts of verbatim group interactions) that substantiated and authenticated each of the themes. Six dominant themes were identified, along with supporting quotations (selected by MacKinnon as best representing the given theme) are reported in manuscript 3.
4.3.5 Outcome measures. The following outcome measures were administered across the four quantitative evaluation points. Several measures were used for certain outcomes, partly in response to the need to assess the acceptability of the questionnaires by participants.

1. For meaning: (a) the Purpose in Life Scale (Crumbaugh & Maholick, 1964, 1981), (b) the Grief and Meaning-Reconstruction Inventory (Gillies, 2006; Gillies & Neimeyer, 2006), and (c) the Integration of Stressful Life Experiences Scale (Holland, Currier, Coleman, & Neimeyer, 2010).

2. For depression, the Center for Epidemiologic Studies Depression Scale (Radloff, 1977).

3. For anxiety, the State-Trait Anxiety Scale (Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983).

4. For grief, (a) the Revised Grief Experience Inventory (Lev, Munro, & McCorkle, 1993; Sanders, Mauger, & Strong, 1985), (b) the Core Bereavement Items (Burnett, Middleton, Raphael, & Martinek, 1997), and (c) the Hogan Grief Reaction Checklist (Hogan, Greenfield, & Schmidt, 2001).

Detailed psychometric properties of the selected outcome measures are provided in Appendix B. The rationale for selecting each of the instruments is included in manuscript three below.

4.4 Ethical Considerations

Institutional ethics approval for this study was obtained prior to data collection from the McGill University-affiliated Jewish General Hospital Research Ethics Committee (Identifier 10-071, see Appendix Q). The pilot RCT was registered via the internet with ClinicalTrials.gov (identifier NCT01384942, see Appendix R). The study adhered to the Canadian Tri-Council ethical guidelines for conducting research with human participants (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and
Humanities Research Council of Canada, 1998). The study was thoroughly explained to all potential participants during the screening interviews. Individuals who voluntarily consented to participate were required to sign an informed consent document (see Appendices C and D) in which they were made aware of the study purpose as well as any potential benefits or risks involved. Participants were given the opportunity before and after consent to ask any questions they had about participating. They were explicitly told that they had the right to withdraw from the study at any time without repercussion. A referral to medical and/or psychological services was made if judged clinically appropriate at screening, as well as any time during the study.
4.5 Manuscript Three

A Pilot Study of Meaning-based Group Counseling for Bereavement.

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Reference (An abridged version of the manuscript below will be published in Omega)

Abstract

Scientific studies demonstrating either the efficacy or effectiveness of interventions for uncomplicated bereavement are lacking. This study reports the results of a novel meaning-based group counseling (MBGC) intervention developed for bereaved adults. MBGC was built on previous scholarly critiques using a formative evaluation methodology within a group of bereaved adults (N = 11). The primary research questions were: (a) How do bereft individuals respond to MBGC? (b) What refinements are needed to MBGC to ensure feasibility? A secondary research question was: (c) Is collection of quantitative outcome measures at baseline and post-intervention feasible? Analysis of multiple qualitative data sources resulted in numerous refinements to MBGC. Results indicate that the majority of participants found the meaning-based intervention beneficial. Limitations included concurrent external therapies and a small sample size that was largely homogenous. There were no major counter-indications to proceeding with a pilot randomized controlled trial.
A Pilot Study of Meaning-based Group Counseling for Bereavement

While past literature has revealed little positive change resulting from psychosocial interventions for uncomplicated grief (Neimeyer & Currier, 2009), studies to date mainly suffer from design flaws (Larson & Hoyt, 2007). Uncomplicated grief is broadly defined as a bereavement response that, while psychologically unsettling, does not impair an individual’s physical, social, or occupational functioning (Stroebe, Hansson, Schut, & Stroebe, 2008; Zisook & Shuchter, 1993). Within the first six to twelve months, individuals tend to experience acute sorrow, a desire to be reunited with the deceased, a struggle to accept the death, psychosomatic symptoms, mild anger, as well as feeling disconnected from the world (Shear et al., 2011).

Genevro and colleagues (2004) have suggested that interventions with adults who are not experiencing complicated grief are not beneficial in reducing psychological distress. In fact, a number of meta-analyses have highlighted the minimal effectiveness of psychotherapeutic interventions for individuals following an uncomplicated grief trajectory (Currier, Neimeyer, & Berman, 2008). However, individuals in uncomplicated grief who are themselves looking for services should receive more effective interventions than those currently being reported. As such, there is a critical need for the development of empirically sound interventions for those experiencing uncomplicated grief who are seeking professional support (i.e., inreaching recruitment, see Schut & Stroebe, 2005).

Meaning-based theories of bereavement have demonstrated increasing potential to inform more effective approaches for bereavement psychotherapy (Neimeyer & Sands, 2011). As such, a novel meaning-based group counseling (MBGC) intervention for adults experiencing uncomplicated grief was developed and pilot tested, building on numerous suggestions for future intervention research described in recent scholarship.
To situate the present study within current trends, the overall framework of meaning making is discussed. MBGC is then briefly described, followed by results of the pilot study.

**Conceptual Frameworks and Existent Meaning-Focused Interventions**

It has been over a decade since a significant shift occurred in bereavement therapy, with a movement away from the longstanding hegemony of stage models of grief (Downe-Wamboldt & Tamlyn, 1997) towards more constructivist and meaning-focused narrative frameworks (Neimeyer, 2001, 2009a). Consequentially, diverse theories of meaning making have emerged. MBGC integrates theories of meaning from various schools of thought including narrative-constructivist, bereavement, existential, coping and trauma, as well as spiritual/religious (for an extensive discussion, see MacKinnon, Milman, Smith, et al., 2013).

The intervention also attends to the emerging empirical scholarship that focuses on the complex nuances, overlapping constructs, and problematic assumptions that can occur when implementing a meaning-based approach (Park, 2010). MBGC moreover draws on the *Dual Process Model of Grief* (Stroebe & Schut, 1999) and a model of brief group psychotherapy as advanced by Yalom and Leszcz (2005).

**Factors Considered in Developing MBGC**

MBGC follows an explicit structure that outlines facilitator training, specifies a strict pre-screening protocol with inclusion/exclusion criteria, and is both systematic and flexible in its delivery to facilitate replication efforts, as has been recommended in the literature (Stroebe, Stroebe, & Schut, 2003). Moreover, the intervention is intended for individuals actively seeking professional support (see Schut & Stroebe, 2005). MBGC’s constructivist epistemology also facilitates attention to issues of diversity (e.g., gender and cultural variations in grief expression).
Lastly, material (e.g., therapeutic exercises; clinical prompts) was integrated from several scholarly conferences and continuing education workshops (Breitbart & Poppito, 2010; Neimeyer, 2010), audiovisual material produced by the American Psychological Association (2008), and two specific meaning-focused interventions developed for oncology patients (Breitbart et al., 2010; Lee, Cohen, Edgar, Laizner, & Gagnon, 2006).

**Research Objective and Questions**

The research objective was to assess the feasibility of a manualized group counseling intervention in collaboration with participants experiencing an uncomplicated grief response who were seeking support. Bearing in mind the goals of pilot psychosocial interventions (van Meijel, Gamel, van Swieten-Duijfjes, & Grypdonck, 2004), the following primary research questions were selected: (a) How do bereft individuals respond to MBGC? (b) What refinements are needed to MBGC to ensure feasibility? Feasibility was defined as the majority of participants reporting that MBGC facilitated their bereavement adaptation. In addition, any suggested changes to MBGC by participants were only minor. Minor changes were defined as modifications to the structure and tasks of MBGC that were small, straightforward, and easily rendered. In preparation for further testing, a secondary research question was: (c) Is the collection of quantitative outcome measures at baseline and post-intervention feasible? To address these questions, the present study follows a formative evaluation methodology, adhering to the Stage Model of Behavior Therapy Research as outlined by Rounsaville, Carroll, and Onken (2001).

**Method**

**Inclusion and Exclusion Criteria**
The study was announced by posters displayed at various healthcare agencies (e.g., community health services), e-mail LISTSERVs (e.g., mental health associations), and in collaboration with a non-profit volunteer organization associated with an urban university teaching hospital. All participants self-selected to be in the study.

Individuals presenting for bereavement services who had experienced a death-related loss within six weeks to two years of the first meeting of the group and whose clinical profile corresponded with an uncomplicated grief response were invited to participate. Participants who reported symptoms consistent with a prolonged/complicated grief response were excluded. Participants needed to be at least 18 years of age or older and have sufficient ability to speak and read English. Individuals were assessed for their ability to participate in a group counseling context and excluded following the framework of Piper, Ogrodniczuk, Joyce, and Weideman (2011) (e.g., little self-reflective capacity, frustration intolerance, etc.). Individuals whose cognitive capacity would make study participation burdensome or impossible (e.g., concentration impairment) were excluded.

The type of relationship with the deceased (e.g., spouse, parent, sibling, etc.) did not impact inclusion or exclusion, with the exception of parental bereavement. Parents of a deceased young child (<18 years old) and those where the death resulted from suicide, suspected suicide, or homicide were excluded as the themes and tasks of MBGC do not sufficiently address these particular bereavement experiences.

**Intervention Structure and Delivery**

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8 Prolonged grief disorder is one of the most recent terms used synonymously to describe complicated grief that includes chronic yearning for the deceased and intense grief symptomatology (e.g., meaninglessness, trouble accepting the death) that significantly impair daily functioning (see Prigerson et al., 2009). An alternative framework has also been advanced by Shear and her colleagues (2011).
MBGC is a closed twelve-session manualized group counseling intervention (for an extensive description, see MacKinnon et al., in press). Sessions occur weekly, and are 90 minutes in duration. With three phases (beginning, middle, and termination), the intervention follows a semi-structured format of meaning-based themes and activities that tend to overlap and are often revisited at various points during the intervention as per the needs of participants (see Table 1).

MBGC was delivered by an intervention team composed of two licensed psychologists (Authors 1 and 3 of this manuscript). A research assistant (Author 5, a licensed guidance counselor) acted as an observer. Training for the intervention team prior to intervention delivery included reviewing the intervention manual (available from Author 1 upon request), discussing the execution of MBGC, as well as studying pertinent articles related to meaning making and group counseling.

**Procedure**

Approval for the study was obtained from the Jewish General Hospital Research Ethics Committee (Protocol 10-071). The study was registered with ClinicalTrials.gov (identifiers NCT01285128 and NCT01384942). Participants completed informed consent documentation with Author 1 who explained the study and addressed any questions or concerns. In order to assess whether the potential participant’s psychological and bereavement needs were likely to exceed what could be provided by the MBGC, screening interviews were conducted immediately after informed consent was obtained to assess eligibility based on the inclusion and exclusion criteria. Screening interviews were conducted by Author 1 (in tandem with Author 5 when scheduling was possible) and took between 40 and 90 minutes, depending upon the complexities of the individual’s bereavement profile. Several diagnostic tools were used during the screening
interviews in order to evaluate the appropriateness of MBGC to address a given individual’s bereavement-related distress. First, the *Psychosocial Assessment Elements* (Keefer, 2005) guide was used to structure the interview, gauging the individual’s current psychological functioning and assessing whether MBGC was an appropriate intervention for their current needs. Second, individuals completed the *Prolonged Grief Disorder-13* (PG-13) (Prigerson, & Maciejewski, 2008b) to assess for complicated/prolonged bereavement. As this diagnostic tool remains in the early stages of empirical validation, the cut-off score was not strictly used for inclusion/exclusion but rather helped inform the clinical interview. Third, individuals’ capacity to partake in a group was evaluated through the frameworks of both Piper and colleagues (2011) and Yalom and Leszcz (2005). Specifically, participants were invited to comment on their expectations of group participation, their ability to contribute to group interactions, and their capacity to give and receive support from others. If participation in the group was not deemed possible (e.g., scheduling conflicts) or an individual failed to meet the inclusion criteria (e.g., prolonged grief response), individuals were provided contact information for more appropriate psychosocial services. Fourth, determining sufficient cognitive capacity to participate was based on the ability of the participant to complete the screening procedure. Final decision regarding inclusion/exclusion rested with the clinical judgment of the interviewer(s). Following admittance to the study, demographic information was collected from participants.

**Qualitative data sources and adaptation procedure.** Multiple qualitative data sources were systematically collected. First, co-facilitators completed independent field notes after the session, attending to meaning-based themes, observations of group dynamics, and characteristics of specific group members. In addition, co-facilitators identified objectives for the next session. Second, the research assistant independently completed a detailed observation protocol noting (a)
implicit and explicit events in the course of the group, (b) themes of meaning, (c) observations of specific members, and (d) group dynamics. Third, a treatment fidelity checklist was used to ascertain adherence to the intervention. The checklist was independently completed at the conclusion of every session by both the facilitators and the research assistant and then compared to ensure adherence and reliability. Fourth, while participants were encouraged to provide feedback on the effectiveness of the intervention throughout its delivery, four feedback meetings were built into the last 10 minutes of sessions 3, 6, 9, and 12. These meetings were an opportunity for participants to voice suggestions for improvements to MBGC. Finally, each session was digitally recorded and transcribed in its entirety. Following each session, Author 1 identified specific audio segments deemed of clinical and research significance (e.g., problematic delivery of a given MBGC exercise; participants responses that were atypical) that were subsequently reviewed by Authors 2 (a licensed psychologist) and 9 (an experimental psychologist with expertise in meaning-making interventions). The purpose of this was to ensure systematic delivery as specified in the MBGC intervention manual, and to receive guidance and supervision.

These five qualitative data sources were synthesized into weekly research reports, presented and discussed during a weekly research team meeting with Authors 1, 2, and 9. The research report highlighted (a) aspects of the intervention that were more or less clinically useful as determined by participant responses as well as observations by the intervention team; (b) the response of the group to the meaning-based themes and tasks; (c) pertinent group dynamics; and (d) critical incidents. These reports and corresponding meetings allowed consensus of divergent observations and facilitated implementing refinements to MBGC. Adaptations stemming from
the research team meeting were then discussed during two weekly 30-minute intervention team meetings (comprised of Authors 1, 3, and 5) prior to, and after, each session.

**Follow-up interviews.** At the conclusion of MBGC, participants were invited to partake in an individual audio-recorded follow-up interview. Interviews occurred within three weeks of completion of the intervention and were between 30 and 35 minutes in duration. Interviews were conducted by one of the research assistants (Author 5) to reduce the potential for social desirability bias (i.e., to please the co-facilitators) and allow participants to speak freely. The interviews followed a semi-structured guide that assessed participants’ experience of the intervention and which aspects of the group were more and less useful, as well as suggestions for improvement. Interviews were transcribed verbatim and analyzed with particular attention to identifying any barriers in the group functioning and evaluating how participants perceived the usefulness of the meaning-based approach.

**Outcome measures.** Questionnaires were administered at two times to assess feasibility (i.e., participants’ completion of measures): (a) less than three months before the intervention period and (b) within two weeks of the intervention’s conclusion. Four primary outcomes were selected based on their theoretical role in meaning making and bereavement: grief, depression, anxiety, and meaning. Multiple questionnaires were chosen for the outcomes of meaning and grief as many of the scales showed strong face validity but lacked extensive evidence of statistical reliability or validity. Depression and anxiety were each measured with well-established and psychometrically-robust measures.

Three grief measures were selected. First, the Revised Grief Experience Inventory (RGEI; Lev, Munro, & McCorkle, 1993; Sanders, Mauger, & Strong, 1985) assesses grief symptomatology. There are four subscales: existential tension, depression, guilt, and physical
distress. Items are summed, with some reverse coded, to provide a total score. The RGEI has demonstrated consistently strong internal reliability with Cronbach’s alphas ranging from 0.93 to 0.96 (Engelkemeyer & Marwit, 2008; Kowalski & Bondmass, 2008). There appear to have been no validity studies of the RGEI to date (Nezu, Ronan, Meadows, & McClure, 2000).

Second, the Core Bereavement Items (CBI; Burnett, Middleton, Raphael, & Martinek, 1997) evaluates common symptoms of bereavement. The measure is scored by summing all items to form a total score. Lower scores on the CBI are indicative of less grief distress. The CBI has demonstrated reasonable internal reliability ($\alpha = 0.91-0.95$, see Byrne & Raphael, 1997; Holland, Nam, and Neimeyer, 2012) with corresponding high results for the three subscales ($images and thoughts \alpha = 0.74$; $acute separation \alpha = 0.77$; and $grief \alpha = 0.86$). Test-retest reliability has yet to be reported for the CBI.

Third, the Hogan Grief Reaction Checklist (HGRC; Hogan, Greenfield, & Schmidt, 2001) estimates several aspects of an individual’s psychological grief distress within the past two weeks. There is no total score. Instead, individual scores are calculated for each subscale through summation of each item. A study of the psychometric properties of the HGRC (Neimeyer, Hogan, & Laurie, 2008) found consistently robust Cronbach’s alphas for each of the subscales ($despair \alpha = 0.89$; $detachment \alpha = 0.87$; $disorganization \alpha = 0.84$; $panic behavior \alpha = 0.90$; $blame and anger \alpha = 0.79$; and $personal growth \alpha = 0.82$). Test–retest reliability ranged from 0.56 to 0.85 over a 4-week period. The reported high correlations with the Texas Revised Inventory of Grief speak for convergent validity of the HGRC.

Depression was measured using the Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977). The measure is scored by summing the responses to all items (four items are reversed scored). Scores of 16 or more suggest major depression. McDowell and
Newell (1996) have reported various studies detailing the psychometric properties of the CES-D. The measure demonstrates strong internal reliability (general population $\alpha = 0.85$; psychiatric-patient sample $\alpha = 0.90$). Test-retest reliability was reported as $r = 0.76$ and split-half reliability ranged from 0.76 to 0.85. The measure has revealed robust convergent validity with the Hamilton Depression Scale and the Raskin Depression Rating Scale.

The State-Trait Anxiety Inventory (STAI; Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983) assesses both state (a temporary variation in emotionality) and trait (a comparatively stable feature of personality) anxiety. Separate scores for state and trait anxiety are calculated using a scoring template with some items reversed. Higher scores indicate greater levels of anxiety. The state-anxiety subscale is reliable with both men ($\alpha = 0.86$) and women ($\alpha = 0.95$), with similarly strong results on the trait subscale (male $\alpha = 0.89$; female $\alpha = 0.91$). McDowell (2006) recently reported similarly strong reliability across various groups including working adults, cancer patients, and the elderly. Test-retest reliability was also reported (state anxiety ranged from 0.16 to 0.62; trait anxiety ranged from 0.65 to 0.86). The STAI has confirmed construct validity for both the state and trait subscales. There are also strong correlations with other measures of anxiety including the Taylor Manifest Anxiety Scale, the Multiple Affect Adjective Checklist, and the IPAT Anxiety Scale (McDowell, 2006).

A total of three meaning measures were selected. First, the Purpose in Life Test (PIL; Crumbaugh & Maholick, 1964; 1981) is a commonly-used self-report measure that evaluates Frankl’s (1981) theory of existential meaning. Each item of the PIL is ranked on a 7-point Likert-type scale. Individual scores are summed to provide a total score ranging from 7 (corresponding to low purpose) to 105 (corresponding to high purpose). The PIL has established
validity \( (\alpha = 0.84, \text{Shek, 1988}) \), sufficient reliability \( (r = 0.92, \text{Crumbaugh & Maholik, 1968}) \), and test-retest coefficients ranging from 0.68 to 0.83 \( (\text{Reker, 1977; Meier & Edwards, 1974}) \).

Second, the Grief and Meaning-Reconstruction Inventory (GMRI; Gillies, 2006) is a scale from an unpublished doctoral dissertation. It assesses several meaning-reconstruction themes in bereavement. All 29 items are anchored on a 5-point Likert-type scale, ranging from strongly disagree to strongly agree. With certain items reversed scored, the responses are summed with higher scores indicating more attempts at meaning reconstruction. The scale was included due to high face validity. Initial results demonstrated adequate statistical reliability \( (\alpha = 0.84) \). Regarding test-retest reliability, the Pearson’s correlation coefficient was 0.71 over a period of four to six weeks. Exploratory factor analyses identified five principal subscales including continuing bonds, personal growth, sense of peace, emptiness and meaninglessness, as well as valuing life. Emptiness and meaninglessness were positively correlated with the Inventory of Complicated Grief (correlations ranging from 0.50 to 0.68). Convergent and discriminant validity analysis of the GMRI showed significant negative correlations with well-validated distress measures (for example, the Inventory of Complicated Grief, Hogan Grief Reaction Checklist, and the Hopkins Symptom Checklist). For example, full scale GMRI and Inventory of Complicated Grief were significantly negatively correlated (correlations ranging from -0.31 to -0.39).

Third, the Integration of Stressful Life Experiences Scale (ISLES; Holland, Currier, Coleman, & Neimeyer, 2010) is designed to gauge the degree to which stressful life experiences are adaptively accommodated. Higher scores indicate the ability to integrate difficult experiences with corresponding increases to internal coherence and hope for the future. The ISLES had strong internal consistency \( (\alpha = 0.93 \text{ in a general stress sample and } \alpha = 0.94 \text{ in a bereaved}) \).
sample). A similarly high Cronbach’s alpha (i.e., $\alpha = 0.94$) for the ISLES was recently reported by Lichtenthal, Burke, and Neimeyer (2011). Test-retest reliability was consistent, with correlations conducted approximately three months after the initial assessment ($r = 0.57$ for both the general stress sample and the bereaved sample). The ISLES also demonstrated convergent and divergent validity based on its associations with the World Assumptions Scale, the SF-36, the Symptom Checklist Revised, and the Inventory of Complicated Grief-Revised.

Lastly, to gauge whether changes in coping and adaptation were attributable to MBGC, certain external effects were documented. Specifically, participants were asked at the conclusion of the intervention whether they either (a) began, (b) stopped, (c) never followed, or (d) followed throughout MBGC a prescribed psychotropic medication regime (e.g., anti-depressants). In addition, participants were invited to disclose any concurrent professional support (e.g., individual psychotherapy).

**Data Analysis.** An executive summary was prepared that synthesized the twelve weekly research reports as well as the follow-up interviews. A final meeting with multiple members of the research team (Authors 1 to 5 and 9) took place three weeks later. The goal of the meeting was to thoroughly discuss the qualitative and quantitative findings and adjust MBGC for limitations based on participant feedback.

In order to confirm the validity of the adaptation made based on the research reports and executive summary, session transcripts were later analyzed using qualitative content analysis to deductively and inductively identify convergent and divergent themes (Creswell, 2003; Fereday, & Muir-Cochrane, 2006). Deductive themes were organized around the research questions. Transcript analysis permitted a more thorough identification of participants’ response to MBGC, grouped across several convergent themes.
Results

Data collection took place over seven months. The first three months involved recruitment, screening potential participants, and collecting baseline data. Administration of the intervention took place over the subsequent three months. The last month involved completion of the follow-up interviews and outcome measures.

A total of 14 out of the 26 individuals (54%) self-referred to the study after seeking bereavement support were excluded for various reasons (see Figure 1). A total of 12 participants provided signed informed consent and were invited to participate following the screening interview. Participants were mostly female (n = 9, 75%). The sample was predominantly Christian (n = 6, 50%) and Jewish (n = 4, 33%). Individuals were mostly of White-European ethnicity (n = 11, 92%). All individuals reported being heterosexual and ranged in age from 27 to 76 years (M = 54.00, SD = 17.10). Participants reported that the death occurred, on average, within approximately six months (M = 189.50 days; SD = 122.50 days, Medn = 127.5 days) from the first session of the group. Because most participants reported the death occurring within 6 months, only five participants completed the PG-13. Most participants were grieving the recent death of their spouse (n = 10, 83%) with others grieving the death of their father (n = 2, 17%). The vast majority (n = 11, 92%) reported grieving a death due to cancer. Most participants (n = 10, 83%) reported previous deaths in their lives.

Eleven participants attended the group with relatively high frequency and completed the entire intervention as planned. One participant came for only three of the first six sessions and was subsequently withdrawn from the study after failing to return two follow-up phone messages. Mean attendance was 10.27/12 sessions (SD = 1.95). Participants provided advanced notice for 96% of absences. On the whole, female participants missed sessions less often (female
session absenteeism $M = 0.75, SD = 0.89$) than the three male participants (male session absenteeism $M = 4.33, SD = 1.53$). Participants usually attributed absences to inclement weather or unexpected social obligations.

It was determined that three participants followed a medically-prescribed psychotropic medication regime before and during the intervention, though none started during participation in MBGC. One participant partook in concurrent weekly individual psychotherapy during the intervention. Finally, two individuals participated in a second bereavement support group and only disclosed this at the conclusion of the MBGC.

**Treatment fidelity**

MBGC was delivered as planned with no major deviations in session tasks or themes from the original intervention manual. The majority of the 44 items of the weekly session audit form were completed by the intervention team with relatively high consistency. Divergences decreased steadily over time, partially aided by regular meetings of the intervention team. Disagreement tended to be over clinical manifestations of meaning-based theories. Refinements to these items were made during the study, permitting greater consensus. Particular incongruity was found in rating the positive and negative meaning reconstruction pathways of the modified Dual Process Model of Grief (Stroebe & Schut, 2001). The decision was thus made to use the original Dual Process Model (Stroebe, & Schut, 1999).

**Adaptations to MBGC**

Adaptations are summarized along two broad thematic groups: content alterations and process alterations. With regards to content alterations, a modified visual depiction of the Dual Process Model (DPM) of Grief (Stroebe & Schut, 1999) was developed. A simplified image using more colloquial language was developed. It also transposed the loss and restoration orientations. This latter refinement was in response to some misperceptions of the model by
participants who tended to interpret the model in linear/stage terms (e.g., some felt bereavement adaptation occurred when one progressed from the loss to the restoration orientation).

Second, participants were eager to engage in the meaning-based exercises earlier in the course of the intervention. As such, the beginning phase, which followed a more conventional grief intervention format, was shortened to 2 sessions. Third, participants desired more time for exploring spiritual and religious sources of meaning. Fourth, participants were eager for more discussion of their perceptions, beliefs, and symbolism of dreaming about the deceased. As such, the revised MBGC draws on Hill and colleagues’ (2000) work on dreaming.

The fifth modification concerned some of the therapeutic exercises. Participants found that the two written exercises (Hello Again Letter, Neimeyer 2012a, and Life Imprints Exercise, Neimeyer 2012b) could be introduced earlier. Also based on participants’ feedback, exercises were spaced out and their presentation order reversed to decrease the reportedly highly degree of psychological effort required to complete these exercises. In addition, some participants expressed during MBGC that they felt insecure that their writing ability would be judged by other group members. The introduction of the writing exercises was revisited, emphasizing that the goal of the exercise was not to evaluate writing ability.

Additionally, the Lifeline Exercise (described by Lee et al., 2006) was reformulated into a Griefline Exercise, encouraging participants to situate the recent loss within the context of other life losses. The use of the Griefline Exercise was also limited to once as opposed to twice as was originally planned. Moreover, a great deal of anxiety and ambivalence regarding the ending of the group was observed, necessitating a more extensive discussion of termination earlier than was originally designed. As a result, a co-constructed closing ritual was removed from MBGC.
More time was made in the final session for exploring participants’ feelings about the group’s ending, revisiting gains made in the group, and exploring directions for the future.

With regards to process adaptations, an implicit norm of absenteeism (while not critically large) and lateness occurred throughout the intervention. Upon further consideration, the researchers suspected that the high number of participants in the group may have created less sense of accountability. Maximum group size for future groups of MBGC was reduced from 10-12 to 6-8, which also permitted individual participants more opportunities to express their unique grief experiences.

Lastly, an initially high frequency of therapeutic ruptures between participants was observed during the earlier stages of the group. Ruptures tended to be characterized as unintentional discrepancies in group member communication including undervaluing or insensitively assessing another’s remarks with resultant irritation and disappointment. Irritation was often linked with the health care system, as well as with members perceived to be unsupportive. Attempts by the intervention team to engage participants in a discussion about the role of ruptures, anger, and its effects on group members who felt marginalized were met with partial success. It was consequently decided to develop strategies and techniques to manage such ruptures (reported in MacKinnon, Smith, Henry, Berish, Milman, & Copeland, 2012).

Participant Responses to the Intervention

Participation in MBGC provoked numerous responses in group members. These responses are presented below along five thematic categories. Direct citations in the manuscript consistently begin with Member 1, Member 2, and so on. This convention represents an attempt to preserve participant anonymity and does not indicate that the citations are always the same members speaking.
**Being with others in bereavement.** First, members reported numerous benefits of being with others in grief. Group members became bonded by their shared feelings of sadness, guilt, regret, despair, powerlessness, disorganization, and emptiness. While many participants were initially worried about being in a group setting (e.g., fear of being overwhelmed by the sadness of others; fear of not fitting in), these fears were not substantiated. There was a decreased sense of isolation with heightened feelings of acceptance. The intervention served to cushion these difficulties as two members stated in the tenth session:

**Member 1:** Well, [the group] kind of fills a gap in our lives, that we can come and that there’s not that abyss in front of us. When we’re together, that helps too. We’re not alone.

**Member 2:** Yeah. It’s true.

In this way the group became a place for sharing aspects of grief that could not easily be shared in the broader social network. Furthermore, participants often became lobbyists for other group members, celebrating members as they struggled to embark in new directions (e.g., beginning new activities). Individuals reported being pleasantly surprised to discover that the group could tolerate both sadness and happiness. Conversely, the challenge of being with others was observed in the initial sessions during moments of strong affective expression, which created transitory feelings of helplessness and disorganization. During these moments, it became difficult for members to integrate feedback from the group as they were temporarily emotionally flooded.

**Impact of the written exercises.** Participants reported that while the two written exercises were emotionally taxing, they were on the whole therapeutically useful. While some participants followed the exercise instructions strictly, others improvised alternatives that better met their needs, while respecting the spirit of the exercises.
First, the *Life Imprints Exercise* (Neimeyer, 2012b) encouraged participants to identify the understated and sometimes tacit ways in which the deceased shapes and continues to influence them (i.e., imprints). Participants’ responses to this exercise were varied. Some participants got back in touch with comforting memories constructed with the deceased of a time before their illness when they were happy and safe. One participant noted in session 9 several imprints that her two husbands, both deceased, had left on her life.

**Member 1:** What I learned was to be caring, loving, thoughtful, open to people’s feelings, and to always have a kind touch. I also learned to be encouraging and complementary and non-judgmental – to me that was a biggie… I worked hard on that one. I appreciate the glowing effects of receiving unconditional love and I now project those feelings to the people I love. But what I did learn from both of them was to be true to myself, to believe in myself and how beautiful life could be.

Similarly, the *Hello Again Letter* (Neimeyer 2012a) taps the theme of the continuing bond, encouraging participants to open a new dialogue with the deceased by composing a letter using such prompts as “What I have always wanted to tell you is…” and “What you never understood was….” The moments when letters were shared were often poignant, evoking considerable affect in the group as a whole. The group was appreciative of members taking the risk in sharing the often-intimate details of the letter. New insights were derived, often highlighting the mixed, complex, and sometimes contradictory feelings of grief.

In addition, certain participants found that the imprints left by the deceased were unclear. A minority of individuals did not complete the exercises, suggesting to the group they were not ready to confront certain aspects of their loss. However these participants still reported some insights in the attempt. The endeavor to start writing drew attention to the need for reprioritization (e.g., making space for pleasurable activities). The exercises also underscored the often-contradictory feelings of wanting to protect the reputation and legacy of the deceased, while also needing to give a voice to certain unpleasant aspects of their relationship.
**Challenging and reframing.** Group participants developed an implicit norm of challenging and/or reframing each other’s comments over the course of MBGC. This norm advanced naturally in response to content disclosed as well as evolving group dynamics. Specifically, group members challenged other participants’ unproductive attempts at meaning-making, often leading to more constructive efforts. In the citation below from session 7, the group frequently challenged Member 2’s self-criticalness (e.g., “I’ve become very lazy now”) by reframing his present behavior:

*Member 1:* Why are you so hard on yourself?
*Member 2:* I don’t like to be like that, you know.
*Member 3:* I don’t think you’re lazy.
*Member 4:* Yeah.
*Member 5:* That’s the wrong word. I think [daily household cleaning is] just low on your priority list. It’s no longer important for you.
*Member 2:* That’s good. That’s what I’m going to be saying to myself. It sounds much better.

Some of this challenging was done gently and participants responded well. However, some members found the delivery of challenges difficult to hear, perceiving judgment and non-acceptance. These reactions tended to occur when the participant held rigid beliefs and conceptualizations (e.g., spiritual/religious beliefs) that were not easily amenable to reframing (e.g., a reunion with the deceased in heaven was the only source of hope).

**Universality and difference.** While participants felt validation and normalization of their grief (i.e., universality), they concurrently reported that their experience was unique (i.e., difference). This recurrent paradox of feeling both similar and dissimilar often found expression in statements of feeling both connected to the group, but also separate. Often these competing states of universality and difference accentuated the desire of members to listen to dissimilar grief narratives. These divergent grief stories often evoked a realization of just how distinct one’s grief experience was, but also concomitant expressions of gratitude from the group. What
emerged was a norm of *valuing of the diversity of grief* within the group. Differences, while sometimes being reminders of one’s isolation, were prized. This phenomenon was no more clearly demonstrated than during the tenth session when the only remaining participant grieving the death of a parent expressed:

**Member 1:** I’ve felt like I’m slightly on the outside of the group, because I… I’m the only one in here grieving for my parents. I mean, you’re grieving for spouses… and it’s given me an ability to, like [a member] just said, “I understand. I’m not alone.” I didn’t lose the father of my children. I lost my actual father, so it’s… it’s… it’s a different loss, but it’s the same, like grief is grief.

**Member 2:** I think it was good that [Member 1] was here, because it put things in perspective. Yes, we lost our spouses, but yes, we’ve lost our parent in the past, and we never had this opportunity to go through a grieving. So I think it’s good to have a little bit of a mixed bag, because everyone grieves, and we all grieve differently.

Member 2’s response highlights that the experiences of both universality and difference could hold great value.

**The group as a learning forum.** Drawing on Attig’s (2010) framework of grief as a process of re-learning the world, it became clear through retrospective analysis of the transcripts that the intervention functioned, in part, as an experiential learning environment. First, participants learned about the characteristics of grief, including how grief can vary based on such factors as relationship (e.g., spouse, parent), previous death-related losses, and quality of the relationship with the deceased (e.g., close, conflictual, ambivalent, etc.). Participants also learned about the role of gender variations in grief expression. For example, the grieving widows in the group found that the loss of the male companion made them feel less safe at home.

Second, participants learned to begin making more sense of their particular bereavement reactions. Members were able to begin articulating changes in the sense of self, including the realization that one was fundamentally changed as a result of the loss. Some were able to express
aspects of personal growth achieved through participation in MBGC. One participant commented in session 11:

**Member 1**: I think back about the first time I met you and how crazy I must have come across, and how much calmer and more “zen” I feel now. It is something that my friends have… have pointed out, too. They’re like, “You’re so much calmer. You’re so much more in control of your emotions now,” and I think that this group has been a big part of that.

Learning about one’s grief was not always easy, as some members came to realize how interdependent they were on the deceased. Other participants discovered they were carrying a large degree of regret. The challenge of increased self-awareness was captured during the following group exchange in session 7:

**Member 1**: Perhaps you’re trying to identify what you’re learning from the experience.

**Member 2**: There’s something to be learned.

**Member 1**: Yeah. But some of it might not be very pleasant, but it… it has to be learned.

**Member 2**: Yeah. I remember saying that everything happens for a reason. There’s a reason why I had to lose my husband early. Maybe I had to grow in some way, and learn different things, and do things on my own, which I wasn’t doing before.

Of note, some participants expressed a desire to create and/or rediscover a more meaningful life, with priority given to nurturing present relationships, finding more moments for relaxation and calm, as well as the desire to initiate new behaviors.

Third, MBGC was a forum for learning to express one’s grief with others. Participants learned to put words to the often unspoken aspect of grief. Within the safety of the group, members learned to be able to express unpleasant aspects of grief that could not have easily been shared (e.g., anger with the deceased for having died). In finding the courage to speak, participants learned how to function in a group setting (e.g., what was helpful for others) and discovered that their contributions were valuable. Participants were in fact surprised by the graciousness of other members. A pertinent example of a participant’s risking to share occurred in session 9 and was one of the moments when the group was the most animated:
**Striking a meaning-balance.** Participants reported that an important aspect of successful grief adaptation occurred when they achieved a degree of equilibrium in making meaning. In essence, some participants reported coming to a realization that certain preoccupying questions were unanswerable and provoked increased distress. During the seventh session, participants identified a sense of choice in deciding whether or not to relinquish or continue to invest energy in grappling with certain preoccupying meaning-based questions.

**Member 1:** So you have to figure out a way to move beyond just dwelling on meaning, because I was doing a lot of that in summer [prior to participation in MBGC], and that’s a very hard process that didn’t result in anything. It *really* didn’t. I spent a lot of time thinking about it, and I didn’t get anything out of it, like you.

**Member 2:** Maybe you have to ask different questions.

**Member 1:** I have. It’s a good point.

Participants were able to identity a sense of agency in whether or not to invest time and energy in grappling with certain questions. Some participants built on this exchange, and were able to relinquish certain preoccupying questions over the course of MBGC.

Another interesting finding concerns the use of clinical prompts and questions encouraging participants to make meaning of the death that tended not to be productive. In fact, participants reported that the death itself remained a senseless event. Participants described the need to stop trying to make meaning of the death and in fact were coping better when they were able to relinquish certain meaning-making attempts. However, clinical prompts that emphasized
making meaning of one’s grief (rather than making meaning of the death itself) were more productive and participants were able to recognize gains they had made over the course of the intervention. Consistently, several participants reported they were better able to make sense of their own response to loss.

**Outcome measures**

Of the 11 participants who completed the intervention, two were lost to follow-up and failed to complete the post-test measures. Participants reported that the questionnaires were emotionally taxing at times and tended to take slightly longer (40 minutes) to complete than was originally envisioned (30 minutes). On the whole, participants did not object the content of the questionnaires, with one notable exception. Certain participants strongly objected to items in the Purpose in Life Inventory that assessed meaning in global terms (e.g., rating whether one’s life has been completely worthless versus very worthwhile). Some participants found that these broad statements elicited feelings of despair.

Baseline questionnaires were not administered just prior to the start of the intervention (e.g., baseline collection ranged from 3 months to 1 day before session 1). Moreover, follow-up interviews were conducted prior to the post-intervention questionnaire data, which may have influenced responses.

Only descriptive statistics were calculated (see Table 2). The calculation of inferential statistics would be misleading given the small sample size and the goals of a pilot study (Arnold et al., 2009). Because the standard deviation is extremely unreliable in small sample sizes, inferential calculations would likely produce spurious results. Only the results of the 9 participants who completed both baseline and post-intervention measures were included. Changes on the means of the meaning and anxiety measures were almost non-existent. Our
findings indicate possible improvements in levels of bereavement on the CBI, as well as on the grief components of despair and disorganization on the HGRC.

**Discussion**

Revisiting the primary research questions, it was determined that MBGC met the threshold for feasibility based on the a-priori thresholds outlined in the methods section above. Participant responses to this pilot study suggest that the intervention may facilitate positive coping and adjustment for adults experiencing an uncomplicated grief trajectory. There were several minor adaptations (e.g., reducing group size; re-ordering certain exercises), but no requests for major alterations. Overall there was relatively little attrition during delivery \( n = 1 \) and data collection \( n = 2 \). Participants were also able to complete the pre- and post-outcome measures without significant difficulties. No participant reported becoming more distressed as a result of MBGC. One participant reported very little positive improvement in the follow-up interview.

The results of the study suggest that MBGC functioned as a bridging chapter for participants between the period immediately following death and the commencement of a different chapter of their lives. The intervention appeared to foster a process of collective meaning-reconstruction through spontaneous learning interactions between group members. Striking a meaning-balance was similar to previous studies that suggest that a more anguished search for meaning predicts a more prolonged grief response (Updegraff, Silver, & Holman, 2008).

Participants were enthusiastic to learn about multiples aspects of grief (their own and others’), as well as identify new ways to cope, adapt, construct sense, find benefits, adaptively continue the bond with the deceased, and make meaning. The intervention thus may well have
facilitated a psychological re-ordering process, with reprioritization of life goals, and increased self-awareness over the twelve sessions.

This pilot investigation of MBGC mirrors certain aspects of analogous bereavement interventions, while concurrently standing alone in terms of attending to certain methodological factors. Similar to other studies, MBGC follows a rigorous screening procedure (see Sikkema et al., 2006; Piper, Ogrodniczuk, Joyce, & Weideman, 2011) that, while resource intense, may have largely prevented poor participant-intervention matches. Similar intervention studies are also increasingly integrating cogent bereavement theories. For example, a recent study was reported of a bereavement group intervention grounded in the Dual Process Model of Grief with promising results in a RCT (randomized controlled trial) design with 298 bereft spouses over age 50 (Lund, Caserta, Utz, & de Vries, 2010). However, MBGC appears to be one of the only recent attempts to apply current meaning-making theories within the context of bereavement group counseling. The only exception appears to be early efforts by Lichtenthal (2011), who is attempting to develop a meaning-centered intervention for bereft parents.

This study appears to stand out from parallel studies in certain distinct ways. Specifically, this feasibility study attempted to account for numerous critiques specified in previous bereavement intervention meta-analyses (Currier, Neimeyer, & Berman, 2008; Forte, Hill, Pazder, & Feudtner, 2004; Schut et al., 2001; Stroebe, Stroebe, & Schut, 2003). Comparatively, an appraisal of the few articles published in the past 10 years suggests that previous critiques and recommendations for intervention improvements have been largely neglected. First, the present study has clear screening procedures and attempts to strike a balance between participant homogeneity, unlike similar studies that do not stipulate selection practices and tend to include an overly diverse sample. For example, some investigations involve participants grieving
the death of spouses, parents, siblings, and children (Maruyama & Atencio, 2008) as well as interventions that include death due to accident, advanced illness, and suicide (e.g., Geron, Ginzburg, & Solomon, 2003; Johnsen, Dyregrov, & Dyregrov, 2012). Second, the present study attends to previous recommendations for assessing bereavement trajectory, whereas recent studies tend to neglect this guideline (e.g., Johnsen, Dyregrov, & Dyregrov, 2012). Third, this study relies on an inreaching recruitment strategy, whereas other investigations continue to rely on outreaching recruitment strategies (delivering an intervention regardless of whether individuals initiated the requests themselves; see Lund, Caserta, Utz, & de Vries, 2010).

This pilot study is also one of the rare recent attempts to refine a bereavement intervention in collaboration with participants. The multiple sources of qualitative data collected during pilot testing of MBGC also distinguish this study from previous bereavement group studies that tend to rely on pre-post designs with only quantitative outcome measures reported. Having participants’ verbatim responses in both group and follow-up interviews permitted researchers the opportunity to make important refinements and systematically assess responses to MBGC. For example, the theme of striking a meaning-balance (i.e., learning that grief is about struggling to answer certain questions while concurrently relinquishing the unanswerable ones) only emerged after content analysis.

Several limitations of this feasibility study exist. First, baseline outcome measures were collected within a three-month window prior to the commencement of the group. As such, initial data may not entirely reflect participants’ psychological symptoms prior to MBGC as other factors, including natural grief adaptation, may have occurred. In addition, the two individuals who partook in a concurrent bereavement support group may have confounded the evaluation of MBGC. Lastly, findings were limited by the sample characteristics. Participants were
predominantly female Caucasians, widowed, heterosexual, and grieving a death due to cancer. As such, we do not have data regarding MBGC’s feasibility with a more diverse population.

Certain issues need to be addressed based on problematic aspects of the present study. First, given the high levels of anxiety observed at the conclusion of MBGC, future iterations of MBGC may need to build in more stress-reduction exercises (e.g., Sagula & Rice, 2004). Second, it may also be interesting to seek out select alternative outcome measures that more explicitly target specific meaning-based themes such as the continuing bonds, meaninglessness, sense making, and spirituality. Third, it will be important to better control for confounding effects (e.g., follow-up interviews should be conducted after all quantitative data are collected). Fourth, it may be useful to better assess the effects of the group on bereft participants’ perceived social support. Fifth, adding a third time point (e.g., three month follow-up) may be indicated to assess the sustainability of impact. Indeed, Henry et al. (2010) found more participant improvement over time than at one month following the meaning-making intervention in oncology. Sixth, future studies may wish to adapt MBGC for an individual modality following the precedent of parallel meaning-centered interventions (see Breitbart et al., 2012). Lastly, this simple pre-posttest design does not account for improvements in bereavement adaptation that may be the result of natural bereavement adaptation over time. Thus a future pilot RCT of MBGC with an equivalent control arm is necessary. Overall, given the findings and limitations of this pilot study, MBGC appears to be a feasible intervention worthy of further empirical investigation.
**Manuscript 3: Table 1.** Meaning-based group counseling for bereavement after adaptation

<table>
<thead>
<tr>
<th>Phase</th>
<th>Session</th>
<th>Themes and tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beginning</td>
<td>1</td>
<td>Introductions/Norm Setting*</td>
</tr>
<tr>
<td>Phase</td>
<td>2</td>
<td>Introductions continued/Common symptoms and experiences of grief/Sharing meaningful objects</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Meaningful events and the <em>Grief Line Exercise</em> (Breitbart et al., 2010; Lee et al., 2006a, 2006b)</td>
</tr>
<tr>
<td>Middle</td>
<td>4</td>
<td>The Theory of Shattered Assumptions* (Janoff-Bulman, 1992)</td>
</tr>
<tr>
<td>Phase</td>
<td>5</td>
<td>The Dual Process Model of Grief* (Stroebe &amp; Schut, 1999).</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>Changes in identity and the family system following loss</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>Dreams/Hello Again Letter Exercise* (Neimeyer, 2012a)</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>Sharing the Hello Again Letter Exercise</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>Spiritual, creative, and attitudinal sources of meaning/Life Imprints Exercise* (Neimeyer, 2012b)</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>Sharing the Life Imprints Exercise</td>
</tr>
<tr>
<td>Termination</td>
<td>11</td>
<td>Reinvesting in a new life/Preparing for the end of the group</td>
</tr>
<tr>
<td>Phase</td>
<td>12</td>
<td>Recap of the group/Revisiting therapeutic goals/Looking to the future</td>
</tr>
</tbody>
</table>

* Connotes distribution of a handout to structure the session
**Manuscript 3: Table 2. Descriptive Statistics**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Scale Range</th>
<th>Pre-test (n = 9)</th>
<th>Post-test (n = 9)</th>
<th>% of scale range improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Mean (SD)</td>
<td>Mdn</td>
<td>Mean (SD)</td>
</tr>
<tr>
<td>RGEI</td>
<td>22.00-132.00</td>
<td>81.44(14.33)</td>
<td>83.00</td>
<td>61.00-101.00</td>
</tr>
<tr>
<td>CBI</td>
<td>0.00-51.00</td>
<td>32.89(10.80)</td>
<td>39.00</td>
<td>16.00-46.00</td>
</tr>
<tr>
<td>HGRC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Detachment</td>
<td>8.00-40.00</td>
<td>15.43(3.40)</td>
<td>15.00</td>
<td>11.00-21.00</td>
</tr>
<tr>
<td>Despair</td>
<td>13.00-65.00</td>
<td>36.22(13.21)</td>
<td>34.00</td>
<td>15.00-60.00</td>
</tr>
<tr>
<td>Disorganization</td>
<td>7.00-35.00</td>
<td>21.30(6.41)</td>
<td>19.00</td>
<td>14.00-33.00</td>
</tr>
<tr>
<td>Blame and Anger</td>
<td>7.00-35.00</td>
<td>10.11(3.48)</td>
<td>9.00</td>
<td>7.00-18.00</td>
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<tr>
<td>Panic Behavior</td>
<td>14.00-70.00</td>
<td>28.11(8.55)</td>
<td>28.00</td>
<td>15.00-43.00</td>
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<tr>
<td>Personal Growth</td>
<td>12.00-60.00</td>
<td>37.33(6.25)</td>
<td>40.00</td>
<td>29.00-47.00</td>
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<tr>
<td>STAI: Trait</td>
<td>20.00-80.00</td>
<td>46.36(6.83)</td>
<td>47.00</td>
<td>35.00-58.00</td>
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<tr>
<td>STAI: State</td>
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<td>50.33(10.81)</td>
<td>50.00</td>
<td>33.00-68.00</td>
</tr>
<tr>
<td>CES-D</td>
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<td>25.56(10.21)</td>
<td>28.00</td>
<td>10.00-39.00</td>
</tr>
<tr>
<td>PIL</td>
<td>15.00-105.00</td>
<td>74.01(11.48)</td>
<td>77.00</td>
<td>54.00-87.00</td>
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<tr>
<td>GMRI</td>
<td>29.00-145.00</td>
<td>100.33(7.48)</td>
<td>100.00</td>
<td>88.00-111.00</td>
</tr>
<tr>
<td>ISLES</td>
<td>16.00-80.00</td>
<td>48.44(9.86)</td>
<td>52.00</td>
<td>33.00-60.00</td>
</tr>
</tbody>
</table>

¹Parenthesized ranges beside the scales and subscales refer to minimum and maximum scores.
²Abbreviations: RGEI, Revised Grief Experiences Inventory; CBI, Core Bereavement Items; HRGC, Hogan Grief Reaction Checklist; STAI, State-Trait Anxiety Inventory; CES-D, Center for Epidemiological Studies Depression Scale; PIL, Purpose in Life Test; GMRI, Grief and Meaning Reconstruction Inventory; ISLES, Integration of Stressful Life Experiences Scale.
³There is no total score for the Hogan Grief Reaction Checklist.
⁴Reversed scored: Lower scores are indicative of greater personal growth.
⁵Mean score improved from baseline.
⁶Mean score declined from baseline.
Manuscript 3: Figure 1.
Flowchart of Participants

Enrollment

- Individuals referred to the study after seeking bereavement support (n = 26)
- Excluded individuals (n = 14)
  - Reasons:
    - Did not meet inclusion criteria (n = 3)
    - Scheduling conflict (n = 7)
    - Preferred not to partake in research (e.g., perceived to be too burdensome) (n = 4)

Consent

- Met inclusion criteria, signed consent and completed baseline questionnaires (n = 12)

Intervention

- Withdrawn from the study (n = 1)
  - Reason: Attended only 3 sessions, did not return telephone messages

Post-Intervention

- Received the intervention as planned (n = 11)
  - Lost to follow-up (n = 2)
    - Reason: Did not return phone messages to schedule time to complete follow-up questionnaires and follow-up interview

Analysis

- Included in the quantitative analysis (n = 9)
- Included in the qualitative analysis (n = 12)
CHAPTER 5: PILOT CONTROLLED TRIAL PHASE

Meaninglessness inhibits fullness of life and is therefore equivalent to illness. Meaning makes a great many things endurable – perhaps everything.


5.1 Preface

Consistent with the stage model of behavior therapy research (SMBTR, Rounsaville, Carroll, & Onken, 2001), the promising results of the pilot study reported in Chapter 4 above suggested progressing to the next stage of intervention evaluation. This next phase involved indicating the control arm, stipulating the actions for randomization, as well as fixing feasibility and success thresholds for continuing to a fully-powered RCT (Arnold et al., 2009; Lancaster, Dodd, & Williamson, 2004). As a prelude, a synopsis is presented of meta-analytic/summary reviews of bereavement interventions conducted since the late 1990s. A brief discussion of the procedures of randomization precedes the presentation of the final manuscript.

5.2 Current Trends in Bereavement Intervention Effectiveness and Efficacy

Health problems, increased use of medical services, and even mortality have been associated with the first weeks and months of bereavement (Stroebe, Schut, & Stroebe, 2007). A recent empirical study using a small sample ($N = 50$) of widowed men and women tentatively concluded that medical examination and psychotherapy three times in the first year of bereavement may promote physical health and survival (Grimby & Johansson, 2008).

The question remains: how successful are bereavement interventions in promoting not only physical health, but also psychological well-being? In an attempt to address this query, a number of comprehensive reviews concerning the effectiveness of bereavement...
Interventions have been published since the late 1990s. Review articles tend to collectively evaluate individual, family, and group modalities with no recent papers uniquely considering bereavement support group efficacy. Several reviews are presented below with particular emphasis on bereavement group efficacy when reported.

In a comprehensive review with strict inclusion criteria, Kato and Mann (1999) reviewed a total of 13 bereavement intervention studies (4 individual; 1 family; 8 group), including both qualitative and quantitative designs. They found that the majority of studies were riddled with methodological problems (e.g., unspecified theories of bereavement; no attempt to control for time elapsed since death). In addition, only two of the eight group therapy studies indicated positive change (i.e., Constantino, 1988; Polinskey, 1990). Mean effect sizes for all outcomes were deemed to be of small magnitude (0.11) across all studies. Of note, power calculations were not specified as inclusion criteria for this meta-summary, resulting in inclusion of studies with small samples that were likely underpowered with corresponding unreliable effect size shifts.

In the same year, Allumbaugh and Hoyt (1999) examined 35 pre/post-test and RCT-designed bereavement intervention studies. They reported an overall medium effect size improvement (0.43). The review suggested that interventions were more effective when professionals were highly trained, interventions had a greater number of sessions, and clients were self-selected. A total of 12 out of the 35 studies (34%) used a group modality. Effect sizes for group modalities were found to be less (mean: 0.40) than for individual therapy (mean: 0.65).

Both the reviews of Kato and Mann (1999) and Allumbaugh and Hoyt (1999) were later critiqued by Schut, Stroebe, van den Bout, and Terheggen (2001), who
contended that these meta-analyses were premature, with inferences based on only a small number of studies. Furthermore, a subset of the same authors challenged the methodology used in these two early meta-analyses, such as excluding follow-up data (Schut & Stroebe, 2005), as well as choosing to compare studies with no regard to type of intervention (e.g., voluntary “self-help” bereavement counselling; individual and/or family therapy programs for grief complications).

Building on these criticisms, Schut et al. (2001) conducted their own meta-summary, focusing uniquely on empirical studies of grief interventions and therapy. The researchers delineated three broad categories of bereavement intervention. The first category is of particular importance in this dissertation: general/primary preventive interventions. Primary intervention studies target uncomplicated bereavement. Of the total 16 general preventive studies, 14 (88%) were of group interventions. Schut et al. (2001) found that primary interventions were on the whole not empirically sound, suffering from serious methodological flaws. The researchers concluded in their review that they were unable to locate intervention programs that were well-described, rigorously tested, replicated, generalizable, efficacious, and with clearly-identified indications and counter-indications for success. Interestingly, Schut et al. (2001) also found that almost all studies with less favorable results used outreach procedures rather than relying on individual self-selection (inreaching recruitment). The authors did not draw any comparison or identify distinguishing trends between individual and group modalities.

The same group of scholars later published two updated reviews (Schut & Stroebe, 2005; Stroebe et al., 2007). It was reported that methodology and design had
improved for primary interventions. They argued that the greater use of *inreaching*
recruitment strategies, as well as including participants later in the bereavement trajectory
(several months or years following the death) may have contributed to better results.
Regrettably, only four studies were identified as primary interventions. These four studies
all used group modalities. Of these, three targeted HIV/AIDS-related bereavement
(Goodkin et al., 1999; Sikkema, Hansen, Kochman, Tate, & Difranisco, 2004;
Sikkema, Hansen, Meade, Kochman, & Lee, 2005) and the other addressed children and
adolescents bereft of their parents (Sandler et al., 2003).

Jordan and Neimeyer (2003) proposed three explanations for the findings that
grief counselling may sometimes be ineffective. First, grief counselling may be
unnecessary for the majority of the bereaved (a suggestion echoed in more recent
scholarship; see Neimeyer & Currier, 2009). Second, bereavement interventions may be
fruitless when treatment fails to account for the contextual factors of the death (e.g.,
cause of death such as suicide). In addition, interventions that are offered prematurely
following death are more likely to be ineffective or detrimental as the bereft may not be
ready to discuss their bereavement too quickly (Schut et al., 2001; Worden, 2009).
Finally, the numerous methodological flaws reported in the vast majority of reviews may
obscure any valid benefits derived from bereavement interventions.

In a later systematic review, Forte, Hill, Pazder, and Feudtner (2004) identified 74
intervention studies that evaluated whether the treatment of bereaved individuals reduced
bereavement-related symptoms. They distinguished 10 mutual/self-help studies and 29
professionally-led support groups targeting discrete bereft populations. Unfortunately,
they reported that any conclusions regarding the efficacy of interventions were
impossible due to five distinct impediments that need to be resolved. First, they argued that the plethora of research from multiple disciplines creates excessive and disparate theoretical bases guiding interventions. Second, the variations between studies fail to allow for adequate cross-intervention comparisons, exemplified in the diversity of outcome measures. Often studies utilized assessment tools uniquely prepared for the given study. Third, with the exception of pharmacological studies of depression in bereavement, a significant proportion of studies failed to clearly describe the intervention procedures, hampering replication efforts. Fourth, the authors were unable to locate any research replicating previous efficacy studies. Finally, there was a general failure to randomize participants into treatment and control conditions.

Perhaps some of the most strongly-voiced concerns derive from a report of bereavement interventions generated by the Center for the Advancement of Health (Genevro, Marshall, & Miller, 2004). The report suggests that interventions with adults who are not experiencing complicated grief are not beneficial in reducing bereavement-related symptomatology. Citing a review by Hansson and Stroebe (2003), primary prevention interventions such as crisis teams, self-help groups, psycho-educational programs, and brief group psychotherapy for adults who are experiencing an uncomplicated bereavement trajectory were argued to be counter-indicated.

More recent reviews have challenged the prevailing skepticism surrounding grief counselling. In one of the latest quantitative reviews, Currier, Neimeyer, and Berman (2008) examined 50 studies not included in either Kato and Mann (1999) or Allumbaugh and Hoyt’s (1999) reviews. A total of 63% of these studies used group modalities. Currier et al.’s (2008) rigorous inclusion criteria specified studies with both control and treatment
groups, though randomization of participants was not a necessity. Currier and his colleagues (2008) had broad inclusion criteria that permitted the analysis of non-randomized studies excluded by Kato and Mann (1999). They reported that the bereavement intervention studies they included tended towards positive differences immediately after the intervention when compared to controls with some exceptions. Ranges of effect sizes comparing pre and post-treatment were -0.65 to 2.54, whereas effect sizes for follow-up comparisons between intervention and non-intervention groups ranged from -0.40 to 0.76. It is not clear why gains made at follow-up are often not sustained over time. Of note, the authors reported that a comparison of bereavement intervention efficacy across modality (i.e., individual versus group) failed to generate statistically-significant differences in outcomes post-treatment. However, many of the studies included in this recent meta-analysis tended to be underpowered with relatively small sample sizes, curtailing any definitive statistical conclusions. It was also not reported whether lower effect sizes were related to duration of time post-intervention. The mean effect sizes for the randomized studies were 0.16 for post-treatment and 0.05 at follow-up, with effect sizes for non-randomized studies ranging from 0.51 post-treatment to 0.04 at follow-up.

Building on these findings in a later article, Neimeyer and Currier (2009) commented that compared to the efficacy of general psychotherapeutic treatment (effect size ~0.80), randomized grief therapy interventions tend to have relatively unimpressive results (effect size ranges from 0.10 to 0.20 post-intervention; <0.10 at follow-up). More positive effects of non-randomized bereavement interventions were reported post-intervention (~0.50) that appreciably diminished at follow-up (~0.10). These differences
may be explained in part through the impact of participant motivation (i.e., self-selection to treatment condition may yield stronger outcomes than randomization). They also distinguished between intervention types. *Universal grief interventions* that target the bereft population in general were found to be largely ineffective (effect size close to zero post-intervention; -0.05 at follow-up). *Selective interventions* encompassing specific at-risk populations (e.g., parents grieving the death of a child due to violence) had small effect sizes (0.10 to 0.20 post-intervention; <0.10 follow-up). Finally, *indicative interventions* (i.e., focusing on complicated/prolonged grief) showed the most clearly favorable results (effect size 0.50 post-intervention; 0.60 at follow-up).

Of late, Larson and Hoyt (2007, 2009) argued that claims of inefficaciousness of bereavement interventions lack solid empirical foundations. First, the authors claimed that the results of Fortner’s (1999) dissertation (that is usually attributed to Neimeyer, 2000) used a novel and unproven statistical process\(^9\) to make spurious claims of deteriorative treatment effects from bereavement counselling. Fortner (2008) has since acknowledged that his original statistical analysis contained some flaws. Second, Larson and Hoyt (2007, 2009) reviewed a number of bereavement intervention meta-analyses and convincingly challenged three powerful claims that have shaped the current zeitgeist: that a large portion of clients are harmed; that effect sizes for grief counselling are close to zero; and that grief counselling is ineffective or harmful for those with uncomplicated grief. Larson and Hoyt (2007) suggested that future scholars acknowledge the limitations of novel statistical methodologies.

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\(^9\) For an extended discussion of the limitations of the Treatment Induced Deleterious Effects (TIDE) statistical method used by Fortner (1999) based on the unpublished Master’s thesis of Anderson (1988), the reader is invited to read Larson and Hoyt’s (2009) recent critical review. Fortner (2008) himself has also commented on the incorrect use of the TIDE procedure in producing spurious results.
The conclusions of Larson and Hoyt (2007, 2009) have been endorsed in statements by the Association of Death Education and Counselling (n.d.) and the American Psychological Association (2007) suggesting that the concerns about harm have largely been baseless. Retaining a degree of healthy caution, Larson and Hoyt (2009) concluded that grief counselling appears to be effective with bereaved individuals, particularly those who seek out services, a finding echoed by Neimeyer and Currier (2009). Zech, Ryckebosh-Dayez, and Delespaux (2010) similarly articulate that effective bereavement interventions appear to necessitate motivated individuals (Schut & Stroebe, 2005; Stroebe et al., 2007), a focus on problematic issues of grief adjustment, as well as practitioner competence.

5.3 Randomization Methods and Intervention Series

Certain details of the randomization procedures, not mentioned in the third manuscript, are mentioned here. Only Robin Cohen (doctoral co-supervisor) was cognizant of the random computer-generated sequence using the Random String Generator (http://www.random.org/strings/). Cohen requested that Series A (generated November 29, 2010; seed 18060) be randomized into permuted blocks of 4, 6, and 6. Cohen then requested that Series B (generated August 24, 2011; seed 2345) be randomized into permuted blocks of 4, 4, 6, and 2. She was not involved in referral or recruitment in any way. This aspect of the study design is graphically represented in Dissertation Figure 1 below.
Dissertation Figure 1. Study Arm and Randomization Design
5.4 Manuscript 4

Reconstructing Meaning with Others in Loss: Results of a Bereavement Group Pilot Randomized Controlled Trial.

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Reference (An abridged version of the manuscript below will be published in Death Studies)

Reconstructing meaning with others in loss: Results of a bereavement group pilot randomized controlled trial. *Death Studies.*
Abstract

More effective psychosocial interventions that target uncomplicated bereavement are needed for those actively seeking support. The research objective of this study was to assess whether a unique Meaning-Based Group Counseling (MBGC) intervention was feasible within a pilot randomized controlled trial design. Twenty-six bereft individuals were randomly assigned to either MBGC or a control bereavement support group. Twenty participants (11 experimental; 9 control) completed all aspects of the study including self-report measures at baseline, post-intervention, and 3-month follow-up of meaning in life, anxiety, depression, and grief. Results indicate that MBGC remained a feasible intervention with minimal attrition.
Reconstructing Meaning with Others in Loss: Results of a Bereavement Group Pilot Randomized Controlled Trial

Uncomplicated grief typically follows death-related loss and is characterized by significant distress without a corollary impact on social, occupational, and daily functioning (Stroebe, Hansson, Stroebe, & Schut, 2001). Shear and colleagues (2011) suggest that the common symptoms of uncomplicated grief encompass sadness, intrusive images, anger, somatic distress, as well as social isolation.

Unfortunately, empirical evaluations of interventions for uncomplicated grief are fraught with methodological limitations (Stroebe, Stroebe, & Schut, 2003). Scholars have suggested that errors in research design impede drawing any substantive conclusions of the effectiveness of these interventions (Larson & Hoyt, 2009). The development of theoretically-based uncomplicated bereavement interventions for individuals actively seeking support, whose effectiveness is supported by methodologically sound studies, appears to be one of the next important steps in advancing applied research.

Correspondingly, the meaning-making paradigm (Neimeyer & Sands, 2011) is a contemporary and perhaps potent theoretical framework to understand bereavement and its resolution. While the discourses of meaning-making are often conveyed in terms of perceptions and beliefs (Park & Folkman, 1997), Neimeyer, Prigerson, and Davies (2002) maintain that in the context of bereavement, the search for meaning also involves culture, language, and interpersonal communication. Sharing one’s bereavement experience with others can thus facilitate meaning reconstruction and bereavement adaptation (Neimeyer, 2006).
Meaning-making in bereavement can involve a process of re-establishing psychological well-being through making sense of one’s own responses to loss and exploring the continuing bond with the deceased (MacKinnon, Milman, Beauchemin, et al., 2013). Attempts to translate this knowledge into clinical practice are flourishing (Neimeyer, 2012c) with increasing empirical evidence that individuals tend to engage in meaning making following significantly stressful events (see Park, 2010).

However, the meaning-making approach does not yet extend into the bereavement support group literature. We hypothesized that the application of a meaning-based approach for group counseling responding to past critiques would be an important first step in beginning to remedy the relative ineffectiveness of current uncomplicated grief interventions. As such, we developed the Meaning-Based Group Counseling (MBGC) intervention (MacKinnon et al., in press) as part of a psychosocial intervention development model (Rounsaville, Carroll, & Onken, 2001). We then assessed the feasibility of MBGC (reported in MacKinnon, Smith, Henry, Milman, et al., 2012). This paper reports the results of a pilot randomized controlled trial (RCT). A description of current debates surrounding uncomplicated grief interventions precedes the presentation of the methods and results of a pilot RCT for MBGC. This paper concludes with directions for future research.

**Background**

Individuals who are bereft commonly participate in bereavement support groups. However, early evidence has suggested that a group modality is somewhat less effective than its individual counterpart (Kato & Mann, 1999). In addition, psychotherapy for uncomplicated grief has come under some harsh criticism in the past decade. One review
found that improvements in bereavement symptomatology due to psychosocial interventions tend to be temporary at best (Schut, Stroebe, van den Bout, & Terheggen, 2001). A later review suggested that interventions with adults experiencing uncomplicated grief were not beneficial in reducing future psychological distress (Genevro, Marshall, & Miller, 2004). Some scholars have even gone so far as to argue that these interventions may impede a genuine grieving process (Stroebe, Schut, & Stroebe, 2007).

Conversely, others have argued that past studies have been severely hampered by methodological biases, suggesting that any definitive conclusions are premature (Currier & Holland, 2007; Larson & Hoyt, 2007). First, interventions often fail to specify a theoretical framework (Kato & Mann, 1999) or are guided by excessive theoretical bases (Forte, Hill, Pazder, & Feudtner, 2004). Second, interventions tend to lack rigor insofar as they are not well-described or meticulously tested, use un-validated outcome measures, and do not have explicit indications for success (Schut et al., 2001). Third, studies fail to properly randomize participants into experimental and control arms, or do not have a control group (Forte et al., 2004). Fourth, studies tend to have inconsistent inclusion criteria or fail to properly screen participants (Currier, Neimeyer, & Berman, 2008). Lastly, past interventions for uncomplicated grief have targeted individuals regardless of whether or not they are motivated to seek professional support (see Schut & Stroebe, 2005) and are based on a relatively small number of recent studies (Stroebe et al., 2007).

This investigation carefully attended to these aforementioned methodological concerns. A previous feasibility trial of MBGC ($N = 11$) was conducted first (initially
reported in MacKinnon, Smith, Henry, Milman, et al., 2012) as recommended for psychotherapy development (Rounsaville et al., 2001). Results suggest that the intervention was feasible: 92% of participants completing the entire intervention, with an average of 86% session attendance. Qualitative data suggested that participants found MBGC useful in ameliorating their bereavement distress. Participant feedback led to several minor modifications to MBGC. Descriptive statistics showed small mean improvements as well as modest percentage of scale range improvements between pre- and post-test measures of depression and grief. No counter-indications were identified, supporting continuation with a pilot RCT, the results of which are reported here.

The objective of this study was to ascertain whether or not MBGC was a feasible intervention using a pilot randomized controlled trial methodology with a larger sample size. Secondary objectives included (a) identifying further changes to MBGC based on participant feedback; (b) Assessing if the outcome measures remain acceptable to participants; (c) Ascertaining if the randomization was feasible and whether a sufficient number of participants completed all data collection points; (d) Deciding whether the results support proceeding with a full RCT. Consistent with the goals of pilot studies (van Meijel, Gamel, van Swieten-Duijfjes, & Grypdonck, 2004), the research objectives did not include an assessment of statistically-significant differences as the small sample size would likely overestimate any effects of the intervention (Lancaster, Dodd, & Williamson, 2004).

**Methods**

The study was approved by the Jewish General Hospital Research Ethics Committee (Montreal, Quebec). It was registered with ClinicalTrials.gov (identifier
NCT01384942) prior to any recruitment. The study design was a two-arm (experimental [EXP] and control [CTRL]) by three-repeated-measures (pre, post, and follow-up) pilot randomized controlled trial. Outcome measures were administered at three times: (a) Time 1 took place within the four months prior to the start of MBGC, immediately following the screening interview; (b) Time 2 was completed within two weeks of the completion of the intervention; and (c) Time 3 was defined as three months following completion of MBGC. Participants failing to respond within two weeks of the scheduled Time 2 or 3 data collection dates were given one reminder via telephone. Failure to complete either the Time 2 or 3 measures resulted in the participant’s data being withdrawn from the descriptive statistical analyses.

Feasibility and acceptability threshold criteria for claiming success were established a priori (as per Arnold et al., 2009). The pilot RCT of MBGC would be declared successful if (a) qualitative data indicated that individuals did not experience an overall detrimental effect from participating in MBGC; (b) there was no substantial attrition (i.e., dropouts resulted in less than 4 members in either treatment arm); and/or (c) the majority of participants completed all questionnaire batteries.

**Study Population and Recruitment Process**

Candidates for the intervention were recruited in collaboration with a community organization associated with an urban university teaching hospital. The study was announced by posters displayed at various healthcare agencies (e.g., outpatient hospital clinics) and e-mail LISTSERVs (e.g., mental health associations). As this pilot study was not intended to identify significant differences, a small sample size of 24 to 32 was
selected (consistent with similar pilot studies, see Gagnon et al., 2010; Henry et al., 2010).

Individuals were eligible to participate in the study if they met the following inclusion criteria: (a) 18 years of age at the time of the first group session; (b) actively seeking support for themselves; (c) experiencing an uncomplicated grief trajectory (defined in the introduction); (d) the death had occurred between six weeks and two years prior to the first meeting of the group; (e) ability to speak and read in English; and (f) ability to function in a group as judged during screening following the selection recommendations of Piper et al. (2011) as well as Yalom and Leszcz (2005). Candidates were excluded if they were: (a) experiencing a prolonged grief response; (b) a parent grieving the death of a child under 18 years old; (c) grieving a suicide-related death, a suspected suicide, or a homicide; or (d) exhibiting personality traits that would be counter-productive for a group (e.g., Axis II disorders on DSM-IV-TR)

Candidates were invited to take part in a screening interview after giving written informed consent. They then completed a demographic form. Interviews ranged from 30 to 90 minutes depending on the level of psychological distress. When possible, interviews took place with two members of the research team (Authors 1 and 9), each a facilitator in one of the treatment arms. The Psychosocial Assessment Elements (Keefler, 2005) interview guide was used to structure the interview and gauge current psychological functioning. The Prolonged Grief Disorder-13 (PG-13) (Prigerson, & Maciejewski, 2008b) was used to rule out prolonged grief when the death occurred more than six months from the date of the interview. The PG-13 is not designed to be given until six
months after the death. Final decision for inclusion or exclusion rested with the clinical judgment of the interviewers.

**Randomization**

Participant randomization was accomplished using Random Number Generator (www.random.org). Series A (the first EXP and CTRL groups) was randomly determined with permuted blocks (i.e., subjects were allocated randomly within each block) of 4, 6, and 6; Series B (second EXP and CTRL groups) was fixed in random permuted blocks of 4, 4, 6, and 2. The ratio of randomization was 1 EXP for each 1 CTRL. A member of the research team with no direct participant contact was the only one cognizant of the randomly-generated sequence. This member was responsible for allocation concealment and prepared coupons specifying group allocation in sequentially numbered, opaque sealed envelopes. Following successful completion of the screening interview and acceptance into the study, the next envelope in the ordered series was opened to determine the treatment allocation for a given participant. Author 1 then advised the participant of their treatment assignment. In Series A, eight participants were randomized to the EXP arm and six to the CTRL arm. In Series B, six participants were randomized to the EXP arm and six to the CTRL arm. The two intervention series were conducted separately.

**Experimental Condition**

MBGC for bereavement is an original and manualized intervention developed for adults experiencing uncomplicated grief (MacKinnon et al., in press). MBGC is comprised of various semi-structured meaning-based tasks and themes embedded over 12 weekly sessions of 90 minutes (see Table 1). The theoretical framework underpinning
this intervention combines diverse meaning-making models (see MacKinnon, Milman, Smith, et al., 2013), the Dual Process Model of Grief (Stroebe & Schut, 1999), and a model of brief group psychotherapy (Yalom & Leszcz, 2005). MBGC also combines certain features of existent meaning-focused interventions for oncology patients (Breitbart et al., 2010; Lee, Cohen, Edgar, Laizner, & Gagnon, 2006), material presented at several scholarly workshops (Breitbart & Poppito, 2010; Neimeyer, 2010a), as well as audiovisual material produced by the American Psychological Association (2008). Two licensed mental health professionals co-facilitated MBGC. A research assistant (RA) was also present who functioned as an observer. Facilitators received training before delivery of MBGC from Author 1. EXP facilitators trained in MBGC only led groups in the EXP arm.

**Control Condition**

The CTRL arm was a treatment-as-usual bereavement support group. While a CTRL group that received no treatment might permit a more unencumbered evaluation of MBGC, during study design it was decided that it would be unethical to deny service to bereft individuals seeking support. These CTRL support groups were part of a longstanding program conducted by the same community organization associated with recruitment. Group sessions took place bi-weekly with a total of seven 90-minute sessions. The CTRL group followed more conventional bereavement intervention themes, though assumed a relatively unstructured and a-theoretical approach (see Table 2). Meaning making was not an explicit theme in the CTRL group. Groups were facilitated by two lay volunteers (non-professionals); in one group a licensed social worker acted as a third facilitator. Facilitators in the CTRL arm had received prior
training in bereavement group facilitation through the community organization; they did not receive specific training for this study. CTRL facilitators only led groups in the CTRL arm.

**Treatment Fidelity and Integrity**

A treatment fidelity and integrity checklist (developed specifically for this study based on the components of MBGC) was completed every session by the research assistant and the two EXP facilitators to ascertain adherence to the MBGC protocol. Comparison of each treatment fidelity checklist indicated that MBGC was delivered consistently with facilitators closely adhering to the intervention manual. There was no such audit process for the CTRL arm.

**Masking**

Neither participants nor researchers were blind to treatment arm randomization. Block randomization prevented the researchers conducting the screening interviews from forecasting which arm participants would be randomized to. In order to minimize cross-contamination, participants were asked to only discuss the intervention with other members of their respective groups. Facilitators did not examine participants’ responses to the questionnaires until after follow-up data were collected.

**Qualitative Data Sources**

In order to effect possible further refinements to MBGC in the future and assess participants’ responses to it, several qualitative data sources were accumulated in the EXP condition. Independent field notes were written by the co-facilitators for each session. Second, the RA completed a comprehensive observation protocol with the purpose of attending to group meaning-making processes. Third, participants in the EXP
arm were encouraged to provide feedback on the intervention and suggest changes throughout. Lastly, the sample was assessed for other types of professional psychosocial services used during the study, as well as any psychotropic medications taken.

**Quantitative Outcome Measures**

A total of four primary outcomes were chosen: grief, depression, anxiety, and meaning in life. The majority of outcome measures were selected due to their comprehensive assessment of grief symptomatology and psychometric properties. A few measures were chosen for their strong face validity. The outcomes of anxiety and depression were assessed with one measure each. Three questionnaires were chosen for each of the grief and meaning outcomes as those questionnaires have, compared to the anxiety and depression scales, far fewer studies demonstrating their psychometric reliability and validity. Questionnaires that specify a timeframe (e.g., the severity of a grief symptom within the past two weeks) are explicitly noted as several scales do not assess time.

A total of three grief measures were selected. First, the Revised Grief Experience Inventory (RGEI) (Lev, Munro, & McCorkle, 1993) was designed to measure the grief experience. Items are summed to provide a total score. Higher scores on the RGEI indicate greater levels of grief-related distress. The scale ranges in score from 15 to 105. Second, the Core Bereavement Items instrument (CBI) (Burnett, Middleton, Raphael, & Martinek, 1997) was originally developed using a pool of bereavement phenomenology questions with a sample of bereft spouses, adult children, and parents. The scale is scored by summing all items to form a total score. Total scores range from 0 to 51. Lower scores on the CBI are indicative of less grief-related distress. Lastly, the Hogan Grief Reaction
Checklist (HGRC) (Hogan, Greenfield, & Schmidt, 2001) consists of a list of thoughts and emotions an individual may have experienced within the past two weeks related to the death of a significant loved one. There is no total score for the HGRC. There are six subscales with score ranges in parentheses, including blame and anger (7 to 35), detachment (8 to 40), despair (13 to 65), disorganization (7 to 35), panic behavior (14 to 70), and personal growth (12 to 60). Subscale scores are calculated through summation of each constituent item. Higher scores are indicative of elevated grief symptoms, and lower scores suggest less grief. The personal growth subscale is reversed scored.

For the outcome of depression, the Center for Epidemiologic Studies Depression Scale (CES-D) (Radloff, 1977) was used. It assesses symptoms of clinical depression within the past week. The instrument is scored by summing all item responses, with higher scores representing a higher degree of depressive symptomatology. The scale range is 0 to 60.

For anxiety, the State-Trait Anxiety Inventory (STAI) (Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983) was used. The present study used both subscales, including state (a temporary variation in emotionality) and trait (a comparatively stable feature) anxiety. Higher scores suggest greater levels of anxiety. The scale range for both subscales is 20 to 80.

Three measures were selected for the outcome of meaning in life. The Purpose in Life Test (PIL) (Crumbaugh & Maholick, 1964) is a commonly-used self-report measure that evaluates Frankl’s theory of existential meaning. Each item of the PIL is ranked on a 7-point Likert-type scale. Individual scores are summed to provide a total score ranging from 7 (low purpose) to 105 (high purpose). The Grief and Meaning-Reconstruction
Inventory (GMRI) (Gillies, 2006) is an instrument from an unpublished doctoral dissertation to operationally assesses meaning-reconstruction processes in bereavement within the past week. All 29 items are anchored on a 5-point Likert-type scale with responses of “strongly disagree” to “strongly agree” with a range of scores from 29 to 145. Higher scores indicate more attempts at meaning reconstruction. The scale was included due to high face validity. More detailed psychometrics for the GMRI are provided as it is the only scale that is not yet published in a peer-reviewed publication. Results of the original scale development study demonstrated adequate internal consistency (α = 0.84). Regarding test-retest reliability, the Pearson’s correlation coefficient was 0.71. Exploratory factor analyses identified five principal subscales including continuing bonds, personal growth, sense of peace, emptiness and meaninglessness, as well as valuing life. Convergent and discriminant validity analysis of the GMRI showed significant negative correlations with well-validated distress measures (e.g., Inventory of Complicated Grief, Hogan Grief Reaction Checklist). Lastly, the Integration of Stressful Life Experiences Scale (ISLES) (Holland, Currier, Coleman, & Neimeyer, 2010) is designed to gauge the degree to which an individual is able to adaptively integrate a stressful life event. Higher scores indicate the ability to integrate difficult experiences with corresponding increases in internal coherence and hope for the future. The ISLES scores range from 16 to 80.

Only descriptive statistics were calculated for the outcome measures (i.e., means and standard deviations). To facilitate interpretation, the percentage of scale range improvement between Time 1 and 3 was calculated for each scale in both the EXP and CTRL groups. In order to obtain this value, a percentage score was derived by dividing a
given mean outcome score by the maximum possible score of the same measure, and then multiplying the result by 100 to produce a percent. Two percentage values were calculated from each mean outcome score for Times 1 and 3. The percentage of scale range improvement was determined by subtracting the Time 3 and Time 1 percentage values.

Results

Data collection took place over 17 months (September 22, 2010 to February 22, 2012). Progress of participants from recruitment and screening through each phase of the study is shown in Figure 1. A total of 19 potential participants were excluded (42%). A minority who were referred did not meet the inclusion criteria \( n = 10 \) of 19, 53%, usually presenting with either a prolonged grief response or having experienced a loss that fell outside the 6 weeks to 2 years inclusion criteria. A high number of individuals \( n = 22 \) who at first expressed interest in the study failed to return two telephone messages left by the researchers.

Recruitment Rate

Participants were recruited over a period of four months prior to the beginning of their respective group. On average 6.5 individuals \( (SD = 4.93; Mdn = 6) \) signed consent, completed baseline questionnaires, and were randomized each month. On average, a participant in the EXP arm needed to wait 26 days \( (SD = 26.85; Mdn = 14.5) \) before their respective group began. Those in the CTRL group waited on average 50 days \( (SD = 39.15; Mdn = 51.5) \).

Sample Characteristics

The majority of participants included in the study were referred by allied mental
health professionals ($n = 17, 65\%)$. The remaining participants were referred from the affiliated community organization ($n = 9, 35\%)$. Demographic data are summarized in Table 3. Participants were predominantly female, heterosexual, religiously identified as either Jewish or Christian, and of European ethnicity. Individuals in the EXP group were slightly older on average ($M = 53.36, SD = 19.18$) than their CTRL counterparts ($M = 45.00, SD = 15.31$). A sizeable percentage of participants were grieving the death of either a spouse (EXP $n = 6, 43\%$; CTRL $n = 4, 33\%$) or a parent (EXP $n = 5, 36\%$; CTRL $n = 6, 50\%$). The majority of the sample reported some level of university education (EXP $n = 10, 83\%$; CTRL $n = 9, 82\%$). Annual family income varied, with CTRLs reporting a large range in annual income and the EXP group reporting a greater proportion of participants in the middle socio-economic range ($n = 10, 83\%, $40,000 to $79,000 CAD$). Participants reported that the death occurred approximately 8 months ($M = 244.04$ days; $SD = 186.69$ days; $Md = 183$ days) from the first session of the group. A total of 20 (77\%) individuals invited to participate completed the PG-13, as screening for these participants took place more than 6 months after the death (the required timeframe of the PG-13). Lastly, the majority of all participants ($n = 17, 65\%$) reported grieving a least one previous death-related loss (not including the recent loss that drew them to the study).

**Attendance**

A total of 13 participants attended the two EXP groups with relatively high frequency. One participant attended the first session and subsequently withdrew due to an unforeseen scheduling conflict. This participant was removed from the following attendance calculations. The mean attendance in MBGC was 86\%, corresponding to 10.3
out of 12 sessions ($SD = 0.95$). Lastly, participants in the EXP arm missed on average 14% of sessions. Comparatively, those in the CTRL arm missed on average 26% ($M = 1.80, SD = 0.79$) of 7 sessions available.

**Contamination and External Therapies**

No participant in the EXP arm reported discussing the study with anyone in the CTRL arm (and vice-versa). In addition, data were collected to assess external support participants sought during the study, as well as possible contamination across treatment arms. Missing data resulted in responses from only 18 participants (69%). Four participants (29%) in the EXP arm and one participant in the CTRL arm (10%) reported participation in concurrent individual psychotherapy, both prior to and throughout the study. A minority of participants reported taking either anti-depressants or anxiolytics [EXP ($n = 4, 40\%$) & CTRL ($n = 1, 13\%$)].

**Descriptive Statistical Results**

Quantitative data were analyzed using the Statistical Program for the Social Sciences, version 19. Participants generally completed the entire questionnaire battery with six individuals (23%) lost to attrition (see Figure 1). Table 4 contains means and standard deviations of the outcome measures taken at baseline, within two weeks after completion of the intervention, and at three-month follow-up. A comparison of averages suggests that the EXP group on the whole had lower averages of meaning and higher mean scores of depression at baseline compared to the CTRL group. Means across the anxiety and grief measures were similar across treatment arms at Time 1. Looking at trends across the three time periods, mean scores in the CTRL group improved at two weeks post-intervention, though were often not maintained at 3-month follow-up (Time
3). Conversely, some measures in the EXP group showed moderate mean improvement at two weeks after the intervention that were either maintained or continued to improve three months post-intervention. Figure 2 contains percentage of scale range improvement between Time 1 and Time 3. The largest mean difference was found in the EXP group with an improvement of 20% from baseline on the CBI.

**Qualitative Responses to MBGC**

No participants reported withdrawing from the study due to increased psychological distress. Participants commonly \((n = 18, 90\%)\) found the questionnaire battery acceptable (i.e., no consistent negative comments on items or scales). There was minimal missing data, with the maximum being 20% for 2 items. Some participants wrote comments in the margins of the measure, often adding contextual details. For example, some participants felt that their responses to the outcome measures were influenced by recent health problems. Furthermore, participant feedback suggested that there is a need to develop grief measures that are more time sensitive. Specifically the PIL, ISLES, RGEI, and CBI fail to set a timeframe for their items. Many participants wrote on the measures that their symptoms of distress fluctuated greatly over time. Finally, there were no major refinements indicated to the intervention during this study.

EXP participants were invited to complete a follow-up interview \((n = 9\) of 11, 82\%), which was part of a separate study (preliminary results reported in MacKinnon, Milman, Beauchemin, et al., 2013). Briefly, the objective of this follow-up study was to obtain participant feedback and suggestions for MBGC improvement. Early results indicated general satisfaction and betterment from partaking in MBGC. For instance, participants found advantages in grieving with others, including the validation of their
common grief experiences. The meaning-based written exercises (Neimeyer, 2012a) emerged as particularly beneficial, bringing about new insights. A minority reported that the inherent diversity of the group contributed to feeling isolated at certain moments. For instance, some found that the large age range amongst the participants was a deterrent to identifying more closely with other group members. In addition, some desired to participate in a group that focused uniquely on grieving the death of a spouse. Lastly, one participant expressed the desire for the group to be longer, later realizing in the follow-up interview that an ending to the group was also necessary and appropriate.

Discussion

When the threshold criteria for success are examined, the results appear to indicate that the pilot RCT of MBGC was both feasible and successful. First, no individuals in the EXP condition reported overall greater levels of psychological distress following participation. Second, there was no substantial attrition during intervention delivery or data collection. Third, approximately 75% of participants completed all the questionnaire batteries. This figure is comparable to corresponding percentages of completion rates for other group psychotherapy trials (see Breitbart et al., 2010, 42%). Participants were largely satisfied with the tasks and themes of MBGC, as well as the order in which they were presented. Only one minimal refinement to MBGC was indicated based on participant feedback, namely to subsume a discussion of gender variations in grief under a larger family systems theme. This decision was made when the membership of one of the EXP groups only represented one gender, and it was decided that discussing the intersections of systemic changes and their relationship to gender would elicit a richer conversation.
Recruitment for the study was relatively seamless. Referrals from allied health care professionals tended to yield the greatest number of eligible individuals who were subsequently included in the study. Individuals in both treatment arms largely attended and completed their respective groups.

The outcome measures appeared to be acceptable to individuals, with no major negative comments. The mean scores at three months for MBGC participants showed no decrease from baseline. In addition, the averages of most outcomes improved more at 3-month follow-up in the EXP than in the CTRL condition, suggesting that future studies of MBGC include additional follow-up times (e.g., 6 months) so as to glean a better sense of how long the effect of MBGC may last.

Consistent with the objective of re-evaluating the choice of outcome measures used in this pilot study (Lancaster et al., 2004), the GMRI may not have been the best scale for assessing the MBGC. While having strong face validity, closer examination found that many of the items of the GMRI were unlikely to be substantially affected by MBGC (e.g., item 5, “I will see my loved one again”; item 15: “this death brought my loved one peace”). Moreover, more sensitive measures that assess both state as well as trait grief and meaning with specific time frames (e.g., “within the past 2 weeks” is a common convention) are desirable.

Some participants made requests to have more homogeneity in the group. The desire to want to “be with people like me” was a common sentiment expressed during screening, and may relate to the desire for normalization and validation of one’s grief experience. However, accommodating these requests poses a major challenge in that attempting to recruit participants using narrow inclusion criteria jeopardizes feasibility.
Conversely, the benefits of encountering dissimilar grief experiences of an objectively similar event (e.g., loss of a spouse) were identified by some participants as one of the principal gains from MBGC. While striking a perfect balance between homo- and heterogeneity is challenging, findings from this study suggest that having a more diverse membership (e.g., age range, gender, type of loss) may provide added benefits compared to a strictly homogeneous group composition (echoing Yalom & Leszcz, 2005).

Finally, the results of this study suggest proceeding to a larger, well-powered RCT to explore the efficacy of MBGC. MBGC attempted to address a number of previous critiques of past studies for uncomplicated grief. Attending to past design flaws may have facilitated some of the promising results reported in this pilot study.

A number of lessons learned during the course of this pilot are specified below in the limitations section. The discussion of limitations lays the foundation for further investigations.

**Limitations**

As is expected in a pilot study, no cause-and-effect outcomes can be concluded. There are two possible reasons that the mean improvements in the EXP group may have tended to be larger than those in the CTRL group. First, individuals in the EXP arm were more frequently in concurrent individual psychotherapy as well as utilized more prescribed psychotropic medications. Second, those in the EXP arm may have had higher levels of psychological distress at baseline than CTRLs. Because the CTRL group started at lower levels of depression and higher levels of meaning, there may have been less space for improvement, whereas the larger improvements in the EXP arm may be in part due to regression towards the mean.
Furthermore, limited success was made in attempting to address previous critiques concerning problematic comparison (i.e., CTRL) groups in bereavement intervention design (Schut & Stroebe, 2005). The benefit of using a treatment-as-usual comparison permitted a partial appraisal of customary practices of interventions for uncomplicated grief that may be indicative of common norms in the field. This appraisal highlighted several procedural dilemmas that curbed the methodological rigor of this study. Comparisons of the EXP and CTRL arms were confounded by greater absenteeism and attrition in the CTRL groups, and different frequencies and number of sessions in each treatment arm. The EXP condition provided almost double the number of sessions and may have created an imbalanced dose-response effect. Facilitation of each intervention was also confounded in that the EXP groups were consistently led by licensed mental health professionals whereas one CTRL group was led by trained volunteers with a social worker and another with only trained volunteers. Moreover, the tasks and themes in each of the two CTRL groups were inconsistent. Due to resource limitations, it was not possible to gather the same level of data or ensure sufficient monitoring in the CTRL condition. The lack of monitoring of the CTRL group content therefore makes it hard to say with certainty what was and was not offered. Overall, the findings from the CTRL arm may in part mirror previous intervention studies for uncomplicated grief with relatively small improvements (Currier et al., 2008). Future research refinements may correct for these limitations as outlined below.

**Directions for Future Research**

This study highlighted some of the practical challenges of conducting a bereavement intervention trial, particularly the complexities of an adequate CTRL arm.
One of the primary benefits of this study was the comparison of an EXP condition with standard treatment. An alternative might be to develop a CTRL arm based on traditional community support groups, but with 12 sessions and regular auditing. Placing participants randomized to a wait-list CTRL arm might also be an alternative. A three-armed (EXP, treatment as usual, wait-list CTRL) pilot study might also be a promising next step. Overall, a straightforward solution to the CTRL dilemma remains elusive and future research to determine what could function as a feasible and ethical CTRL arm is important.

**Conclusion**

Constructivist theory suggests that humans have a natural proclivity to create a symbolic world of meanings to help them negotiate life (Neimeyer, 1995). Thus the meaning-making paradigm is a potentially-appropriate guide for psychosocial interventions with bereft individuals whose assumptive framework is often bleached of meaning in the aftermath of death (Neimeyer, 2010b).

In view of this study’s limitations, the results, albeit promising, should be interpreted with care and caution (Arnold et al., 2009; van Meijel et al., 2004). The ability of MBGC to mitigate psychological distress is not yet established. At this stage of intervention development, it is appropriate to claim that MBGC is a feasible enterprise. Qualitative data concerning participant feedback suggests that MBGC may facilitate bereavement adaptation.
**Manuscript 4: Table 1. Experimental Arm: Weekly Meaning-Based Group Counseling**

<table>
<thead>
<tr>
<th>Session</th>
<th>Tasks and Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Establishing norms; Exploring bereavement narratives</td>
</tr>
<tr>
<td>2</td>
<td>Conventional bereavement group principles (Yalom &amp; Vinogradov, 1988); Members share meaningful objects associated with the deceased</td>
</tr>
<tr>
<td>3</td>
<td>The <em>Griefline Exercise</em> (Lee et al., 2006b); Meaningful events (Breitbart et al., 2010)</td>
</tr>
<tr>
<td>4</td>
<td>Understandings and applications of the Theory of Shattered Assumptions (Janoff-Bulman, 1992)</td>
</tr>
<tr>
<td>5</td>
<td>Understandings and applications of the Dual Process Model of Grief (Stroebe &amp; Schut, 1999)</td>
</tr>
<tr>
<td>6</td>
<td>Sharing perceived changes in self and the family in the aftermath of loss</td>
</tr>
<tr>
<td>7</td>
<td>Discussing the meaning of dreaming about the deceased; <em>Hello Again Letter</em> (Neimeyer, 2012a) introduced</td>
</tr>
<tr>
<td>8</td>
<td>Exploring member`s responses to the <em>Hello Again Letter</em></td>
</tr>
<tr>
<td>9</td>
<td>Identifying creative, attitudinal, and spiritual meaning sources <em>Life Imprints</em> (Neimeyer, 2012b) introduced</td>
</tr>
<tr>
<td>10</td>
<td>Exploring member`s responses to the <em>Life Imprints</em></td>
</tr>
<tr>
<td>11</td>
<td>Exploring the meaning of the group and its impending conclusion</td>
</tr>
<tr>
<td>12</td>
<td>Gains made and future directions</td>
</tr>
</tbody>
</table>

**Manuscript 4: Table 2. Control Arm: Bi-weekly Conventional Bereavement Support Group**

<table>
<thead>
<tr>
<th>Session</th>
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</tr>
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<tbody>
<tr>
<td>1</td>
<td>Introductions; Norm setting</td>
</tr>
<tr>
<td>2</td>
<td>Symptoms of grief: <em>Grieving Person’s Bill of Rights</em></td>
</tr>
<tr>
<td>3</td>
<td>Feelings and emotions associated with grief, funeral, and presence at time of death</td>
</tr>
<tr>
<td>4</td>
<td>Coping and support; Finding and establishing a support network</td>
</tr>
<tr>
<td>5</td>
<td>Bereavement related film with discussion OR: Motivational speaker (not related to bereavement)</td>
</tr>
<tr>
<td>6</td>
<td>Memories: Sharing keepsakes AND/OR Music therapy session</td>
</tr>
<tr>
<td>7</td>
<td>Recovery; Personal strengths; Journaling</td>
</tr>
</tbody>
</table>
Table 3. Baseline Socio-Demographic Variables (*sample sizes vary with missing data)

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<th>Control $(n = 12)$</th>
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<td>$M$ (SD)</td>
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<td><strong>Relationship Being Presently Grieved</strong></td>
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<td><strong>Previous Death-Related Losses</strong></td>
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**Manuscript 4: Table 4. Descriptive Results**

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<tr>
<th>Measure (with range)</th>
<th>EXP (n = 11)</th>
<th>CTRL (n = 9)</th>
<th>EXP (n = 11)</th>
<th>CTRL (n = 9)</th>
<th>EXP (n = 11)</th>
<th>CTRL (n = 9)</th>
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<tbody>
<tr>
<td>RGEI (22-135)</td>
<td>80.52(12.43)</td>
<td>77.22(22.66)</td>
<td>77.09(16.30)</td>
<td>76.57(20.79)</td>
<td>73.45(13.68)</td>
<td>67.29(17.55)</td>
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<td>CBI (0-51)</td>
<td>35.34(8.73)</td>
<td>26.89(11.87)</td>
<td>31.68(10.45)</td>
<td>26.44(12.42)</td>
<td>25.01(10.90)</td>
<td>24.33(11.65)</td>
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<td>HGRC†</td>
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<tr>
<td>Blame and Anger (7-35)</td>
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<td>13.67(5.48)</td>
<td>11.27(5.24)</td>
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<td>Despair (13-65)</td>
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<td>29.36(12.49)</td>
<td>30.67(13.00)</td>
<td>27.27(11.91)</td>
<td>25.44(8.26)</td>
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<td>Detachment (8-40)</td>
<td>15.91(6.36)</td>
<td>16.89(8.27)</td>
<td>14.60(5.63)</td>
<td>18.56(8.85)</td>
<td>12.27(4.65)</td>
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<td>17.56(8.09)</td>
<td>12.47(4.37)</td>
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<td>Panic Behavior (14-70)</td>
<td>33.73(15.82)</td>
<td>32.00(9.06)</td>
<td>26.56(11.05)</td>
<td>37.11(13.20)</td>
<td>24.45(10.41)</td>
<td>29.29(9.92)</td>
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<td>38.91(14.65)</td>
<td>33.89(11.12)</td>
<td>34.64(11.72)</td>
<td>35.67(9.29)</td>
<td>34.91(14.61)</td>
<td>33.89(8.89)</td>
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<td>CES-D (0-60)</td>
<td>23.93(13.54)</td>
<td>17.89(14.97)</td>
<td>18.55(11.47)</td>
<td>14.89(10.15)</td>
<td>14.09(10.33)</td>
<td>11.22(8.54)</td>
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<td>STAI: State (20-80)</td>
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<td>49.43(12.05)</td>
<td>41.84(14.69)</td>
<td>44.56(6.77)</td>
<td>40.45(10.88)</td>
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<td>STAI: Trait (20-80)</td>
<td>43.43(13.56)</td>
<td>46.49(18.34)</td>
<td>41.73(12.16)</td>
<td>43.00(7.26)</td>
<td>39.82(9.86)</td>
<td>41.44(8.66)</td>
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<td>PIL (15-105)</td>
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<td>77.33(12.92)</td>
<td>75.05(11.30)</td>
<td>78.78(7.55)</td>
<td>76.18(10.54)</td>
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<td>GMRI (29-145)</td>
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<td>98.28(14.01)</td>
<td>97.81(12.55)</td>
<td>101.49(11.31)</td>
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<td>45.00(16.17)</td>
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Parenthesized ranges beside the scale names refer to minimum and maximum scores. Abbreviations: EXP, Experimental Arm; CTRL, Control Arm; PIL, Purpose in Life Test; GMRI, Grief and Meaning Reconstruction Inventory; ISLES, Integration of Stressful Life Experiences Scale; STAI, State-Trait Anxiety Inventory; CES-D, Center for Epidemiological Studies Depression Scale; RGEI, Revised Grief Experiences Inventory; CBI, Core Bereavement Items; HRGC, Hogan Grief Reaction Checklist. †There is no total score for the Hogan Grief Reaction Checklist. *Reversed Score: Lower scores are indicative of greater personal growth. a Score improved from baseline; b Score declined from baseline; c No change in scores from baseline.
Manuscript 4: Figure 1. Participant Flow

Individuals assessed for eligibility ($n = 45$)

Excluded individuals ($n = 19$)

Reasons:
- Did not meet inclusion criteria ($n = 10$)
- Scheduling conflict ($n = 5$)
- Preferred not to partake in research ($n = 1$)
- No longer wished support ($n = 2$)
- Unwilling to travel ($n = 1$)

Met inclusion criteria, signed consent and were randomized ($n = 26$)

Completed MBGC as planned ($n = 13$)
- Withdrew from the study ($n = 1$) Reason: Withdrew after first session due to unforeseen scheduling conflict

Completed treatment-as-usual control as planned ($n = 10$)
- Withdrew from the study ($n = 2$) Reason: 1 participant did not attend any sessions. The other participant attended the first session and withdrew

Lost to follow-up ($n = 1$)
- Reason: Did not return questionnaires.

Lost to follow-up ($n = 2$)
- Reasons: Both did not return questionnaires or complete follow-up interview

Included in the analysis at 3 month follow-up ($n = 11$)

Included in the analysis at 3 month follow-up ($n = 9$)
Figure 2. Percentage of Scale Range Improvements

Abbreviations: EXP, Experimental Arm; CTRL, Control Arm; PIL, Purpose in Life Test; GMRI, Grief and Meaning Reconstruction Inventory; ISLES, Integration of Stressful Life Experiences Scale; STAI, State-Trait Anxiety Inventory; CES-D, Center for Epidemiological Studies Depression Scale; RGEI, Revised Grief Experiences Inventory; CBI, Core Bereavement Items; HRGC, Hogan Grief Reaction Checklist.
**CHAPTER 6: GENERAL DISCUSSION**

I would say that our patients never really despair because of any suffering in itself. Instead, their despair stems in each instance from a doubt as to whether suffering is meaningful. Man is ready and willing to shoulder any suffering as soon and as long as he can see a meaning in it.

-Viktor Frankl, 1961, p. 5

6.1 Preface

The final chapter of the dissertation begins with a brief summary across the previous five chapters encompassing the findings of all four manuscripts. Implications for counselling psychology training, practice, and research are then examined. Some of the shortcomings of the dissertation are specified, followed by prospective areas of future inquiry that can be erected on the foundations of the dissertation. General conclusions complete this terminal chapter.

**6.1.1 Summary of dissertation findings.** Chapter 1 was a general introduction that outlined the overall rationale for the thesis given current trends in bereavement theory, research, and practice. The remaining chapters of this dissertation approximated the evolution specified in the SMBTR (Stages 1A and 1B) as outlined by Rounsaville, Carroll, and Onken (2001).

Stage 1A of the SMBTR involves specifying the theoretical models of interest as well as the process of therapeutic change to alleviate psychological distress. As such, Chapter 2 began by defining key constructs including loss, bereavement, grief, and mourning. To situate the primary theoretical models used in the dissertation, co-existent theories of bereavement, including general grief theories, intra- and inter-personal models, as well as integrative models, were outlined. The particularities of grieving a cancer death then served as a springboard to introduce the first manuscript, titled *Means to Meaning in Cancer-Related Bereavement: Identifying Clinical Implications for Counseling Psychologists.* The objective of this first
manuscript was to detail a broad review of the current intersections between meaning and bereavement scholarship. Subsequent clinical implications for counselling psychologists were framed for a cancer-bereft population.

Additional tasks of stage 1A (SMBTR) include identifying gaps in the knowledge base and demarcating a sound rationale for the study. Stage 1A also involves composition of a preliminary intervention manual, identifying the target population, specifying outcome measures, outlining a protocol for supervising and monitoring performance, and engaging in intervention training. To this end, Chapter 3 began by outlining characteristics and research underpinning the phenomenon of uncomplicated as well as complicated/prolonged grief in the bereft population. This description of bereavement trajectories preceded the second manuscript, *Bridging Theory with Emerging Trends in Intervention Research: Meaning-based Group Counseling for Bereavement.* This article is essentially a summary of the intervention manual, linking meaning-based theories and group counselling practice with an uncomplicated-bereft population, laying the foundation for the initial feasibility study. An intervention manual was also developed (see Appendix A) that charts the theoretical underpinnings, delivery, auditing procedures, as well as supervision and training requirements of MBGC. The specification of outcome measures was carried forward into the next chapter.

Chapter 4 adhered to stage 1B of the SMBTR, requiring specification of pilot testing procedures, demonstration of feasibility of the new intervention, as well as specification and justification of inclusion/exclusion criteria, and identification of specific clinicians to conduct the intervention. The third manuscript was first introduced by a discussion of bereavement-service utilization, followed by developments in group counselling interventions for bereavement, methodological considerations for pilot testing, and recruitment challenges of the dissertation.
studies. The third manuscript described the feasibility trial, titled: *A Pilot Study of Meaning-based Group Counseling for Bereavement*.

Chapter 5 started with a detailed account of current trends in bereavement intervention efficacy. This chapter also reported the pilot RCT, attending to the remaining guidelines of SMBTR Stage 1B, including specifying the control condition, defining the procedures for randomization, and demarcating acceptability-threshold criteria for claiming success as well as counter-indications for proceeding to a full RCT (Arnold et al., 2009; Lancaster et al., 2004). The results of the pilot RCT were presented in the fourth and final manuscript, *Reconstructing Meaning with Others in Loss: Results of a Bereavement Group Pilot Randomized Controlled Trial*.

Briefly, the results of this dissertation suggest that the meaning-making paradigm offered a potentially interesting and viable approach to conceptualizing bereavement with corresponding clinical implications. MBGC was first developed by MacKinnon in collaboration with his supervisors and doctoral committee. The intervention was later refined in consultation with participants. MBGC was deemed a feasible psychological intervention in both pilot and pilot RCT phases with minimal attrition and qualitative data supporting its clinical usefulness in promoting bereavement adjustment. Outcome measures were largely acceptable. Given these propitious results, a full RCT of MBGC appears feasible, though sample size calculations (reported below) suggest that it will likely require two recruitment sites.

**6.2 Implications for Training and Practice**

Counselling psychology has tended to neglect bereavement as a topic of relevance in training, as well as research (Servaty-Seib & Taub, 2010). The dissertation makes several important contributions to counselling psychology training and practice. To begin, this study
begins to move the discussion of bereavement theories and counselling practices beyond the dominant stage models (Archer, 2008; Downe-Wamboldt & Tamlyn, 1997; Payne, Jarrett, Wiles, & Field, 2002) towards contemporary constructivist models of practice. The constructivist underpinnings of MBGC are in tune with counselling psychology’s feminist and multicultural practice foundations (Goodman et al., 2004). Specifically, bereft individuals are seen as empowered and active agents in their adaptation within a constructivist paradigm (Neimeyer, 2006a), consistent with feminist psychotherapy leanings (Enns, 2004). In addition, the constructivist paradigm embraces the multiplicity of belief systems, and challenges universal and essentialist truths (Neimeyer, 1995), values shared within counselling psychology training, practice, and research (Bedi et al., 2011; Haverkamp, Robertson, Cairns, & Bedi, 2011; Morrow, 2006; Ponterotto, 2005). As such, the first manuscript (MacKinnon, Milman, Smith et al., 2013) could serve to introduce counselling psychology students to both bereavement and corresponding contemporary meaning-based constructivist approaches to counselling.

Moreover, previous meaning-making interventions tended to be framed within either stress/coping (Lee, Cohen, Edgar, Laizner, & Gagnon, 2006) or existential (Breitbart et al., 2012) perspectives. The emphasis on the narrative-constructivist approach to meaning-making is an important and distinguishing aspect of this psychological clinical trial.

In addition, short-term group psychotherapy requires some framework to guide the tasks, themes, and goals of treatment (Yalom & Leszcz, 2005). This dissertation thus strongly contests the assertion that constructivist approaches are incompatible with manualization (Bridges, 2002) and impair therapist creativity to intervene (Raskin, 1999). MBGC attempts to strike a balance, assuming a semi-structured approach that blends constructivist approaches with facilitator and member ingenuity, all within the frame of a manualized group modality.
The meaning-making scholarship contains overlapping and obscure constructs that can be difficult to define and understand (Park, 2010), thus confounding straightforward translation of concepts to clinical practice. While the success of rendering the predominantly-scholarly discourses of meaning making into colloquial terms was not explicitly assessed with participants, no participant reported confusion with the meaning-centric discussions.

Closely linked to constructivist thought, the narrative underpinnings of MBGC may also be useful for counselling psychology training, in particular for helping students develop skills to intervene with bereft clients. MBGC encourages practitioners to attend to the narrative fractures that arise in bereavement (Neimeyer, 2006b). Further, MBGC offers both techniques and therapeutic exercises to potentially advance bereavement adaptation through psychotherapeutic insight-oriented conversation.

Lastly, group counselling is an important aspect of professional training, though it is often a marginalized component of academic curricula (Fuhriman & Burlingame, 2001; Yalom & Leszcz, 2005). The MBGC manual can be used in counselling psychology group course syllabi as an example of an empirically-driven constructivist intervention in keeping with the field’s value of embracing cultural diversity. In essence, MBGC can be used as a model to help students learn how group interventions are structured, as well as suggest skills to facilitate and intervene with groups.

6.3 Limitations

The four manuscripts of the dissertation each contain limitations sections, succinctly summarized and briefly expanded upon below. First, the lack of cross-cultural research in meaning making undermines the generalizability of the paradigm. The Western-centric nature of the scholarship was comparable to the demographic characteristics of the dissertation
participants. The majority of group members were of dominant western cultures (i.e., heterosexual, older female, Judaeo-Christian), limiting the transferability of the findings with diverse populations. MBGC also assumes a largely Western approach to bereavement adaptation (i.e., discourse psychotherapy) that is not always the most effective approach with all bereft populations (Doka, 2010; Parkes, Laungani, & Young, 1997; Rosenblatt, 2008). In addition, the screening procedures used in assessing grief trajectory (i.e., uncomplicated versus prolonged) did not explicitly attend to variations of grief that exist beyond the prevailing socio-cultural customs (Klass & Chow, 2011).

The study was limited by the outcome measures selected. One of the difficulties was the limited number of psychometrically-robust meaning scales available. Some meaning scales initially considered during design (e.g., The Meaning in Life Questionnaire; Steger, Frazier, Oishi, & Kaler, 2006) either measured meaning independent of bereavement, or were not well suited to assess the effectiveness of a psychological clinical trial. Additionally, many bereavement outcome measures continue to suffer from a lack of follow-up validation and reliability testing (Neimeyer, Hogan, & Laurie, 2008). Participants also pointed out that many of the outcome measures used did not have a specific timeframe for symptoms evaluated. As such, a temporally-refined assessment of bereavement symptoms at the given data collection points was not possible in this dissertation.

The findings of the dissertation are also limited due to data collection methods. Baseline measures were not collected immediately preceding the first session of either experimental or control groups but rather upon recruitment into the study, leaving open the possibility that natural grief adaptation may have influenced member responses prior to MBGC or CTRL participation. We also did not assess for other types of support sought and/or received prior to participation.
Moreover, during the Phase 1 feasibility study (manuscript 3), follow-up interviews were conducted prior to quantitative data collection, thus potentially influencing the latter.

Certain extraneous support factors also dilute an unhindered valuation of the research objective. Specifically, some individuals partook in concurrent individual therapy, others in a concomitant bereavement support group in Phase 1, and/or followed a prescribed psychotropic regime during the study. As reported in manuscript 4, participants in the CTRL arm tended not to engage in concurrent psychotherapeutic or psychopharmacological support. Given the above concern, it is impossible to fully assess the degree to which participant responses to the study (e.g., acceptability of the intervention) were influenced by factors external. Moreover, the purity of the pilot RCT design was tainted as a result of the unequal influences between the EXP and CTRL conditions.

The final limitation is the control arm of the pilot RCT. The lack of an auditing and monitoring procedure over the course of the CTRL resulted in major inconsistencies between Series A and B. Specifically there were different tasks and themes in each of the two control groups, as well as incongruous group facilitation. Comparison between experimental and control arms was also hampered by differing session frequencies (weekly versus bi-weekly), as well as group duration (12 sessions versus 7 sessions).

6.4 Research Implications

Internationally-validated organizational guidelines recommend that family caregivers in palliative care are provided with psychosocial support before death but also into bereavement (Hudson et al., 2012). However the same guidelines confirm that evidenced-based interventions are lacking. An associated international survey of researchers identified intervention
development and testing in bereavement as a critical priority (Hudson, Zordan, & Trauer, 2011). This dissertation is an important contribution to this call for research.

Successfully completing the pilot RCT of MBGC achieved the second stage tier in the SMBTR (Rounsaville et al., 2001). The next stage in the model is a fully-powered RCT, incorporating the lessons learned in this dissertation. The results reported in manuscript 4 support proceeding to this third stage of intervention testing. As such, a number of factors are first presented below for executing a full RCT of MBGC. The remainder of the subsection focuses on other possible directions for future research.

6.4.1 Future randomized controlled trial. It was decided that the HGRC personal growth subscale would be the primary outcome for a future RCT of MBGC. This subscale was selected due to its strong face validity associated with the goals of MBGC. Items of this subscale include assessing participants’ perceptions of learning to cope with life, feeling stronger in response to their grief, being more tolerant of themselves and others, experiencing increased hope for the future, and finding ways to let go of grief. In addition, the HGRC was selected because numerous studies have examined its statistical reliability and validity (Hogan et al., 2001; Hogan & Schmidt, 2002; Neimeyer & Hogan, 2001; Neimeyer et al., 2008).

The calculation of the sample size needed for a full RCT was a particular challenge as we were unable to locate any pre-post or RCT uncomplicated bereavement interventions published in peer-reviewed journals using the HGRC personal growth subscale from which to estimate effect size. Relying on pilot data to calculate sample size has two potential pitfalls. First, the differences between means found in a pilot study are likely greater than one would expect in a full trial (Lancaster, Dodd, & Williamson, 2004). Second, the standard deviation from a pilot study tends to be smaller than in a full trial. As such, we took two approaches to calculate the

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sample size, one relying on an unmodified (and possibly misleading) standard deviation. A second (more conservative) sample size was calculated using the upper limit of the 80% confidence interval of the standard deviation as has been recommended for pilot studies (Browne, 1995). We then examined the face validity of the effects sizes obtained, as explained below.

First, we calculated the means of the difference scores between Time 1 and 3 for both the EXP ($M = -4.00$) and CTRL ($M = 0.00$) groups on the personal growth subscale. We then calculated the pooled standard deviation ($SD_p = 8.85$) of the difference means. These calculations were then used in deriving the effect size ($d = -0.45$). Using the statistical program G*Power, we calculated the sample size for a $t$-test of the difference between two independent means (two-tailed; $\beta = 0.80$; $\alpha = 0.05$). The resulting value of the critical $t$ was -1.98. Using the above method, it was determined that a full RCT to assess the efficacy of MBGC would require a total sample size of 158 participants (79 participants per each treatment arm).

Given this requisite sample size, we examined the recruitment rate in the pilot RCT (reported in manuscript 4). It was determined that on average 6.5 individuals ($Mdn = 6$; $SD = 4.93$) were admitted to the study each month. We also decided on a maximum group size of 8 participants per group offering 4 series per year (~64 participants annually and randomly distributed across 8 groups [4 EXP; 4 CTRL]), we factored in 25% attrition (analogous to the rate of attrition in the feasibility and pilot RCT of MBGC). Therefore we would forecast that ~48 participants would complete all aspects of the study per year.

Achieving the needed sample size of 156 participants would thus require a period of between three to four years. At least two recruitment sites, each conducting separate intervention series of EXP and CTRL groups, appear justified. Using the pilot RCT recruitment rate as a
reference, two sites would permit recruiting \( \sim 13 \) participants a month. In order to achieve sufficient participants (6 to 8 in a given EXP or CTRL group) and assuming a three-month recruitment period prior to intervention, \( \sim 39 \) individuals could be recruited per year. Consequently, around 10 \((39 \div 4)\) participants could be randomly assigned to each of two EXP and CTRL groups for each series. While approximately ten participants per group is slightly above the maximum group size, this higher value does allow for participant attrition during the intervention, which was observed in the dissertation.

Second, we calculated a more conservative sample size using the upper limit of the 80% confidence interval of the standard deviation. Using the method reported by Sheskin (2011) (EXP Time 1 \( M = 21.00 \); CTRL Time 1 \( M = 19.94 \)), we then determined the effect size using the same procedure described above \((d = -0.21)\). This value yielded a considerably higher sample size of 708 when input into G*Power (two-tailed; \( \beta = 0.80; \alpha = 0.05; t = 1.96 \)). Thus 354 participants would be needed in each treatment arm.

The two methods described above provide us a span of possible sample sizes for a full RCT, ranging from 158 to 708 participants. Given the range and provisional attrition rates of 25%, it appears necessary to add more recruitment sites than used in the pilot RCT, possibly conducting the full trial in two cities.

We attempted to situate our effect size ranges within the greater scholarship. Given the numerous critiques leveled at previous uncomplicated bereavement interventions (with corresponding negligible effect sizes, see summary in manuscript 2), we decided to examine the effect sizes reported for interventions for complicated/prolonged bereavement \((d = 0.58 \) at follow-up, see Currier, Neimeyer, & Berman, 2008). However, because individuals in complicated/prolonged bereavement are likely in more distress, effect sizes are liable to be larger
with this population as there is more room for participants to improve. The conservative effect size of \( d = -0.21 \) calculated above for our pilot RCT thus appears to have strong face validity in that MBGC is not necessarily expected to produce the robust results of complicated/prolonged interventions. However, we argue that our conservative effect size supports the notion that methodologically sound uncomplicated bereavement interventions may be able to produce small to medium effect size shifts at follow-up.

Lastly, a future RCT should attend to the risk that any group psychotherapy treatment may introduce dependencies among observations (Baldwin, Murray, & Shadish, 2005). For example, common elements that members are exposed to (e.g., same co-facilitator) may homogenize their response. These dependencies can violate the independence of observations assumption of inferential statistical procedures and increase the risk of type I (false positive) errors (i.e., that MBGC is efficacious when in fact it is not). Methods such as those outlined by Baldwin, Murray and Shadish (2005) can be used to assess and account for the magnitude of the dependencies in a full trial of MBGC.

6.4.2 Other areas for future research. Several conceivable routes for potential future investigations proposed in each of the four manuscripts are revisited and briefly expanded upon below. Modifications to the modality (i.e., an individual intervention), target population, and outcome measures used to assess MBGC are first presented, followed by potential clinical competency studies. Possible studies regarding meaning-making processes in bereavement group contexts precede a discussion of prospective meta-analytic research, as well as more refined investigations of bereavement service utilization.

MBGC may be modified in several ways and exposed to future empirical evaluation. A discernible course would be to modify MBGC to be offered as an individual intervention similar
to other meaning-focused studies (Breitbart et al., 2012). Altering the intervention for complicated/prolonged bereavement may also represent an appealing avenue for future scholars. Should this direction be taken, it might be useful to integrate aspects of Piper, Ogrodniczuk, Joyce, and Weideman’s (2011) short-term group psychotherapy intervention for complicated bereavement.

Future researchers may also be interested to see how individuals with complicated/prolonged bereavement might respond to MBGC. However, we recommend great caution in administering MBGC with complicated grievers. At no time during intervention design was the scholarship on complicated grief ever considered when developing the tasks and themes of MBGC. The only exception was reviewing relevant literature to inform the inclusion/exclusion criteria, as well as meta-summaries and meta-analyses of bereavement interventions. Uncomplicated grief has been identified as a distinct phenomenon (Burke & Neimeyer, 2013) and cannot be considered equivalent to complicated grief. Further, the feasibility and pilot RCT of MBGC were conducted uniquely with uncomplicated grievers. We cannot infer from our preliminary findings that MBGC has any effect on uncomplicated grief; correspondingly we cannot infer MBGC’s possible effectiveness on complicated grief; it could even be detrimental. Therefore, before any study examining the impact of MBGC on complicated grief is undertaken, a thorough literature review exploring the intersections of complicated grief, group therapy, and meaning making would need to be undertaken so as to refine the primary structure of MBGC. Pilot testing similar to the methods used in this dissertation could then naturally follow.

It may also be interesting to refine the choice of outcome measures for future studies of MBGC. Meta-reviews of meaning outcomes have appeared (Brandstätter, Baumann, Borasio, &
Fegg, 2012) since the dissertation was originally designed and may offer interesting alternative questionnaires. Unfortunately, none of the reported 59 meaning scales were specifically developed with a bereft population. However, the *Sense Making Scale* (SMS, Pakenham, 2007) may be a potentially interesting measure. Developed with a sample of multiple sclerosis (MS) patients (*n* = 388) and MS caregivers (*n* = 232), the scale has 5 subscales relevant to testing the impact of participating in MBGC (i.e., *redefined life purpose, spiritual perspective, causal attributions, changed values and priorities*, and *acceptance*). While some of the SMS subscales have demonstrated strong internal consistency (e.g., redefined life purpose *α* = 0.91; changed values and priorities *α* = 0.80), Brandstätter, Baumann, Borasio, and Fegg, (2012) found the test-retest reliability unsatisfactory (e.g., redefined life purpose *r* = 0.43; changed values and priorities *r* = 0.43). The SMS requires further psychometric validation and could therefore be included as a secondary outcome measure in a full trial.

In addition, future investigations could explore and identify the minimal clinical competencies required to conduct a bereavement support group. An important area could be gaining more knowledge on the influence of bereavement training on the effectiveness of bereavement interventions. These directions are consistent with the call for empirically-supported clinical competencies in counselling psychology training and practice (Beatch et al., 2009). Unfortunately, there appears to be an illusory perception that bereavement counselling can be conducted by practitioners irrespective of specific training they have received (Neimeyer, 2012). Several studies support Neimeyer’s assertion that there are serious deficiencies in practitioner awareness of the research base. Ober, Granello, and Wheaton (2012) found that a slight majority (54.8%) of licensed professional counselors in the United States (*n* = 369) had not completed a single specific course on bereavement. The most familiar model of bereavement was
Kübler-Ross’s (1969) stage model (42.8%). Only a minority were familiar with contemporary models of bereavement (i.e., task model, 28.2%; meaning-making 25.5%; the dual process model 15.4%; the theory of continuing bonds 14.9%). In a related qualitative study (N = 6), bereavement counselors reported that they tend to rely on a wide variety of theoretical knowledge when intervening, but make no use of empirical findings (Coyne & Ryan, 2008). In another article, clinical competencies to adequately facilitate bereavement support groups were identified, though were relatively narrow in scope (e.g., clinician self-awareness of loss history; the capacity to abide intense emotions associated with grief; Lorenz, 1998).

A more refined understanding of the dynamic processes of meaning making in the context of groups, based on data collected during the dissertation, could be an important contribution to the scholarship. In fact, a more thorough qualitative analysis of the MBGC session transcripts and exit interviews to ascertain some of the more subtle effects of meaning making in the context of a group intervention using a mixed inductive-deductive content analysis is currently underway (MacKinnon, Milman, Beauchemin et al., 2013).

A study that examines bereavement service utilization rates for uncomplicated grievers actively seeking support would also be welcome. Present studies fail to assess for grief trajectory (Cherlin et al., 2007; Currow et al., 2008) or only assess for complicated/prolonged bereavement and service utilization (Lichtenthal et al., 2011). Having a sense of the proportion of uncomplicated grievers actively seeking support will help researchers better understand the need for future interventions for uncomplicated bereavement.

6.5 Final Conclusions

There is an established body of scientific evidence suggesting that humans are hard wired to make attachments (Bowlby, 1961, 1980; Schore, 2000; Seigel, 2001). However, this natural
inclination to attach (e.g., to relationships, work, objects, etc.) co-occurs in a world of perpetual losses (e.g., divorce, job loss, death) that steadily accumulate over the lifespan.

When individuals encounter these parallel experiences of attachment and loss, a heightened sense of meaninglessness can be provoked (Yalom & Lieberman, 1991). Meaninglessness can be a daunting challenge when we consider the assumption that humans have an innate tendency to construct a symbolic world of meaning that facilitates orientation in life and coping with adversity (Neimeyer, 1995). This propensity towards meaning making has largely been articulated to date in the constructivist (Neimeyer, 2009a), existential (Mendelowitz & Schneider, 2008), and stress/coping literatures (Park, 2010). This meaning-making inclination has also been legitimized in neuro-psychological research. For example, there is longstanding proof that incoming sensory stimuli are coded by the perceptual system into meaningful patterns (Bentin & Golland, 2002; Yalom, 1980).

There are thus important research questions concerning the ingrained human propensities to make attachments and construct meaning. One such question of particular relevance to this dissertation is whether humans can create (or re-create) meaningful constructions of the world that are robust enough to support a life story seemingly devoid of meaning when the attachment system is threatened in the aftermath of death (May & Yalom, 2005; Neimeyer & Sands, 2011). This doctoral dissertation is an attempt to address, in part, some of these complex issues that elude simple explanation.

We are witnessing a surge of scientific inquiring as bereavement begins to assume a more central role in the scholarship consistent with the fundamental role it has long held in human life (Neimeyer, 2006a); this dissertation is in support of this scholarly effort. The findings in the literature and in this dissertation contest the assertion that interventions for adults in
uncomplicated bereavement, including brief group bereavement psychotherapy, are counter-indicated (Genevro et al., 2004; Schut & Stroebe, 2005). Further, Hertzog (2008) summarized the major goals of pilot studies, including an appraisal of feasibility, sufficiency of outcome measures, identifying problems with data collection schemes, responding to methodological dilemmas, and planning for a large study. These aims were largely met in the current dissertation. Results suggest a full RCT is warranted, however more than one site is likely need to ensure sufficient recruited

In closing, bereavement remains one of the profound existential mysteries, often provoking more questions than answers. Bereavement challenges humans to live with the questions and learn, sometimes together, ways of meaningfully “rescuing joy from heartbreak” (Simmons, 2000, p. xiv).
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Clinical Psychology, 59*(3), 479-482.


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MEANING AND GROUP BEREAVEMENT

Appendix A

INTERVENTION MANUAL

MEANING-BASED GROUP COUNSELLING FOR BEREAVEMENT

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People cope with the death of those they love with remarkable and sometimes inspiring resilience – except when they don’t, in which case they risk becoming immobilized in a world seemingly devoid of that one, compellingly essential attachment figure, unable to assimilate the apparent impossibility of the death into a life story now bleached of meaning by bereavement.

-Robert Neimeyer, 2010b, p. 88

Despite the blandishments of popular culture, the goal of life is not happiness but meaning. Those who seek happiness by trying to avoid or finesse suffering will find life more and more superficial.

-James Hollis, 2006, p. 232

Life is mainly froth and bubble

Two things stand like stone —

Kindness in another’s trouble.

Courage in your own.

-Adam Lindsay Gordon, 2000, p. 42
# MBGC Intervention Manual

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Introduction

This intervention manual outlines the development and procedures of the meaning-based group counselling intervention (MBGC) for uncomplicated bereavement. It begins with a brief discussion of the purpose of MBGC, information concerning the development of the intervention, and acknowledgements. Second, there is a discussion of the intended population and screening procedures. Third, the principal theoretical frameworks that inform the intervention are presented. Fourth, the phases, tasks, and themes of the intervention are then outlined in detail including a session-by-session breakdown. A series of appendices are located in the manual, including session handouts and treatment fidelity (audit) forms.

Purpose

The purpose of developing MBGC was to provide an empirically-driven, short-term, meaning-based, manualized group counselling intervention to assist bereft individuals in uncomplicated bereavement in coping and adapting following a death-related loss.

The MBGC intervention manual can be used, either entirely or in parts, by clinicians to inform their practice when offering support to groups of bereft populations. The intervention manual can also be used by clinician-researchers in replication studies to further assess the efficacy and/or effectiveness of MBGC.

Intervention Classification

MBGC can be classified as a primary bereavement intervention (following the convention used in Schut, et al., 2001) targeting the uncomplicated grief trajectory.

Facilitation

The intervention is not designed to be administered by para-professionals. The intervention should only be administered by licensed mental health professionals (e.g., counsellors, psychologists, psychiatrists, social workers, etc.) or allied health care professionals (e.g., clergy, physicians, etc.) who have extensive clinical training in mental health. Furthermore, the intervention should only be administered by a professional with considerable clinical experience. Ideally the group should be led by two experienced clinicians allowing for a more comprehensive facilitation. Alternatively, the intervention can be administered by a junior clinician under the supervision of an experienced one.
Development of the Intervention Manual

MBGC was developed as part of a clinical-research study in partial fulfillment of Christopher J. MacKinnon’s doctoral degree in Counselling Psychology at McGill University (completed October 2013). For a more extensive discussion of the development, theoretical frameworks, methodology, and results of the clinical-research study underpinning MBGC the reader is directed to review the doctoral dissertation of Christopher J. MacKinnon (MacKinnon, in press). Several published articles and a book chapter are also available (see section Literature related to MBGC below).

This intervention manual was initially authored by MacKinnon in the Summer of 2009. It was developed through a comprehensive review of bereavement and meaning-making scholarship as part of MacKinnon’s comprehensive examination. It was later updated in the Summer of 2013 to reflect recent trends in the scholarship.

Extensive consultation and feedback was received from MacKinnon’s research co-supervisors, Dr. S. Robin Cohen and Dr. Nathan Grant Smith. Valuable input was also received from his doctoral dissertation committee including Dr. Harvey Max Chochinov and Dr. Annett Körner. Particularly extensive input was received from committee member and intervention co-facilitator Dr. Melissa Henry. The intervention manual also benefited from the input of two research assistants associated with the study: Mel Berish (Champlain College), and Evgenia Milman (McGill University).

In addition, materials presented at several continuing education workshops were instrumental in developing this manual (Breitbart & Poppito, 2010; Neimeyer, 2009; Neimeyer, 2010a). Audiovisual material produced by the American Psychological Association entitled Constructivist Therapy Over Time featuring Dr. Robert Neimeyer was also reviewed (American Psychological Association, 2008), with tasks and themes of meaning reconstruction integrated into the present manual.

Finally, permission was received from Dr. Virginia Lee (McGill University) to review the procedures manual for her Meaning-Making Intervention (MMi) for advanced oncology patients (Lee, 2004). Selected elements of the MMi were integrated into MBGC (specified below).
Referencing

To reference this manual, please use the following citation:


Study Registration

The empirical evaluation of MBGC was registered with ClinicalTrials.gov, an international registry of governmentally- and privately-supported clinical trials. The specific registry numbers for this study were NCT01285128 and NCT01384942.

Permissions

The image on the cover of the intervention manual, Office Chairs Arranged in a Circular Formation is a stock photo image purchased from 123RF.com, a royalty-free stock photo internet library (transaction number 2040221006).

Figure 1 (Modified Dual Process Model of Grief) was originally based on the work of Stroebe and Schut (1999). It is included with the permission of Francis and Taylor Publishing (License Number 3187831433563) and the permission of the American Psychological Association.

Acknowledgments

A number of individuals and agencies graciously referred individuals to participate in the feasibility (MacKinnon et al., conditional acceptance ) and pilot randomized control trial (MacKinnon et al., conditional acceptance b) of MBGC: The Hope and Cope Program at the Jewish General Hospital (Pedro Mejia, Suzanne O’Brien, Dr. Tanya Fitzpatrick, Sandy Lipkus); McGill Counselling Services (Jim Robinson, Donna Kuzmarov); The Balfour M. Mount Palliative Care Unit at the McGill University Health Center (Johanne de Montigny, Sue Sweitzer, Vivianne Korah); The Palliative Care Unit at the Jewish General Hospital (Dr. Bernard Lapointe, Vasiliki Bitzas, Vivian Myron); the Argyle Institute of Human Relations (Lisa Courte, Dr. Joan Keefler, Dr. Dr. Alison Mindel, Janice Tester); Cedars CanSupport; Naomi Kogan (Jewish General Hospital); the Psychosocial Oncology Program at the McGill University Health Center (Dr. Anita Mehta, Kimberly Thibodeault); Tracey Liben (McGill University Health Center); Dr. Emily Kerner (McGill University); Norma Gilbert (CSSS Cavendish); and Dr. Simon Amar (McGill University Health Center).
Rationale for MBGC and Cautionary Remarks

Literature concerning interventions targeting uncomplicated bereavement (primary interventions) is an area of scholarship charged with controversy (Bonanno & Lilienfeld, 2008). Some have suggested that these interventions should not be undertaken based on meta-analytic reviews and meta-summaries (Genevro, et al., 2004).

However, many past studies of primary interventions have design flaws (see Allumbaugh & Hoyt, 1999; Currier & Holland, 2008; Currier, Kato & Mann, 1999; Forte, et al., 2004; Neimeyer, & Berman, 2008; Schut, Stroebe, van den Bout, & Terheggen, 2001; Stroebe, Stroebe, & Schut, 2003) including the following:

- Interventions are not well-described
- Interventions are theoretically ambiguous
- Studies use un-validated outcome measures
- Studies fail to (or improperly) randomize participants to experimental and control conditions
- Studies have unclear indicators for success
- Studies have inconsistent inclusion/exclusion criteria
- Studies do not screen participants
- Studies use problematic recruitment strategies.

Thus, it appears that any definitive conclusions of either the effectiveness or efficacy of primary bereavement interventions may be premature at this time.

The development and pilot testing of MBGC attempted to correct for a number of these limitations (for a more detailed discussion, see MacKinnon et al. 2013). All things being equal, clinicians should remember that the science underpinning MBGC remains in only the earliest stages of development. Any administration of MBGC should proceed cautiously.

Intended Population

MBGC is intended for a culturally-diverse adult population 18 years of age and older. It is strongly recommended that all individuals participating in MBGC undergo extensive psychosocial assessment and screening under the supervision of a licensed mental health professional before being accepted into the group. The screening protocol is found in Appendix A10 (modified version of Keefler, 2005). It is suggested that screening agents have a list of alternative psychosocial resources to provide to individuals who are not appropriate for MBGC.

Inclusion Criteria

Only those individuals who are actively seeking bereavement group services are appropriate for participation. MBGC has only been pilot tested with individuals who have
experienced a death-related loss within 6 weeks and no more than 2 years of the first meeting of the group. Participants who are experiencing an uncomplicated grief response are appropriate for MBGC. Stroebe et al. (2008) defined uncomplicated grief as “an emotional reaction to bereavement, falling within expected norms, given the circumstances and complications of death, with respect to time course and/or intensity of symptoms” (p. 6). While varying degrees of depressive symptoms, fatigue, social isolation, disturbed sleep, low self-esteem, and changes in relationships are often reported, taken as a whole these symptoms do not impair functioning to a significant degree (Shear et al., 2011; Stroebe et al., 2001). Individuals should also be assessed for their ability to participate in a group counselling context (e.g., ability to give and receive feedback/support, ability to trust and be vulnerable, ability to speak with others; see Piper et al., 2011; Yalom & Leszcz, 2005).

**Exclusion Criteria**

Individuals are inappropriate for participation in MBGC if they are experiencing a prolonged (also referred to as complicated/abnormal) grief response. Horowitz, Wilner, Marmar and Krupnick (1980) defined abnormal grief as the heightening of grief to a degree that the individual becomes overwhelmed, engages in maladaptive behaviors, and/or that his/her level of distress is fixed and the individual is unable to adapt to the loss. A diagnostic questionnaire can also be used to assess for prolonged/complicated bereavement (see Prigerson & Maciejewski, 2008 and/or Shear et al., 2011). Parents grieving the death of young child (less than 18 years old) should be excluded as parental bereavement following the death of young child is considered a distinct form of death-related loss that is not accounted for in the themes and tasks of MBGC. Participants should also be excluded in cases where the death was the result of suicide, suspected suicide, or homicide. Finally, individuals who are excessively angry, who are unable to give and receive support from others, or who are reporting active suicidal or homicidal ideations are not appropriate for MBGC.

**Timeframe**

The intervention takes place over 12 weekly sessions of 90 minutes in duration. Fixed session time and length are an important aspect of the therapeutic frame and provide consistency, stability, and reassurance to participants about the boundaries, limits, and opportunities within the allotted treatment time (Pipes & Davenport, 1999).

**Number of Participants**

It is recommended that no less than 6 and no more than 8 adult participants be admitted to any given group of MBGC. A minimum of 6 individuals ensures a viable group given possible absenteeism and attrition. Results of the clinical-research study found that more than 8 participants results in insufficient time for each member to participate given the affect-laden content of sessions.
Theoretical Frameworks

The theoretical foundations of MBGC are presented below.

Meaning Making

MBGC primarily rests on a meaning-making paradigm embedded within a constructivist-narrative approach (Neimeyer & Bridges, 2003). Anti-essentialist in nature and celebrating the multiple constructions of realities (Neimeyer & Raskin, 2000), narrative approaches to psychotherapy have their origins in family systems theory (Neimeyer, 1995; Nichols & Schwartz, 2007). Narrative theorists combine aspects of constructivist models, arguing that humans are inherently storytellers and that one’s sense of reality is largely informed by one’s current stories (Epston & White, 1989, 1990; White, 1995). As a result, the constructivist-narrative approach tends to be appropriate in working with culturally-diverse populations. Furthermore, while the majority of constructivist psychology scholarship concerns the practice of individual therapy, constructivist-narrative approaches have begun to be adapted to group psychotherapy modalities (e.g., Monk, Drewert, & Winslade, 2005).

Narrative psychotherapy is conceptualized as a form of literary liberation, which encourages clients to become the authors in the creation of more hopeful life stories (Neimeyer & Raskin, 2000). The process of therapy involves externalizing and deconstructing internalized narratives (White, 1993), collaborating with individuals in difficulty by exploring alternate stories, developing new assumptions, as well as defining new possibilities through a process of re-authorship and meaning-making (Goldenberg & Goldenberg, 2005; White, 1993).

Narrative reconstruction, further refined as meaning making (or reconstruction) in the grief literature, has been identified as potentially useful in working with the bereft whose life stories are often disrupted following a death (Neimeyer, Prigerson, & Davies, 2002). Early studies such as the one conducted by Davis, Nolen-Hoeksma, and Larson (1998) have reported that the ability to make meaning following death may predict better psychological adjustment.

Neimeyer (2006) has outlined six propositions of meaning making embedded within a constructivist approach that act as an assumptive frame for MBGC.

First, an encounter with death either validates or invalidates our constructions of the world. Death-related loss can be an unprecedented experience in which one has no prior constructions. It is therefore important to assess the degree to which the loss can be integrated in one’s current experience, and what changes come with integrating this loss. This proposition is in keeping with Janoff-Bulman’s (1992) theory of trauma and loss that contend there are three assumptions that are shaken (Park, 2010) in the aftermath of death: (a) benevolence of the world suggests that individuals generally regard the world as a
safe place, believe in the preponderance of good fortune, and predict that outcomes will be positive; (b) meaningfulness of the world taps the belief that events in the world make sense; and (c) worthiness of the self is a belief of self, that one is inherently good, capable, and moral in thoughts, feelings, and actions.

Second, grief is a uniquely personal and intimate process, highly linked to one's sense of self. When events such as loss disturb one's identity, individuals respond by attempting to interpret them in a fashion consistent with their beliefs, theories, and assumptions about the world. Part of grieving is attending to these deeply-personal and idiosyncratic meanings of loss and involves relearning not only an altered world (Attig, 2001; 2010), but also an altered sense of self.

Third, Neimeyer (2006) argued that grieving is something that individuals do, emphasizing that the bereft have agency in responding to the loss of their loved one. This contention is linked not only to attitudinal responses (Frankl, 1981), but also to the Dual Process Model of grief (Stroebe & Schut, 1999, see below for more details) where individuals can oscillate between actively attending to the loss, as well as engaging in activities that restore their sense of well-being. The implications include exploring with clients the complex and diverse choices they are faced with and facilitating adaptive decision making and responses in the face of loss.

Fourth, grief presents a challenge to the process of reconstructing a personal world of meaning. Individuals may assimilate the loss into a pre-existing structure of personal meaning and derive strength from a re-asserted belief system. Conversely, individuals may accommodate the loss, altering some pre-existing meaning structures that are no longer appropriate in helping them make meaning of the loss. Assimilation and accommodation are represented here as a dichotomy, and it is more likely that individuals may find themselves blending aspects of both in re-establishing a coherent narrative of self (Neimeyer, 2006).

Fifth, the difficult emotions that surface during grief can be conceptualized as indications of one's efforts at making meaning. Neimeyer (2006) argued that feelings serve an important and normative function during grief and can be framed as adaptive and integral to meaning reconstruction. For example, denial can be understood as a temporary cognitive suspension of material due to the fact that an individual may not yet have developed the necessary structure to fully integrate the meaning of the painful loss.

Sixth, Neimeyer (2006) contended that meaning reconstruction following grief occurs within three interdependent social systems: the self, the family, and the broader society. Endorsing the notion that an individual is a complex system existing within the context of a familial and socio-cultural world allows for greater flexibility in contextualizing adjustment difficulties. Specifically, individuals are influenced by multiple socio-cultural systems during their bereavement experience. Expanding upon these notions, the potential of the group allows for individuals similarly affected by loss to construct together a meaningful narrative. Furthermore, it permits the possibility of facilitating a corrective re-capitulation of the primary family group (Yalom & Leszcz, 2005), a group therapeutic factor that
emphasizes the processing of difficult feelings and experiences collaboratively with others in a secure environment.

In addition to the six propositions described above, there is increasing attention paid in the scholarship to the subtle impact by the deceased on the bereft that continues into bereavement. Termed the continuing bond, it is often subsumed under the meaning-making paradigm (Stroebe, Schut, & Boerner, 2010). MBGC attends to the continuing bond as a means to meaning. The characteristics and impact of the continuing bond can been viewed along a continuum from constructive to maladaptive. Constructive bonds may facilitate bereavement adjustment, highlighting adaptive, comforting, and productive imprints (i.e., the legacy of the deceased on the bereft). The bereft may be able to create ways to resituate the deceased symbolically into a re-authored life narrative (e.g., "I am so sad he is gone, but I am so glad for everything he taught me that I will never forget.”) Conversely, certain aspects of the continuing bonds may promote more distress (Field & Filanosky, 2009), often in the cases were the bonds are more concrete (e.g., "I can't stop thinking about him buried at the cemetery). Sometimes the bonds become rigid (e.g., "I keep replaying all those fights we used to have"), repetitive and/or unrelinquished (e.g., "I keep calling out to her that I can't live without her"), or meaningless (e.g., "I don’t understand why she had to die") (see Neimeyer, Baldwin, & Gillies, 2006; Stroebe, Abakoumkin, Stroebe, & Schut, 2011). The goal of MBGC includes attempts to reinforce constructive bonds and challenge maladaptive ones.

Overall, these propositions structure the tasks and themes of MBGC. The meaning-reconstruction approach to bereavement is consistent with constructivist-narrative approaches, which tend to be collaborative in nature and downplay the correction of assumed dysfunctional thoughts, feelings, or behaviors (Carlsen, 1988). It is also growth-and development-oriented, champions process over content, and encourages reflexivity rather than promoting psycho-education (Neimeyer & Bridges, 2003). MBGC is not intended to necessarily resolve in any complete sense the current difficulties of the bereaved individuals.

Empirical Support for Meaning-Making

There is increasing scientific support for the validity of the meaning-making paradigm. However certain aspects are garnering more support, while more cautionary notes are being sounded for others. Going into this evidence base is beyond the scope of this manual. For a discussion of the clinical implications of meaning-making theories and intersecting empirical evidence, the reader is encouraged to read MacKinnon, et al. (2013). For an extensive discussion of recent empirical trends, the reader is directed to a seminal work published by Dr. Crystal L. Park (2010) in Psychological Bulletin.

The Dual Process Model of Grief

In the Dual Process Model of Grief, Stroebe and Schut (1999; 2010) specify that individuals in bereavement will tend towards two orientations. The first is the loss-orientation, which
refers to the tendency of the bereft to focus his or her energies on processing the aspects of the loss itself with the usual focus being on the deceased. Correspondingly, the *restoration-orientation* refers to learning new skills so as to adapt to the changes resulting from the loss. What distinguishes the Dual Process Model from traditional stress-coping theory, is an alternation between loss- and restoration-oriented coping; this alternation is termed *oscillation*. Stroebe and Schut (1999) comment that “at times the bereaved will be confronted by their loss, at other times they will avoid memories, be distracted, or seek relief by concentration on other things” (p.216). A modified version of the original Dual Process Model (Stroebe & Schut, 1999) is used (Figure 1).

Two subtle changes were made to the model for use in MBGC. First, MacKinnon and his colleagues (conditional acceptance a) found that the model tended to be used judgementally by group participants to identify how others were individually progressing (or not progressing) in their grief. This is important to keep in mind when introducing the model, to minimize divisions in the group and allow members to assess their ways of coping in an open, non-judgemental manner. Because the original model has *loss orientation* on the left and *restoration orientation* on the right, it subtly gave the impression to participants that the best way to grieve was to be moving from left to right; moving back to the left was perceived as a form of regression. As such, we transposed (i.e., reversed) the two orientation in the model. Second, to put the model in more colloquial an accessible terms, *loss orientation* was renamed attending to death and *restoration orientation* was renamed attending to life.

*Figure 1: Modified Dual Process Model of Grief (originally based on Stroebe & Schut, 1999). Included with the permission of Francis and Taylor Publishing (License Number 3187831433563) and the permission of the American Psychological Association.*
Short-Term Group Psychotherapy

MBGC adapts a brief group therapy model as articulated by Yalom and Leszcz (2005). This model is best suited to dealing with recent problematic issues over 12 to 20 sessions. The guiding principles of this model include the identification of specific tasks and themes linked to participants therapeutic goals. Thorough screening is recommended to safeguard the viability of the group. The model also champions interpersonal rather than intrapersonal concerns.

Phases, Themes, and Tasks of MBGC

MBGC contains several themes that are incorporated over the duration of three phases of intervention (Beginning, Middle, and Termination). The tasks reflect the contention that the group is instrumental in facilitating a collective and collaborative exploration and reconstruction of both intrapersonal and interpersonal meanings.

Beginning Phase

At the outset of each session, participants are invited to reflect on several specific themes and tasks of meaning reconstruction in loss. The intervention is not expected to follow a linear trajectory. Themes are expected to overlap and be revisited at different times depending on the needs of participants. It is also possible that individual participants will not explore certain themes based on their own sensibilities.

Session 1

The principal matter at the outset is to establish norms of social support and group cohesion that will be maintained for the duration of the intervention. A handout detailing the objectives of the first session can be given to participants (see Appendix A2).

Following a brief welcome and introduction of the group facilitators, the limits of confidentiality are explained to the participants (e.g., active suicidal ideations, active child abuse). Information on seeking support for distress is provided including contact information of the facilitators, as well as phone numbers for emergencies. This information will vary geographically based on community resources; facilitators will have to prepare this independently. Initial introductions by group members can follow. The general framework of MBGC can then be briefly presented to group members (see Appendix A3: Session Breakdown).

Group norms are established in collaboration with group members and are expected to include those suggested by Yalom and Leszcz (2005): confidentiality, regular attendance, punctuality, the importance of self-monitoring, the importance of self-disclosure, the
importance of the group to its members, and the necessary balance between support and confrontation.

In addition, the concept of meaning reconstruction during bereavement can be presented and discussed in colloquial terms. Results of our clinical research study suggest that participants may identify more readily with presenting meaning making as sense making (MacKinnon et al., conditional acceptance a). For example, facilitators can suggest that bereavement is often a difficult experience to make sense of. As such, the goal of the group is to help participants make better sense of their own experience, their response to loss, as well as learn constructive ways to cope, all in collaboration with others members of the group.

Participants are then invited to share what circumstances bring them to the group and why they are seeking help. Participants are also asked to identify any goals they have of participating before the session closes.

Overall, the facilitators can model active listening and appropriate support, while encouraging group members to reflect and identify common and divergent themes in the stories of the participants. At this early point, the facilitators can intentionally introduce a vocabulary of meaning reconstruction when commenting on individual and group process (e.g., How have you made sense of these feelings? What role if any has your spirituality had in helping or hindering your loss? Have certain events been more or less easy to understand? How does this loss fit within your broader life story?).

Lastly, participants are invited at the conclusion of the first session to bring a meaningful object connected with the deceased to share with the group in Session 2. The goal of this activity is to explore the symbolic meaning of these objects, characterize the deceased for other members, and foster group cohesion through sharing.

**Session 2**

Session two adheres to the framework of a traditional bereavement support group following the principles and procedures of grief counselling as outlined by Worden (2009) as well as Yalom and Vinogradov (1988). These principles include actualizing the loss, identifying difficult emotions (e.g., anger, guilt, anxiety, sadness), normalizing responses, and examining current coping style. In addition, participants can be encouraged to contrast the current death with any previous deaths in order to share with other group members a comprehensive characterization of the deceased (Nadeau, 2008). Participants can also share their meaningful objects and the stories associated with them.

**Session 3**

Session three concentrates on encouraging participants to recount significant/meaningful events shared with the deceased (adapted from Breitbart & Poppito, 2010; Breitbart, Rosenfeld et al., 2010). An adapted version of the *Lifeline Exercise* from Lee’s (2004)
Meaning-Making Intervention is also introduced to participants. The *Lifeline Exercise* was adapted in MBGC to the *Griefline Exercise* (Appendix A4). The goal of this activity is to contextualize the bereavement experience in terms of previous losses, as well as build group cohesion and support. It can also be used to explore successful coping strategies used in adapting to previous losses. Difficult life events can also be used as reference points for those that never endured a bereavement loss.

Additional clinical prompts as suggested by Neimeyer (2010a) may be introduced in sessions one to three as needed, including: (a) “What can you tell me about what this loss means to you?” (b) “How would you describe your feelings since the loss on an average day?” (c) “Do you see your grief changing over time?” (d) “What is the most painful part of this experience for you?” (e) “What are the darkest moments of this story?” (f) “What are the parts of this story that others rarely hear?” (g) “Has this loss changed the way you think about life?” (h) “Has this loss changed the way you think about yourself?” (i) “Has this loss changed the way you think about the future?” (j) “How has this affected your relationships with other people?” (k) “What concerns do others have about you?”

**Middle Phase**

The middle phase of the intervention invites participants to engage in constructive meaning-making attempts. Again, the themes of the middle phase sessions are not expected to follow a linear trajectory, and topics may be revisited or introduced earlier.

**Session 4**

Sessions four and five encourage participants to begin to explore and identify implicit or explicit assumptions they have about themselves and the world that may have been shaken after the death. The goal is to facilitate a process of re-establishing a sense of coherence in their life narratives. This will involve inviting participants to identify with, grieve, and rebuild the following assumptions as outlined by Janoff-Bulman (1992). To aid in understanding, participants are provided a handout with clinical prompts to facilitate discussion (Appendix A5).

(A) The assumption of *benevolence of the world* assumes that individuals generally regard the world as a safe place. Grieving this assumption involves reconciling the fact that at times tragedy can occur and the world is not in some ways as safe as it once felt. The challenge becomes rebuilding one’s own feelings of safety and confidence.

(B) The assumption of *meaningfulness in the world* posits that events in the world can be understood. Grieving this assumption involves acknowledging some events are hard to make sense of, or sometimes cannot be made sense of at all.
(C) The assumption of worthiness of the self is the common belief that one is inherently good, capable, and moral person. Following a loss, the belief of the self being worthy is called into question as people begin to realize that bad things indeed do happen to good people (Kushner, 1981). Grieving involves realizing that there is sometimes no connection between decent behavior and tragic events. Essentially, individuals are invited to mourn a belief that bad things don’t happen to them. It involved confronting the natural anxiety surrounding events that can feel random.

The exploration of these three shattered assumptions can be in parallel with encouraging participants to articulate how the loss has validated or invalidated specific personal meanings and assumptions they held. Participants can also be encouraged to begin developing alternative and flexible constructions of the world and self that reflect their new reality in the face of loss.

**Session 5**

The experience of loss is framed by introducing participants to a modified version of the Dual Process Model of Grief (Stroebe & Schut, 1999; Appendix A6). Using the handout, participants are invited to make links between the model and their current experience. They are asked to identify specific loss-oriented activities (e.g., “In what ways are you actively attending to your grief?”), restoration-oriented activities (e.g., “In what ways are you focusing on restoring your life?”), and any effects of oscillation between these two orientations (e.g., “Do you sometimes find yourself pulled in many directions?”).

Participants are also invited to explore how their current diversity of emotions (e.g., sadness, anger, loneliness) may be attempts at meaning making (Neimeyer, 2006). This can be done by encouraging participants not only to identify their feelings, but also to articulate their understanding of their current emotional states (e.g., “How do you understand why you have these feelings?”; “If your body could talk right now, what do you think it might be trying to say?”; “What role do you think these feelings might have in your current experience?”).

**Session 6**

This session encourages participants to reflect on any changes they have experienced in their sense of self and identity (Neimeyer, 2006; Riches & Dawson, 1996). Intervention questions might include: “In what ways, if any, do you feel that you have changed since this loss?” and “How have you experienced these changes or lack of changes?” These alterations in self have been discussed as both positive and negative transformative processes of grieving (Neimeyer, 2000; Neimeyer et al., 2002). These transformations can be extensive if the bereft has assumed new values, organizing principles, roles, and relationships.

Attending to the family system, participants are also asked to comment on ways in which the family has changed, communicates about the loss, shares rituals to acknowledge the
deceased, is influenced by pertinent social cultural factors, or has negotiated difficulties emerging from the loss (Nadeau, 2008). Gender can be part of this discussion, including how gender roles impact the expressions of grief (Doka & Martin, 2010). Differences and similarities in grieving between female and male participants can be explored and compared.

**Sessions 7 and 8**

During these sessions, participants are invited to comment on the meaning of direct or indirect dreams of the deceased, asking participants to elaborate on different aspects of the dream and how they felt during and after the dream. Drawing on features of Hill et al. (2000), participants can express emotions or beliefs that might otherwise be inaccessible. Exploring dreams can be difficult for participants who did not yet dream directly about their deceased loved one. Some may think that a lack of dreaming about the deceased says something about the nature of their relationship to the deceased, perhaps reflecting a lack of love, connection, importance, or the like. It can be therapeutic to probe for other alternative explanations for a lack of dreaming directly about the deceased, such as dreaming about the deceased as being too affect-laden to be remembered. It can also be appropriate to point out that dreams can indirectly represent the deceased, who can be camouflaged behind other symbols. Participants awaiting a dream often assign its meaning as a reunion with the deceased, and they can realize through other members’ sharing that dreaming about the deceased is not always necessarily desired.

Finally, based on the work of Neimeyer (2012a), participants are invited to write with the intention of saying “hello again” to the deceased (Appendix A7). This exercise (as well as the *Life Imprint*, see below) draws on the meaning-based theme of the continuing bond with the deceased. The following prompts are provided in this *Hello Again Letter* for participants to take home in Session 7 to help guide them in writing their letters, and can be used in the group to encourage discussion: (a) “What I have always wanted to tell you is...”; (b) “What you never understood was...”; (c) “What I want you to know about me is...”; (d) “What I now realize is...”; (e) “The one question I have wanted to ask is...”; and (f) “I want to keep you in my life by...”. Participants will be invited to respond to as many of these questions as they desire. One of the goals of this exercise is to externalize aspects of the continuing bond with the deceased that are more and/or less constructive in facilitating bereavement adaptation. The communal sharing of the *Hello Again Letters* is the entire focus of session 8. Facilitators can explore common and divergent themes, participants’ responses to completing (or not completing) the exercise, with corresponding new insights and meanings discovered in the bereavement experience.

**Sessions 9 and 10**

The final sessions of the middle phase mark an attempt to begin synthesizing the gains in the previous group encounters. These sessions introduce Frankl’s (1981) notion of attitudinal responses to events that are beyond one’s control. This is accomplished by encouraging participants to identify ways of regaining power, as well as emphasizing
personal agency and responsibility in negotiating loss. The rationale for leaving this theme until this later stage of the group is based on developmental concerns. Prematurely suggesting to participants that they examine their attitudes may result in a therapeutic rupture. As such, gently suggesting to participants ways in which they can regain a sense of agency later in the intervention may be more sensitive when they feel safer, more connected with others in the group, and able to bear challenges from others.

In addition, participants are invited to identify creative responses to loss, as well as past and present sources of meaning, building on Breitbart et al.’s (2010) meaning-centered group psychotherapy. For instance, the facilitators might ask what past activities have always been meaningful for individuals in addressing their bereavement (e.g., art, music, nature), or brainstorm potential future meaningful activities.

Finally, the Life Imprint Exercise (modeled on the work of Vickio, 1999, with modifications by Neimeyer, 2010a) is presented. Similar to the goals of the Hello Again Letter, participants are invited to complete this written exercise at home (Appendix A8) and share it with the group in the next session (the whole of Session 10).

**Termination Phase**

**Sessions 11 and 12**

These final two sessions attempt to integrate the intensive efforts of meaning making. This phase is largely informed by the work of Epston and White (1995) who challenge traditional psychotherapeutic conceptualizations of termination as loss of the expert therapist for the client. Rather, termination of MBGC can be seen as a rite of passage and the gains experienced by participants drawn out and explored in a series of interrelated questions:

(A) **Orientation questions** call attention to what steps clients have made, what knowledge they have gained, what personal developments they have achieved in the group in the reconstruction of a coherent narrative, and what lessons they learned.

(B) **Unique account questions** examine the process by which clients have made their gains, tracing the unfolding story over the course of MBGC.

(C) **Unique re-description questions** encourage group members to consider alternative knowledge that was created and discovered throughout the course of MBGC.

(D) **Unique possibility questions** concern the future in the context of the past. Epston and White (1995) refer to these as future-oriented/backward-looking questions that invite participants to (a) imagine arriving at some valued destination in life, (b) look back to

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11 For strategies to address ruptures that may occur over the course of a bereavement support group, see MacKinnon, Smith, Henry, Berish, Milman, and Copeland (2012).
identify what steps were needed to arrive there, and (c) identify what steps might still be needed to achieve the desired end.

(E) Circulation questions encourage clients to begin thinking about making links with a broader social network for purposes of sharing their gains, and also for future support. All of these questions can also be explored in the broad story of the group itself, the meta-narrative.

In addition, the initial goals that group members identified at the outset of the group can be explored within the context of these questions.

It is also possible that participants will not be able to readily identify any significant gains, alternative reconstructed narratives, or positive effects of participating. In this instance, exploring with participants any barriers they perceived during the course of the group can be explored, including the identification of activities or discussions that were not had that might have been helpful.

**Literature Related to MBGC**


Appendix A1
USER AND INFORMATION REGISTRATION FORM

You are free to use Meaning-based Group Counselling (MBGC) for bereavement in full or individual aspects, adapt it to your local circumstances or reproduce it without charge providing that you complete the following registration form and agree to the following conditions. This will also allow us to send you updated information when it becomes available.
1. The authors of MBGC will be acknowledged in any publications, reports or presentations that refer or build on said intervention. To reference this manual, please use the following citation:


2. If MBGC is used by others, please ensure that they agree to the user registration form and return this to Christopher J. MacKinnon.

3. MBGC will not be sold or used in any way for profit, either in its original or any adapted form.

I agree to the above conditions.

Your Printed Name: __________________________ Signature: __________________________

Date: __________________________

Organizational Affiliation and Mailing Address:
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Email Address: __________________________

Please mail, fax or scan completed form to:

Christopher J. MacKinnon, Ph.D., Psychologist
Balfour Mount Palliative Care Unit, McGill University Health Center
1650, Cedar Ave. E10, 108.2, Montréal (QC) H3G 1A4
Fax: 514-934-8542 / christopher.mackinnon@mail.mcgill.ca
http://www.mcgill.ca/palliativecare/research/adult-pc-research/chris-mackinnon

Follow new developments of MBGC through Dr. MacKinnon’s profile on www.researchgate.net
### Sufficient Session Breakdown for Facilitators

<table>
<thead>
<tr>
<th>Phase</th>
<th>Session</th>
<th>Themes and tasks</th>
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</thead>
<tbody>
<tr>
<td>Beginning</td>
<td>1</td>
<td>Introductions/Norm setting*</td>
</tr>
<tr>
<td>Phase</td>
<td>2</td>
<td>Introductions continued/Common symptoms and experiences of grief/Sharing meaningful objects</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Meaningful events and the Grief Line Exercise (Breitbart et al., 2010; Lee et al., 2006a, 2006b)</td>
</tr>
<tr>
<td>Middle</td>
<td>4</td>
<td>The Theory of Shattered Assumptions* (Janoff-Bulman, 1992)</td>
</tr>
<tr>
<td>Phase</td>
<td>5</td>
<td>The Dual Process Model of Grief* (Stroebe &amp; Schut, 1999).</td>
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<td></td>
<td>6</td>
<td>Changes in identity and the family system following loss</td>
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<td></td>
<td>7</td>
<td>Dreams/Hello Again Letter Exercise* (Neimeyer, 2012a)</td>
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<td>8</td>
<td>Sharing the Hello Again Letter Exercise</td>
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<td>9</td>
<td>Spiritual, creative, and attitudinal sources of meaning/Life Imprints Exercise* (Neimeyer, 2012b)</td>
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<td></td>
<td>10</td>
<td>Sharing the Life Imprints Exercise</td>
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<tr>
<td>Termination</td>
<td>11</td>
<td>Reinvesting in a new life/Preparing for the end of the group</td>
</tr>
<tr>
<td>Phase</td>
<td>12</td>
<td>Recap of the group/Revisiting therapeutic goals/Looking to the future</td>
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*Indicates distribution of a handout to structure the session
HANDOUT FOR SESSION 1: INTRODUCTIONS AND NORM SETTING

The goals for our first meeting are to:

- Make introductions
- Identifying group norms (rules)
- Share a little bit of the story of your loss
- Discuss how you may/may not have lost some meaning in your life following this loss
- Discuss your expectations of participating in the group
- Identify what goals you would like to achieve by the end of the group
- Discuss other topics you identify as important

********************************************************************************

It is helpful to outline together some group norms (rules) to help structure our time together. To start, we have come up with a few:

1. Confidentiality
2. Regular attendance
3. Punctuality
4. Turning off cell-phones, pagers, etc.
5. Giving and receiving feedback from others: What is helpful and what is not
6. Members are not forced to discuss any issues they do not wish to discuss (Conversely, the more a participant takes part in the discussions, the more they are likely to benefit...)
7. Other norms decided that we can agree on together...
The goal of this exercise is to formulate a *griefline* by identifying significant turning points in the lives of participants from birth to the present.

A line (e.g., use a piece of rope or string) is placed in the middle of the group. Individuals are invited to place themselves on a point of the string corresponding to the place they identified as their present location (use tokens for each person). Birth is at the extreme left of the *griefline*, and the end of their life is at the extreme right. Each participant is asked to mark a space on the line corresponding to their present position. Each participant is then invited to identify one or two significant life events in their past that have had a strong impact on their life; these events may also be marked in some fashion if desired.

<table>
<thead>
<tr>
<th>Birth</th>
<th>Previous significant life events (e.g., losses)</th>
<th>Present location following recent death <em>(Today's date)</em></th>
<th>Death</th>
</tr>
</thead>
</table>

To further the group conversation, participants can be invited to reflect on the following questions:

- What were some major turning points in your life?
- Have you ever experienced anything of this magnitude before?
- How do you understand why you placed yourself at the present location in the griefline? How do you make sense of this location?
- Have there been any changes to your present location on the griefline?
- How do you understand any changes or lack of changes in your present location?
- What goals, hopes, and expectations do you have for the future?
- What are your impressions of the response of other members?
Ronnie Janoff-Bulman (1992) argued that a number of fundamental assumptions that individuals maintain about the world are called into question when traumatic events such as death occur. Namely:

(a) We assume that the **world is a benevolent and safe place**. Grieving involves reconciling the fact that at times tragedy can occur and the world is not, in some ways, as safe as we once felt it was.

(b) We assume that the **world is a meaningful place**, and that all events can be understood. Grieving this assumption involves acknowledging that some events are hard to make sense of, or even cannot be made sense of.

(c) Finally, we assume that inherently **we are good, capable, and moral people**. Grieving involves realizing that there is sometimes no connection between decent behavior and tragic events.

**Some questions to guide our discussion tonight...**

1. How do we integrate this enormous change into our life story?
2. How does one go about rebuilding the pieces of a shaken (or shattered) life?
3. Grief often heightens our sense of randomness in the world: How do we go about making life feel less random and more safe/predictable?
4. How has our sense of **purpose in life** been shaken? What gave us a sense of purpose before? What would need to happen to foster/regain our sense of being more purposeful?
5. What aspects of our loss are particularly senseless or incomprehensible? How have we made sense of other difficult events in our lives? What do we think needs to happen/change for us to begin making sense of our changed life?
6. How can we manage any regrets we feel with regards to this loss?
HANDBOOK FOR SESSION 5: THE DUAL PROCESS MODEL OF GRIEF

Based on Stroebe, & Schut (1999) Adapted for MBGC. Included with the permission of Francis and Taylor Publishing (License Number 3187831433563) and the permission of the American Psychological Association.
A “hello again” letter to your loved one.

Compose a letter to the person who has died. Write with the purpose of saying “hello again,” and not a final goodbye. Try to speak sincerely from your heart, about what is notable in the relationship. You may wish to reflect on what the other has provided you, intentionally or unintentionally, of lasting worth. Give words to the thoughts and feelings that are unspoken and the questions that are unasked.

You may wish to structure your letter using the following prompts:

(a) *What I have always wanted to tell you is*...

(b) *What you never understood was*...

(c) *What I want you to know about me is* ...

(d) *What I now realize is*...

(e) *The one question I have wanted to ask is*...

(f) *I want to keep you in my life by*...

Participants are invited to respond to as many of the above questions as they desire, address other related questions or material at their discretion, and bring their writing to the next group and share.

In a sense, we are all ‘pastiche personalities’ reflecting bits and pieces of the many people whose characteristics and values we have unconsciously assimilated into our own sense of identity. This “inheritance” transcends genetics, as we can be powerfully or subtly shaped not only by our parents, but also by mentors, friends, siblings, or even children we have loved and lost. Not all these life imprints are positive; at times, we can trace our self-criticism, distrust, fears, and emotional distance to once-influential relationships that are now with us only internally. Take a few moments privately to trace the imprint of an important figure in your life at your discretion, and be prepared to discuss some of your reflections.

The person whose imprint I want to trace is:____________________________
This person has had the following impact on:

My mannerisms and gestures:

My ways of speaking:

My work and pastime activities:

My feelings about myself and others:

My basic personality:

My values and beliefs:

The imprints I would most like to relinquish or change are:

The imprints I would most like to affirm and develop are:

Participants are invited to respond to as many of the above prompts as they desire, address other related material at their discretion, and bring their writing to the next group and share.

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1 This handout is a direct citation from Neimeyer, R. A. (2010a). Grief therapy and meaning-reconstruction. Accredited continuing education workshop presented at the Annual Convention of the American Psychological Association, San Diego, CA. Workshop Handout. See also Neimeyer (2012b).
TREATMENT FIDELITY AND INTEGRITY THEMATIC CHECKLIST

To be completed independently by facilitators (and research-assistants/observers if applicable) at the conclusion of each session and compared for purposes of arriving at consensus and evaluating reliability.

Date: ____________________________
Session: __________________________
Session Number: __________________

For the following items, please mark the degree to which they were explored in today’s session in terms of frequency

1= not at all, 2=very little, 3=somewhat, 4=often, 5=very often, 6=not applicable

<table>
<thead>
<tr>
<th>GROUP PROCESSES THEMES</th>
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<tbody>
<tr>
<td>1 Evidence of strong group cohesion and support</td>
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<td>2 Observe interactional group communication</td>
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<td>3 Group stayed on appropriate tasks/themes of the session</td>
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<td>4 Appropriate closure at end of session</td>
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<td>5 Common narratives</td>
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<td>6 Divergent narratives</td>
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<td>7 Group ruptures (between members) observed</td>
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<td>8 Therapeutic ruptures (with therapists) observed</td>
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<th>TRADITIONAL GRIEF INTERVENTION PRINCIPLES/THEMES</th>
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<tr>
<td>9 Participants explored affective reactions to loss (e.g., sadness, guilt, anger)</td>
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<td>10 Participants identified cognitive factors in adapting to loss (e.g., disbelief, confusion, difficulties concentrating, preoccupations, sense of presence, hallucinations; Worden, 2009)</td>
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<td>11 Participants identified behavioural factors in adapting to loss (e.g., sleep and appetite disturbances, dreams, crying, visiting places that remind of the deceased, treasuring objects that belonged to the deceased, absentminded behaviour,</td>
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<td>12</td>
<td>Participants identified social factors in adapting to loss (e.g., loneliness, withdrawal, isolation, support)</td>
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<td>Participants identified therapeutic goals</td>
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<td>14</td>
<td>Participants identified progress in attaining therapeutic goals</td>
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<td>15</td>
<td>Participants reported how they are coping</td>
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**GRIEVING SHAKEN ASSUMPTIONS THEMES**

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<td>Participants examined benevolence of the world</td>
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<td>2</td>
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<td>Participants examined meaningfulness of the world</td>
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<tr>
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<td>Participants examined worthiness of the self</td>
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<td>2</td>
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<tr>
<td>19</td>
<td>Participants examined validations, invalidations, and challenges to constructions of the world and self</td>
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**DUAL PROCESSES OF COPING WITH LOSS AND MEANING-RECONSTRUCTION THEMES**

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<tr>
<td>20</td>
<td>Loss-oriented grief</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>21</td>
<td>Restoration-oriented grief</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>22</td>
<td>Participants shared dreams and attempted to make sense of them</td>
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<td>2</td>
<td>3</td>
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<td>Participants contrasted current loss with previous losses</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>24</td>
<td>Participants characterized the deceased</td>
<td>1</td>
<td>2</td>
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<td>4</td>
<td>5</td>
</tr>
<tr>
<td>25</td>
<td>Participants explored and developed alternative narratives, reframed events</td>
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<td>26</td>
<td>Participants reconstructed identities as survivors of loss in negotiation with others</td>
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<tr>
<td>27</td>
<td>Participants explored how emotions are attempts at meaning making</td>
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<tr>
<td>28</td>
<td>Participants explored positive and negative transformations in identity and sense of self</td>
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<tr>
<td>29</td>
<td>Participants discussed attitudinal responses to loss</td>
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<tr>
<td>30</td>
<td>Group meta-narrative explored</td>
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<td>31</td>
<td>Participants explored creative responses to loss</td>
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<tr>
<td>32</td>
<td>Participants explored past and present sources of meaning</td>
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<tr>
<td>33</td>
<td>Participants explored ways in which they are attempting to make sense of their loss</td>
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<td>34</td>
<td>Participants explored spiritual beliefs</td>
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<td>35</td>
<td>Life imprints</td>
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<td>36</td>
<td>Continuing bonds with the deceased</td>
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<tr>
<td>THERAPIST BEHAVIORS THEMES</td>
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<td>37 Therapists offered group-as-a-whole interventions</td>
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<td>38 Therapists elicited feedback from participants</td>
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<tr>
<td>39 Therapists offered suitable challenges to participants</td>
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<tr>
<td>40 Therapists were active in the session</td>
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<td>41 Therapists offered support to members and group</td>
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<tr>
<th>OTHER SIGNIFICANT THEMES IDENTIFIED</th>
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<td>42 Participants reported embracing a new challenge</td>
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<td>43 Participants reported renewed sense of confidence/agency</td>
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<tr>
<td>44 Participants reported reinvesting in life</td>
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</table>
SCREENING PROTOCOL (Adapted from Keefler, 2005).

When possible, interviews should be conducted jointly by two group facilitators.

**Identifying Information**

Date: ...............................................................  
Participant Identification: .............................................  
Name of Participant: ...................................................  

**Contact Information:**  
Mailing Address..........................................................  
..............................................................  
..............................................................  
A phone message can be left at.............................................  
Email (optional) .......................................................  

Source of Referral (if any) ..............................................  

**Initial Grief Assessment**

- Can your briefly describe the loss you experienced? What was your relationship to the deceased? How would you describe the nature of your relationship? (e.g., strong, loving, difficult, unresolved).

**General Functioning**

- How do you manage to cope with stress, now and in the past?

**History of General Mental Health Functioning and Difficulties**

- Do you have any history of seeking mental health services in the past? What was it related to? What was the nature and duration of treatment? (e.g., 15 week Cognitive-Behavioural Therapy).  
- Are you currently being followed by a mental health practitioner? For how long and what modality (i.e., individual, couple, family, group)?  
- Severity: Assess the disruption in the individual’s present functioning and degree of distress.  
- Past Solutions: Solutions participant has already tried in addressing previous mental health problems.
- Contributing Factors: Any current factors that contribute to the perpetuation of the problem (e.g., cultural, environmental, life cycle, discrimination or systemic variables related to the problem)?
- Have you ever, or are you currently taking any form of medication (e.g., antidepressants, anti-anxiety, anti-psychotics)?

**Complicated Grief Assessment**
- Please describe any difficulties you have had in adapting to the loss.
-Severity: Assess the disruption in the individual’s present functioning and degree of distress.
-Duration/Frequency: The frequency of the problem(s) and its/their duration.
-Meaning: Includes the meanings and beliefs that the participant attaches to the problem that may perpetuate the problem.
-Past Solutions: Solutions the participant has already tried in addressing her/his grief or previous problems.
-Contributing Factors: Any current factors that contribute to the perpetuation of problem (e.g., cultural, environmental, life cycle, discrimination or systemic variables related to the problem)?
-Do you have any symptoms about which you have questions?
-How hopeful are you that you will be able to adapt to this loss?

**Assessment of Ability to Function in a Group** (Piper, Ogrodniczuk, Joyce, & Weideman, 2011)
- Motivation: The participant’s motivation to participate in group counselling focused on grief
-Prompt: “Have you ever been part of a support group, group psychotherapy, or any other groups? If yes, please describe when, the duration, and the nature.”
-Prompt: “How comfortable and willing would you be to share some of your experiences of loss with others similarly affected?”
-Prompt: “What are your hopes/expectations of the group?”
-Prompt: “What kind of support are you seeking from the group?”
-Prompt: “Are there any difficulties you anticipate in participating in a group?”

**Final decision to invite participant to group:**
Yes:...........................No:...........................

If not appropriate, participant referred to: ..............................

1 = Individual Counselling / Psychotherapy  2 = Medical Referral
3 = Psychiatric Evaluation  4 = Addiction Centre
5 = Other (please describe) ..........................................................................

---

12 Facilitators may wish to have individuals complete the Prolonger Grief Disorder-13 (PG-13, Prigerson & Maciejewski, 2008) and/or the Dimensional Complicated Grief Assessment (Shear et al. 2011) to assist with assessing grief severity.
RECOMMENDED LITERATURE FOR FAMILIARIZATION AND TRAINING

The following articles and texts are recommended background reading for facilitators prior to delivery of MBGC.


*Death Studies, 23,* 161-175.


## Appendix B

### PSYCHOMETRIC PROPERTIES OF OUTCOME MEASURES

<table>
<thead>
<tr>
<th>Outcome Measure and Author</th>
<th>Scoring and Interpretation</th>
<th>Reliability</th>
<th>Validity</th>
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</thead>
</table>
| Purpose in Life (PIL) Test (Crumbaugh & Maholick, 1964, 1981) | • The PIL has 15 items. Each item of the PIL is ranked on a 7-point Likert-type scale. No items are reversed scored. Individuals’ scores are summed to provide a total score ranging from 7 (corresponding to low purpose) to 105 (corresponding to high purpose). | • Shek (1988) reported a five-factor solution with two general factors (*existence* and *death*) in a Chinese version of the PIL.  
• Reker and Cousins (1979) reported a six-factor solution (*general purpose in life, goal seeking, goal achievement, contentedness with life, existential vacuum, and futuristic aspirations*).  
• Chamberlain & Zika (1988) reported four divergent factors (*commitment and goal achievement, excitement and enthusiasm with life, being in control, and contentedness with life*).  
• Crumbaugh and Maholick (1964) originally reported that the PIL split-half reliability coefficient was 0.90, with a later study reporting 0.92. (Crumbaugh & Maholik, 1968).  
• Seeman (1991) similarly reported that the PIL had an internal consistency coefficient of 0.91. | • Marsh, Smith, Piek, and Saunders (2003) reported in a sample of alcohol users evidence of strong criterion validity with higher PIL scores associated with low alcohol dependence. Support for the scale's convergent and discriminant validity has also been reported (Seeman, 1991). For example, Simmons (1980) reported that meaning in life as measured by the PIL was positively associated with the ability to make value judgments about the self as measured by the Hartman Value Profile. Furthermore, it was found that the PIL negatively correlated with present and anticipated future satisfaction as measured by the Self-Anchorinign Striving Scales. Conversely, the PIL was not related significantly with the past subscale of the Self-Anchorinign Striving Scale. |
The Grief and Meaning-Reconstruction Inventory (GMRI; Gillies, 2006)

- The GMRI has 29 items. Each item is fully anchored on a 5-point Likert scale with ranges from strongly disagree to strongly agree. Seven items are reversed scores. Items are summed to provide a total score. Individual scores range from 29 (low meaning reconstruction) to 145 (higher meaning reconstruction).

- Exploratory factor analyses identified five principal subscales including continuing bonds, personal growth, sense of peace, emptiness and meaninglessness, as well as valuing life. Emptiness and meaninglessness were positively correlated with the Inventory of Complicated Grief (correlations ranging from 0.50 to 0.68).

- Cronbach's alpha for the GMRI ranged from 0.81 to 0.82. Regarding test-retest reliability, the Pearson's correlation coefficient was 0.71.

- Convergent and discriminant validity analysis of the GMRI showed significant negative correlations with well-validated distress measures (for example, the Inventory of Complicated Grief, Hogan Grief Reaction Checklist, and the Hopkins Symptom Checklist). For example, full scale GMRI and the Inventory of Complicated Grief were significantly negatively correlated (correlations ranging from -0.31 to -0.39).
The Integration of Stressful Life Experiences Scale (ISLES; Holland et al., 2010)

- The ISLES has 16 items. In scoring the ISLES, one item is reversed scored and then all items are summed to produce a total score. The range of the scale is from 16 to 80, with higher scores indicating the ability to integrate difficult experiences with corresponding increases to internal coherence and hope for the future.

- Confirmatory factor analysis with a bereaved sample revealed a model with two subscales: footing in the world and comprehensibility. The model fit the data well, CFI = 0.93; SRMSR = 0.076; RMSEA = .072.

- The Cronbach's alphas for the ISLES were 0.92 in a general stress sample and .94 in a bereaved sample. Test-retest reliability correlations were conducted approximately 3-months after the initial assessment with r = 0.57 for both the general stress sample and the bereaved sample.

- Similarly high Cronbach Alpha’s for the ISLES were recently reported by Lichtenthal, Burke, and Neimeyer (2011) (i.e., á = 0.94). Test re-test reliability was consistent, with correlations conducted approximately three months after the initial assessment (r = 0.57 for both the general stress sample and the bereaved sample).

- Higher scores on the ISLES were generally associated with positive aspects of the World Assumptions Scale (benevolence and self-worth), though not significantly with the meaningfulness subscale. Furthermore the total ISLES and ISLES subscales were positively associated with the perceived general health subscale of the SF-36 and negatively associated with psychological distress as measured by the Symptom Checklist-Revised (SCL-10-R). The ISLES was negatively associated with prolonged grief symptoms as measured by the Inventory of Complicated Grief-Revised. Construct validity was not reported.
State-Trait Anxiety Scale (STAI; Spielberger et al., 1983)

- The STAI has 40 items, all anchored on a 4-point Likert scale ranging from *almost never* to *almost always*. The STAI is scored using a scoring template with differential weights associated with each item. 19 items are reverse scored. The Scale range for both the STAI State and TRAIT subscale is 20 to 80. Higher scores are indicative of higher anxiety with lower scores corresponding to low anxiety.

- Primary factor analysis found four underlying subscales: *State (S)-Anxiety Present; S-Anxiety Absent; Trait (T)-Anxiety Present; and T-Anxiety Absent.*

- For the S-Anxiety scale, Cronbach’s alphas in diverse samples of males and females ranged from 0.86 to 0.95. The T-Anxiety scale had similar strong Cronbach’s alpha levels, ranging from 0.89 to 0.91. Spielberger et al. (1983) found that test-retest coefficients for the T-Anxiety scale ranged from 0.65 to 0.86, and for the S-Anxiety scale, test-retest coefficients ranged from 0.16 to 0.62.

- Spielberger et al. (1983) explored construct validity of the S-Anxiety scale with military recruits in a high stress situation (*mean* = 44.05 to 47.01) and high school students in comparably lower stress conditions (*mean* = 39.45 to 40.54).

- Correlations with other measures of trait-anxiety indicate strong correlations. For example, correlations between the STAI and the Taylor Manifest Anxiety Scale, the IPAT Anxiety Scale, and the Multiple Affect Adjective Check List ranged from 0.73 to 0.85.
Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977)

- THE CES-D has 20 items, all anchored on a 4-point Libert Scale. 4 items are reversed scored. It assess feeling and behaviors of depression within the past week. Each item response scale is from 0 to 3 (none of the time (<1 day) to most of the time (5-7 days). Item scores are summed. Five or more missing items invalidate the questionnaire. Scores of 16 or higher are indicative of clinical depression.

- Four subscales have consistently been reported in the literature: depressed affect, positive affect, somatic symptoms/motor retardation, and interpersonal problems.

- Cronbach’s alpha of 0.85 in a general population sample and 0.90 for a psychiatric-patient sample. Split-half reliability ranged from 0.76 to 0.85, and test-retest reliability was 0.76 (as reported by McDowell & Newell, 1996).

- The CES-D has been tested with diverse measures and found to provide strong validity. For example, convergent validity was established with correlations ranging from 0.44 at admission to 0.69 after treatment with the Hamilton Depression Scale. The CES-D was found to have the following correlations with the Raskin Depression Rating Scale: 0.54 at admission and 0.75 after treatment. Finally, the CES-D showed high sensitivity for detecting depression in diverse patient groups (99% for acute depression, 94% for alcohol dependence, and 93% for schizophrenia; McDowell & Newell, 1996).
Revised Grief Experience Inventory (RGEI; Lev et al., 1993; Sanders, Mauger, & Strong, 1985)

- The 22 items of the RGEI use a 6 point Likert-type scale ranging from slight disagreement to strong agreement. All items are reversed scored. Higher scores correspond to heightened existential distress, depression, guilt, and/or physical distress.

- Cronbach’s alpha for the original scale was reported to be 0.93. Other studies have reported even more robust alpha scores. For example, Kowalski and Bondmass (2008) reported an alpha of 0.95. Later, Engelkemeyer and Marwit (2008) reported 0.96.

- There are limited psychometric data on the RGEI. Factor analysis performed by Lev, Munro, and McCorkle (1993) found four underlying factors accounting for 57.7% of the total variance: existential concerns, depression, tension and guilt, and physical distress (respective alpha coefficients of .87, .80, .72, and .83).

- To the present authors’ knowledge, there have been no validity studies assessing the RGEI.
The CBI has questions that refer to common symptoms of grief that the respondent is instructed to answer on a 4-point scale of frequency with anchors of continuously/always/alot of the time, quite a bit of the time, a little bit of the time, and never. The CBI is scored by adding all 17 items together to form a total score. Lower scores on the CBI are indicative of more symptoms of grief.

The items of the CBI are statistically grouped into the following subscales: Images and thoughts (alpha = 0.74); acute separation (alpha = 0.77); and grief (alpha = 0.86). Byrne and Raphael (1997) reported the Cronbach’s alpha as 0.91. Test-retest reliability of the CBI was not reported.

A recent article by Holland, Nam, and Neimeyer (2012) reported an equally high Cronbach Alpha (0.95). This study also included exploratory and confirmatory factor analysis, yielding a two-factor structure with strong internal consistency (thoughts α = 0.87; emotional response to loss α = 0.93).

Convergent validity for the CBI is strong, with correlations with the following subscales of the Texas Revised Inventory of Grief: Past life disruption $r = 0.77$ and present emotion of grief $r = 0.86$. 
The 61 item HGRC uses a 5-point Likert scale for each item to assess multiple aspects of grief the respondent has experienced in the past two weeks. 12 items are reverse scored. There is no total score for the HGRC as the Personal Growth subscale is negatively correlated with the other subscales. Instead, the score for each subscale is completed by summing the corresponding items. Subscale ranges include blame and anger (7-35), despair (13-65), detachment (8-40), disorganization (7-35), panic behavior (14-70), and personal growth (12-60).

- Exploratory factor analysis by Hogan et al. (2001) was conducted on a bereaved adults sample (N = 586). As reported by Neimeyer, Hogan, and Laurie (2008), the Cronbach’s alphas of the HGRC were consistent across the following six subscales including despair (alpha = 0.89), detachment (alpha = 0.87), disorganization (alpha = 0.84), panic behaviour (alpha = 0.90), blame and anger (alpha = 0.79), and personal growth (alpha = 0.82). The test–retest reliability was between 0.56 and 0.85 over a 4-week interval.

- With regard to convergent and discriminant validity, Neimeyer et al. (2008) reported positive correlations between the HGRC and other measures of grief. Specifically, the authors reported that correlations were higher with similar variables (e.g., HGRC despair subscale and Grief Experience Inventory despair subscale, r = 0.60). Furthermore, higher correlations were found with the Texas Revised Inventory of Grief present subscale (correlations ranged from 0.33 to 0.46) than the Texas Revised Inventory of Grief past subscale (correlations ranged from 0.13 to 0.33).
Appendix C

INFORMED CONSENT: STAGE 1

The development and pilot testing of a meaning-centered group counselling intervention for bereavement.

Research Team

Student/Group Co-Leader
Chris MacKinnon, MA, OPQ
Intervention Co-leader
PhD Candidate, Counselling Psychology, McGill University
Psychology Intern, Psychosocial Oncology Program, Montreal General Hospital
514-340-8222 ext. 5697

Research Supervisors
S. Robin Cohen, PhD, Research Co-Supervisor
Associate Professor, Departments of Oncology and Medicine, McGill University
Project Director, Jewish General Hospital
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Nathan G. Smith, PhD, Research Co-Supervisor
Assistant Professor, Department of Educational and Counselling Psychology, McGill University
514-398-3454

Group Co-Leader
Melissa Henry, PhD, OPQ
Intervention Co-Leader
Adjunct Professor, Department of Oncology, McGill University
Psychologist, Head and Neck Oncology Service, Segal Cancer Center, Jewish General Hospital

Research Assistant
Melanie Berish, MA, OCCOPPQ
Research Assistant
Guidance Counsellor, Champlain College

Purpose of the Study
You are being asked to participate in a study which has the goal of assisting individuals in adapting to the death of a family member or friend. Before deciding to participate in this study, it is important that you clearly understand its requirements, risks, and benefits. The nature of this study will be explained to you in detail by the interviewer (Chris MacKinnon) in person. You are also invited to read this form carefully and ask any questions you have to the interviewer. You may take this form with you and discuss the study with anyone else before making your decision. If you decide to participate you will be asked to sign two copies of this form, one of which will be given to you.
Description of Participation in the Study
The goal of the present study is to develop a group counselling intervention designed to allow participants to share their stories and make better sense of their recent loss. Between 8 and 12 participants will be invited to take part in the group which will be co-led by two experienced psychologists (Chris MacKinnon and Dr. Melissa Henry) who both have expertise in the area of bereavement.

The meaning-centered group counselling intervention for bereavement will include 12 sessions of 90 minutes in duration. The goal of the group is to provide support to individuals who have experienced a death-related loss. Participants will be encouraged to listen to and share stories of their loved ones. They will be invited to give and receive support from others, discuss how life has changed, and explore how to make sense of the loss. A series of tasks and themes, largely informed by an approach to grief counselling called meaning reconstruction will help structure the group sessions. Participants will also be encouraged to articulate their needs and desires in shaping the functioning of the group.

If you choose to participate in this study, one of the group leaders or the Research Assistant will phone you to set up an appointment for an initial individual meeting/interview. The goal of the interview is to consider together whether the study is most appropriate for you or to explore other options for support. This interview will be arranged at a time of mutual convenience. You can ask questions you have about the study during this meeting/interview. The interview will take approximately one hour, which includes the completion of approximately 7 questionnaires.

The exact dates of the intervention will only be set once the schedules of all participants are reviewed and a mutually convenient time is determined. The location of the group will be at the Hope & Cope Wellness Center, 4635 Cote-Saint Catherine Road, Corner Lavoie, easily accessible by public transportation. Metered parking is available on the street. Parking is also available at the Jewish General Hospital, and is free in the evening. You will also be asked to complete a seven questionnaires which will take between 20 and 25 minutes. (a) At the end of the first meeting/interview; and (b) At the conclusion of the intervention. The questionnaires have only been scientifically validated with an English speaking population. As such, the questionnaires will only be available in English. Participants will also be invited to participate in four brief feedback sessions of 5 to 10 minutes at the end of sessions 3, 6, 9, and 12.

You will also be asked to participate in a follow-up interview with the Research Assistant at the conclusion of the group to obtain your feedback on how we might improve the intervention in the future. This interview will be arranged at a time of mutual convenience. The interview will take approximately 30 minutes.

Observation of Sessions
A Research Assistant (Melanie Berish) will be present to observe the sessions and take detailed notes. The research assistant is bound to confidentiality in what she observes and writes. Her observations will only be shared with the research team.

Audio Recording of Sessions
The sessions will be audio-recorded to help the leaders and researchers better understand the functioning of the group. The audio recording will be transcribed verbatim removing all identifying information. The transcripts will possibly be used in future studies which explore finding meaning in grief. Both the tapes and the transcripts will be kept for a period of five and then destroyed.

**Voluntary Participation / Withdrawal**
Participation in this study is purely voluntary and you can withdraw at any time. You do not have to answer any question, either on the questionnaires or during the group sessions, that you do not feel comfortable with. Should a participant be unable to attend a given session they will be encouraged to indicate such as soon as possible in the group or contact Chris MacKinnon by phone to advise him. Reasonable absence by participants will be accommodated based on the clinical judgment of the leaders. However, more than two absences without explanation to the group or the leaders may result in participants’ discontinuation from the study. In addition, should a participants’ absence be adversely affecting the group-as-a-whole, participants will be asked to withdraw from the study.

**Risks and Discomfort**
Some people may find that discussing their experiences raises unpleasant feelings, memories or thoughts. The group leaders will be open to any concerns or questions you wish to express during the study. You will not be compelled in any way to share personal material you do not wish to share. If you experience any significant distress during the course of the intervention, additional support will be offered to you in the form of a referral to the most appropriate health care practitioner. Finally, because this is a new intervention we cannot foresee all possible risks.

**Potential Benefits**
We do not know if you will receive any benefits from participating in this study. However, potential benefits of participating in this study may include that you will find adapting to your present loss easier, in part due to receiving support from others similarly affected. Because your feedback will be regularly solicited, your participation will help shape an intervention that may benefit others similarly affected by loss. Finally, your participation may help guide future counsellors, social workers, and psychologists in providing therapeutic interventions to bereaved individuals.

**Cost and Reimbursement**
You will not be offered any compensation for your participation in this study. There are no costs related to participating in the study itself. We do not expect that your participation will create any additional costs for you.

**Confidentiality**
All data obtained during this study will be kept strictly confidential and will be identified only by a code number. Only the members of the research team will have access to the documents containing your personal information. The present study is in partial fulfillment of the doctoral degree in Counselling Psychology at McGill University of Chris MacKinnon. Your name will not be associated with any of the information presented in the reports, presentations, or publications expected to result from the study. Personal information collected will be used only
to describe the collective characteristics of all participants in the study. The Research Ethics Committee of the Jewish General Hospital may review the records containing your personal information in order to ensure the proper ethical management of the project. All data will be kept in a locked filing cabinet and a password-protected and secure digital storage device in the locked office of Chris MacKinnon in Palliative Care Research at the Jewish General Hospital. The information will be kept for five years after publication of the study results and then destroyed.

Confidentiality is a fundamental principle of counselling and psychology. The delivery of the intervention will adherence to the strict ethical code of L’Ordre des Psychologues du Quebec which is available for you to consult at http://www.ordrepsy.qc.ca/en/protection/code_ethics.html. In rare circumstances, the leaders may be legally required to release a limited amount of information to responsible authorities, with the participant’s best interests taken into consideration; for example, when there is real and imminent danger to yourself and/or others. Participants will also be asked to keep what they have heard from other participants in the group sessions confidential.

If you withdraw (or are withdrawn) from this study, any information collected up to the point of withdrawal for the purpose of this research may still be used in order to protect the scientific integrity of the study.

Questions and Contact Information:
If you have any questions or desire further information with respect to this study you may contact Chris MacKinnon at 514-340-8222 ext. 5697, Dr. Robin Cohen at 514-340-8222 ext 5676, or Dr. Nathan Smith, 514-398-3454. For information about your rights as a participant in the study, or concerns about risks, you may contact the Jewish General Hospital Local Commissioner of Complaints & Quality of Services, Rosemary Steinberg, at (514) 340-8222 ext. 5833.
Declaration of Consent

I have read this consent form and I voluntarily agree to participate in the study entitled “The development and pilot testing of a meaning-centered group counselling intervention for bereavement.” I have had the opportunity to ask questions and all my questions have been sufficiently answered to my satisfaction. I will be able to keep a copy of the consent form for my own records. I have been informed that my participation in this study is entirely voluntary and that I may refuse to participate or withdraw from this study at any time without consequence. I may ask now or in the future any questions about this study. I have been assured that records related to this study will be kept confidential and that no information about me will be released or printed that would disclose my personal identity. This consent is valid until the study is completed; however, I may discontinue my participation in this study at any time without penalty of any kind. By signing this consent form, I do not give up any of my legal rights.

I agree to participate in the follow-up interview.

Yes ☐ No ☐ Initials: __________________

I hereby consent to participate in the study.

Participant __________________ Signature __________________ Date __________

Co-Leader __________________ Signature __________________ Date __________

[Stamp: RESEARCH ETHICS 22 JUN 2010 APPROVAL]
Consentement éclairé : Stade 1

L’élaboration et l’essai pilote d’une intervention de thérapies de groupe centrée sur le sens dans le deuil.

Équipe de recherche

Étudiant/Co-meneur du groupe
Chris MacKinnon, M.A., O.P.Q.
Co-meneur de l’intervention
Candidat au doctorat, Psychologie de l’orientation, Université McGill
Stagiaire en psychologie, Programme en oncologie psychosociale, Hôpital général de Montréal
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Superviseurs de recherche
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Professeure agrégée, départements d’oncologie et de médecine, Université McGill
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Co-meneuse du groupe
Melissa Henry, Ph.D., O.P.Q.
Co-meneuse de l’intervention
Professeure auxiliaire, Département d’oncologie, Université McGill
Psychologue, Service d’oncologie cervico-faciale, Centre du cancer Segal, Hôpital général juif

Adjointe à la recherche
Melanie Berish, M.A., O.C.C.O.P.P.Q.
Adjointe à la recherche
Conseillère d’orientation, Collège Champlain

But de l’étude
On vous demande de participer à une étude dont le but est d’assister les gens à s’adapter à la mort d’un membre de la famille ou d’un ami. Avant de décider de participer à cette étude, il est important que vous compreniez clairement ses exigences, ses risques et ses avantages. La nature de cette étude vous sera expliquée en détail par l’intervieweur (Chris MacKinnon) en personne. On vous invite également à lire ce formulaire attentivement et à poser toutes vos questions à l’intervieweur. Vous pouvez apporter ce formulaire avec vous et discuter de cette étude avec toute autre personne avant de prendre une décision. Si vous décidez de participer, on vous demandera de signer deux copies de ce formulaire, dont une vous sera remise.
Description de la participation à l’étude
Le but de l’étude est d’élaborer une intervention de thérapies de groupe conçue pour permettre aux participants de partager leur histoire et de donner un sens à leur perte récente. Entre 8 et 12 participants seront invités à participer au groupe, qui sera co-mené par deux psychologues expérimentés (Chris MacKinnon et Melissa Henry) ayant tous deux une expertise dans le domaine du deuil.

L’intervention de thérapies de groupe centrée sur le sens dans le deuil comprendra 12 séances de 90 minutes chacune. Le but du groupe est d’offrir un soutien aux gens qui ont vécu la mort d’un proche. Les participants seront encouragés à écouter et à partager des histoires au sujet de leur proche décédé. Ils seront invités à offrir du soutien aux autres et à accepter le leur, à discuter de comment la vie a changé et à explorer comment donner un sens à cette perte. Une série de tâches et de thèmes, surtout inspirée par une approche en conseil du deuil nommée la reconstruction du sens, aidera à structurer les séances de groupe. On encouragera également les participants à articuler leurs besoins et leurs désirs pour façonner le fonctionnement du groupe.

Si vous choisissez de participer à l’étude, l’un des meneurs du groupe ou l’adjointe de recherche vous téléphonera afin de fixer un rendez-vous pour une entrevue/rencontre individuelle initiale. Le but de l’entrevue est de décider ensemble si cette étude est appropriée pour vous et d’explorer d’autres options de soutien. Cette entrevue sera arrangée à un moment qui vous convient. Vous pouvez poser les questions que vous avez au sujet de cette étude lors de cette entrevue/rencontre. La durée de l’entrevue sera approximativement une heure, incluant de 20 à 25 minutes pour remplir environ 7 questionnaires.

Les dates exactes de l’intervention ne seront décidées que lorsque les horaires de tous les participants seront revus et qu’un moment convenant à tous sera déterminé. Le lieu des séances sera le Centre L’espoir, c’est la vie 4635, chemin de la Côte-Sainte-Catherine, coin Lavoie, facilement accessible en transport en commun. Des espaces de stationnement avec parcomètres sont également disponibles sur la rue et le stationnement de l’Hôpital Général Juif est gratuit en soirée. On vous demandera de remplir une série de questionnaires à deux moments différents : (a) à la fin de la première entrevue/rencontre; et (b) à la fin de l’intervention. Les questionnaires ayant été scientifiquement validés qu’auprès d’une population anglophone, seule la version anglaise est disponible. Les participants seront invités à donner leurs commentaires lors de 4 brèves séances de retour de 5 à 10 minutes à la fin des séances 3, 6, 9 et 12.

On vous demandera également de participer à une entrevue de suivi avec l’adjointe de recherche à la conclusion des séances pour obtenir vos commentaires sur la manière dont on pourrait améliorer l’intervention à l’avenir. Cette entrevue de 30 minutes aura lieu à un moment déterminé selon les disponibilités de l’adjointe de recherche et du participant.

Observation des séances
Une adjointe de recherche (Melanie Berish) sera présente pour observer les séances et prendre des notes détaillées. L’adjointe de recherche est liée par la confidentialité dans ce qu’elle observe et écrit. Ses observations ne seront partagées qu’avec l’équipe de recherche.

Enregistrement audio des séances
Les séances seront enregistrées par audio pour aider les meneurs et les chercheurs à mieux comprendre le fonctionnement du groupe. L’enregistrement audio sera transcrit textuellement et dépourvu de toutes informations pouvant servir à l’identification des participants. Ces transcriptions pourront être utilisées dans de futures études explorant le sens à trouver dans le deuil. Les enregistrements et transcriptions seront gardés pour une période de 5 ans puis détruits.

**Participation volontaire**
La participation à cette étude est entièrement volontaire, et vous pouvez vous en retirer en tout temps. Vous ne serez pas tenus de répondre aux questions qui vous mettent mal à l’aise que ce soit dans le cadre d’un questionnaire ou durant les thérapies de groupe. Dans le cas où un participant n’est pas en mesure d’être présent à une séance, il sera encouragé à en faire part lors de la séance ou de contacter Chris MacKinnon par téléphone le plus tôt possible. Une absence jugée raisonnable sera admise selon le jugement clinique des meneurs du groupe. Cependant, plus de deux absences sans explications au groupe ou au meneur du groupe pourront mener au retrait du participant. De plus, le retrait d’un participant serait également envisagé dans le cas où son absence entraînerait des effets néfastes pour le groupe.

**Risques et malaise**
Certaines personnes trouvent que discuter de leur expérience ravive des pensées, des sentiments ou des souvenirs déplaisants. Les meneurs du groupe seront ouverts à tous vos soucis et vos questions au cours de l’étude. Vous ne serez pas forcé à partager des choses personnelles dont vous ne voulez pas parler. Si vous vivez une détresse significative au cours de cette intervention, on vous offrira du soutien supplémentaire sous forme d’une orientation vers le professionnel de la santé le plus approprié. Enfin, parce qu’il s’agit d’une nouvelle intervention, on ne peut pas prévoir tous les risques possibles.

**Avantages potentiels**
Nous ne sommes pas en mesure d’affirmer que vous bénéficierez d’avantages suite à la participation à cette étude. Cependant, les avantages potentiels de la participation peuvent comprendre le fait que votre adaptation à la présente perte sera facilitée, en partie parce que vous recevrez un soutien d’autres gens affectés de pareille façon. Vu que vos commentaires seront souvent sollicités, votre participation aidera à former une intervention qui pourrait aider d’autres gens également affectés par la perte. Enfin, votre participation pourra aider à guider de futurs conseillers, travailleurs sociaux et psychologues pour offrir des interventions thérapeutiques aux gens endeuillés.

**Coût et remboursement**
On ne vous offrira pas de compensation pour votre participation à cette étude. Il n’y a pas de coûts liés à votre participation à l’étude elle-même. On ne pense pas que votre participation crée de coûts supplémentaires pour vous.

**Confidentialité**
Toutes les données obtenues dans le cadre de cette étude seront strictement confidentielles et ne seront identifiées qu’avec un chiffre codé. Seuls les membres de l’équipe de recherche auront accès aux documents contenant vos renseignements personnels. Cette étude servira à compléter en partie le diplôme de doctorat de Chris MacKinnon en Psychologie de l’orientation à
l'Université McGill. Votre nom ne sera pas associé avec les données dans les rapports, les présentations ou les publications qui découleront de cette étude. Les renseignements personnels récoltés ne seront utilisés que pour décrire les caractéristiques collectives de tous les participants à l’étude. Le comité d’éthique de l’Hôpital général juif pourra consulter les dossiers contenant vos renseignements personnels afin de s’assurer de la bonne gestion éthique du projet. Toutes les données seront conservées dans un classeur verrouillé ainsi que dans un appareil d’enregistrement numérique sécurisé et protégé par un mot de passe dans le bureau verrouillé de Chris MacKinnon, en Recherche dans le domaine des soins palliatifs à l’Hôpital général juif. Les données seront conservées pendant cinq ans après la publication des résultats de l’étude, puis seront détruites.

La confidentialité est un principe fondamental d’orientation et de psychologie. La complétion de l’intervention se fera en respectant le code de déontologie strict de l’Ordre des psychologues du Québec, que vous pouvez consulter au http://www.ordrepsy.qc.ca/fr/protection/code_deontologie.html. Dans des circonstances rares, les meneurs peuvent être tenus légalement de fournir certaines informations aux autorités responsables, en tenant compte des meilleurs intérêts du participant; par exemple, quand il y a un danger réel et imminent envers vous ou d’autres personnes. Les participants seront tenus de garder confidentiel les propos émis par les autres participants lors des séances.

Dans le cas où vous vous seriez retiré (ou auriez été retiré) de l’étude, les informations acquises jusqu’à votre retrait pourront être utilisées afin de protéger l’intégrité scientifique de l’étude.

Questions et coordonnées
Déclaration de consentement

J’ai lu ce formulaire de consentement et je donne volontairement mon accord pour participer à l’étude intitulée « L’élaboration et l’essai pilote d’une intervention de thérapies de groupe centrée sur le sens dans le déni ». J’ai eu l’occasion de poser des questions, et on a répondu à chacune d’entre elles à ma satisfaction. Je pourrai garder une copie du formulaire de consentement pour mes propres dossiers. J’ai été informé que ma participation à cette étude est entièrement volontaire et que je peux refuser d’y participer ou m’en retirer à tout moment sans aucune conséquence. Je peux poser, maintenant ou plus tard, des questions au sujet de cette étude. J’ai été assuré que les dossiers liés à cette étude seront confidentiels et qu’aucun renseignement pouvant servir à m’identifier ne sera rendu public. Ce consentement est valide jusqu’à la fin de l’étude; cependant, je peux mettre fin à ma participation à cette étude en tout temps sans aucune pénalité. En signant ce formulaire de consentement, je n’abandonne aucun de mes droits légaux.

J’accepte de participer à l’entrevue de suivi.
Oui □  Non □  Initiales __________________________

Par la présente, je consens à participer à l’étude.

<table>
<thead>
<tr>
<th>Participant</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-meneur</td>
<td>Signature</td>
<td>Date</td>
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</tbody>
</table>
Appendix D

INFORMED CONSENT: STAGE 2A/2B

Informed Consent: Stage 2A: Winter 2011

_The development and pilot testing of a meaning-centered group counselling intervention for bereavement._

**Research Team**

**Student/Group Co-Leader**
Chris MacKinnon, MA, OPQ
Intervention Co-leader
PhD Candidate, Counselling Psychology, McGill University
Psychology Intern, Psychosocial Oncology Program, Montreal General Hospital
514-340-8222 ext. 5697

**Research Supervisors**
S. Robin Cohen, PhD, Research Co-Supervisor
Associate Professor, Departments of Oncology and Medicine, McGill University
Project Director, Jewish General Hospital
514-340-8222 ext 5676

Nathan G. Smith, PhD, Research Co-Supervisor
Assistant Professor, Department of Educational and Counselling Psychology, McGill University
514-398-3454

**Group Co-Leader**
Melissa Henry, PhD, OPQ
Intervention Co-Leader
Adjunct Professor, Department of Oncology, McGill University
Psychologist, Head and Neck Oncology Service, Segal Cancer Center, Jewish General Hospital

**Research Assistant**
Melanie Berish, MA, OCCOPPQ
Research Assistant
Guidance Counsellor, Champlain College

**Purpose of the Study**
You are being asked to participate in a study which has the goal of assisting individuals in adapting to the death of a family member or friend. Before deciding to participate in this study, it is important that you clearly understand its requirements, risks, and benefits. The nature of this study will be explained to you in detail by the interviewer (Chris MacKinnon) in person. You are also invited to read this form carefully and ask any questions you have to the interviewer. You may take this form with you and discuss the study with anyone else before making your decision.
If you decide to participate you will be asked to sign two copies of this form, one of which will be given to you.

Description of Participation in the Study

The goal of the present study is to develop a group counselling intervention designed to allow participants to share their stories surrounding their loss. Approximately 48 participants will be invited to take part, led by either a trained volunteer, a social worker, or two psychologists who all have expertise in the area of bereavement. Should you choose to participate in the study, you will be randomly assigned to one of two groups. One will be the standard Hope & Cope bereavement group and the other the meaning-centered group for bereavement.

The standard Hope & Cope bereavement group will be 8 sessions of 90 minutes. It is led by a trained volunteer, who themselves have experienced a death-related loss, and a social worker. The group follows a more conventional approach of grief support. Participants will be invited to share stories of their loved ones and encouraged to provide and receive support from the group.

The meaning-centered group counselling intervention for bereavement will include/involve 12 sessions of 90 minutes in duration. The goal of the group is to provide support to individuals who have experienced a loss. Participants will be encouraged to listen to and share stories of their loved ones. They will be invited to give and receive support from others, discuss how life has changed, and explore how to make sense of the loss. A series of tasks and themes, largely informed by an approach to grief counselling called meaning reconstruction will help structure the group sessions. Participants will also be encouraged to articulate their needs and desires in shaping the functioning of the group.

If you are interesting in participating in this study one of the group leaders or the Research Assistant will phone you to set up an appointment for an initial individual meeting/interview. The goal of the interview is to consider together whether the study is most appropriate for you or to explore other options for support. This interview will be arranged at a time of convenience. You can ask questions you have about the study during this meeting. You will also be invited to respond to some short questions about your feelings and experiences of loss. The interview will take approximately one hour, which includes the completion of approximately 7 questionnaires.

Following the interview and your acceptance to participate, you will be randomly assigned to either the standard Hope & Cope bereavement group or the meaning-centered group counselling intervention for bereavement. Individuals in the standard Hope & Cope bereavement group will be contacted separately by the organizer of that particular group for details on meeting times and location. The exact dates of the meaning-centered group counselling intervention for bereavement will only be set once the schedules of all participants are reviewed and a mutually convenient time is determined. The location of the meaning-centered group counselling intervention for bereavement will be at the Hope & Cope Wellness Center, 4635 Cote-Sainte-Catherine Road, Corner Lavoie, easily accessible by public transport. Metered parking is available on the street. Parking is also available at the Jewish General Hospital, and is free in the evening.
All participants regardless of which group they are randomized to will also be asked to complete a series of questionnaires, that will take between 20-25 minutes to complete, at three different times: (a) At the end of the first interview; (b) At the conclusion of their respective group; and (c) 3 months after the completion of the intervention in which the questionnaires will be mailed to you with a return envelope marked with the address of Palliative Care Research (postage paid). The questionnaires have only been scientifically validated with an English speaking population. As such, the questionnaires will only be available in English.

Permission will also be sought from participants in the meaning-centered group counselling to be contacted shortly after the conclusion of the intervention to participate in a follow-up interview. Participation in the follow-up interview is optional and is part of a separate study. The details concerning the follow-up study will be explained at the time of follow-up interview.

Observation of Sessions
A Research Assistant will be present to observe the sessions and take detailed notes. The Research Assistant is bound to confidentiality in what she observes and writes, which will only be shared with the research team.

Audio Recording of Sessions
The sessions will be audio-recorded to help the leaders and researchers better understand the functioning of the group. The audio recordings will be transcribed verbatim and possibly used in future studies which explore finding meaning in grief.

Voluntary Participation/ Withdrawal
Participation in this study is purely voluntary and you can withdraw at any time. You do not have to answer any question, either on the questionnaires or during the group sessions, that you do not feel comfortable with. Should a participant be unable to attend a given session they will be encouraged to indicate such as soon as possible in the group or contact Chris MacKinnon by phone to advise him. Reasonable absence by participants will be accommodated based on the clinical judgment of the leaders. However, more than two absences without explanation to the group or the leaders may result in participants’ discontinuation from the study. In addition, should a participants’ absence be adversely affecting the group-as-a-whole, participants will be asked to withdraw from the study.

Risks and Discomfort
Some people may find that discussing their experiences raises unpleasant feelings, memories or thoughts. The group leaders will be open to any concerns or questions you wish to express during the study. You will not be compelled in any way to share personal material you do not wish to share. If you experience any significant distress during the course of the intervention, additional support will be offered to you in the form of a referral to the most appropriate health or mental health practitioner. Finally, because the meaning-centered invention is new, we cannot foresee all possible risks.

Potential Benefits
We do not know if you will receive any benefits from participating in this study. However, potential benefits of participating in this study may include that you will find adapting to your
present loss easier, in part due to receiving support from others similarly affected. Because your feedback will be regularly solicited, your participation will help shape an intervention that may benefit others similarly affected by loss. Finally, your participation may help guide future counsellors, social workers, and psychologists in providing therapeutic interventions to bereaved individuals.

**Cost and Reimbursement**
You will not be offered any compensation for your participation in this study. There are no costs related to participating in the study itself. We do not expect that your participation will create any additional costs for you.

**Confidentiality**
All data obtained during this study will be kept strictly confidential and will be identified only by a code number. Only the members of the research team will have access to the documents containing your personal information. The present study is in partial fulfillment of the doctoral degree in Counselling Psychology at McGill University of Chris MacKinnon. Your name will not be associated with any of the information presented in the reports, presentations, or publications expected to result from the study. Personal information collected will be used only to describe the collective characteristics of all participants in the study. The Research Ethics Committee of the Jewish General Hospital may review the records containing your personal information in order to ensure the proper ethical management of the project. All data will be kept in a locked filing cabinet and a password-protected and secure digital storage device in the locked office of Chris MacKinnon in Palliative Care Research at the Jewish General Hospital. The information will be kept for five years after publication of the study results and then destroyed.

Confidentiality is a fundamental principle of counselling and psychology. The delivery of the intervention will adherence to the strict ethical code of L’Ordre des Psychologues du Quebec which is available for you to consult at [http://www.ordrepsy.qc.ca/en/protection/code_ethics.html](http://www.ordrepsy.qc.ca/en/protection/code_ethics.html). In rare circumstances, the leaders may be legally required to release a limited amount of information to responsible authorities, with the participant’s best interests taken into consideration; for example, when there is real and imminent danger to yourself and/or others. Participants will also be asked to keep what they have heard from other participants in the group sessions confidential.

If you withdraw (or are withdrawn) from this study, any information collected up to the point of withdrawal for the purpose of this research may still be used in order to protect the scientific integrity of the study.

**Questions and Contact Information:**
If you have any questions or desire further information with respect to this study you may contact Chris MacKinnon at 514-340-8222 ext. 5697, Dr. Robin Cohen at 514-340-8222 ext 5676, or Dr. Nathan Smith, 514-398-3454. For information about your rights as a participant in the study, or concerns about risks, you may contact the Jewish General Hospital Local Commissioner of Complaints & Quality of Services, Rosemary Steinberg, at (514) 340-8222 ext. 5833.
Declaration of Consent

I have read this consent form and I voluntarily agree to participate in the study entitled “The development and pilot testing of a meaning-centered group counselling intervention for bereavement.” I have had the opportunity to ask questions and all my questions have been sufficiently answered to my satisfaction. I will be able to keep a copy of the consent form for my own records. I have been informed that my participation in this study is entirely voluntary and that I may refuse to participate or withdraw from this study at any time without consequence. I may ask now or in the future any questions about this study. I have been assured that records related to this study will be kept confidential and that no information about me will be released or printed that would disclose my personal identity. This consent is valid until the study is completed; however, I may discontinue my participation in this study at any time without penalty of any kind. By signing this consent form, I do not give up any of my legal rights.

I agree to be contacted to be given information regarding the follow-up interview.

Yes □ No □ Initials ______________

I hereby consent to participate in the study.

Participant ___________________ Signature ___________________ Date __________

Co-Leader ___________________ Signature ___________________ Date __________

RESEARCH ETHICS
22 JUN 2010 APPL
INITIALS
Consentement éclairé: Stade 2 : Hiver 2011

*L’élaboration et l’essai pilote d’une intervention de thérapies de groupe centrée sur le sens dans le deuil.*

**Équipe de recherche**

Étudiant/Co-meneur du groupe  
Chris MacKinnon, M.A., O.P.Q.  
Co-meneur de l’intervention  
Candidat au doctorat, Psychologie de l’orientation, Université McGill  
Stagiaire en psychologie, Programme en oncologie psychosociale, Hôpital général de Montréal  
514-340-8222 poste 5697

Superviseurs de recherche  
S. Robin Cohen, Ph.D., Co-superviseure de recherche  
Professeure agrégée, départements d’oncologie et de médecine, Université McGill  
Directrice du projet, Hôpital général juif  
514-340-8222 poste 5676

Nathan G. Smith, Ph.D., Co-superviseur de recherche  
Professeur adjoint, Département de psychologie de l’éducation et de l’orientation, Université McGill  
514-398-3454

Co-meneuse du groupe  
Melissa Henry, Ph.D., O.P.Q.  
Co-meneuse de l’intervention  
Professeure auxiliaire, Département d’oncologie, Université McGill  
Psychologue, Service d’oncologie cervico-faciale, Centre du cancer Segal, Hôpital général juif

Adjointe à la recherche  
Melanie Berish, M.A., O.C.C.O.P.P.Q.  
Adjointe à la recherche  
Conseillère d’orientation, Collège Champlain

**But de l’étude**

On vous demande de participer à une étude dont le but est d’assister les gens à s’adapter à la mort d’un membre de la famille ou d’un ami. Avant de décider de participer à cette étude, il est important que vous compreniez clairement ses exigences, ses risques et ses avantages. La nature de cette étude vous sera expliquée en détail par l’intervieweur (Chris MacKinnon) en personne. On vous invite également à lire ce formulaire attentivement et à poser toutes vos questions à l’intervieweur. Vous pouvez apporter ce formulaire avec vous et discuter de cette étude avec toute autre personne avant de prendre une décision. Si vous décidez de participer, on vous demandera de signer deux copies de ce formulaire, dont une vous sera remise.
Description de la participation à l’étude
Le but de l’étude est d’élaborer une intervention de thérapies de groupe conçue pour permettre aux participants de partager leur histoire relativement à leur perte. Environ 48 participants seront invités à participer, menés soit par un bénévole formé, un travailleur social ou deux psychologues ayant toutes une expertise dans le domaine du deuil. Si vous acceptez de participer à l’étude, on vous affectera de façon aléatoire à l’un des deux groupes : le premier est le groupe de deuil standard de L’espoir, c’est la vie, et le deuxième est le groupe centré sur le sens dans le deuil.

Le groupe de deuil standard de L’espoir, c’est la vie consistera en 8 séances de 90 minutes. Il est mené par un bénévole formé, qui a lui-même vécu un deuil, ainsi que par un travailleur social. Le groupe suit une approche conventionnelle de soutien dans le deuil. Les participants seront invités à partager des histoires au sujet de leur proche décédé et seront encouragés à offrir du soutien aux autres ainsi qu’à accepter le leur.

L’intervention de thérapies de groupe centrée sur le sens dans le deuil comprendra 12 séances de 90 minutes chacune. Le but du groupe est d’offrir un soutien aux gens qui vivent un deuil. On encouragera les participants à écouter et à partager des histoires au sujet de leur proche décédé. On les invitera à offrir du soutien aux autres et à accepter le leur, à discuter de comment la vie a changé et à explorer comment donner un sens à cette perte. Une série de tâches et de thèmes, surtout inspirée par une approche en thérapie du deuil nommée *la reconstruction du sens*, aidera à structurer les séances de groupe. On encouragera également les participants à articuler leurs besoins et leurs désirs pour façonner le fonctionnement du groupe.

Si la participation à l’étude vous intéresse, l’un des meneurs du groupe ou l’adjointe de recherche vous téléphonera afin de fixer un rendez-vous pour une entrevue/rencontre individuelle initiale. Le but de l’entrevue est de décider ensemble si cette étude est appropriée pour vous et d’explorer d’autres options de soutien. Cette entrevue sera arrangée à un moment qui vous convient. Vous pouvez poser les questions que vous avez au sujet de cette étude lors de cette entrevue/rencontre. On vous invitera également à répondre à de courtes questions au sujet de vos sentiments et de vos expériences dans le deuil. La durée de l’entrevue sera approximativement une heure, incluant de 20 à 25 minutes pour remplir environ 7 questionnaires.

À la suite de l’entrevue, une fois que vous aurez accepté de participer, on vous affectera de façon aléatoire soit au groupe de deuil standard de L’espoir, c’est la vie, soit à l’intervention de thérapies de groupe centrée sur le sens dans le deuil. Les personnes dans le groupe de deuil standard de L’espoir, c’est la vie seront contactées individuellement par l’organisateur du groupe en question, qui leur donnera les détails sur l’heure et le lieu des rencontres. Les dates exactes de l’intervention de thérapies de groupe centrée sur le sens dans le deuil ne seront décidées que lorsque les horaires de tous les participants seront revus et qu’un moment convenant à tous sera déterminé. Le lieu des séances de l’intervention de thérapies de groupe centrée sur le sens dans le deuil sera le Centre L’espoir, c’est la vie 4635, chemin de la Côte-Sainte-Catherine, coin Lavoie, facilement accessible en transport en commun. Des espaces de stationnement avec parcomètres sont également disponibles sur la rue et le stationnement de l’Hôpital Général Juif est gratuit en soirée.
On demandera à tous les participants, peu importe le groupe auquel ils sont assignés aléatoirement, de remplir une série de questionnaires à trois moments différents : (a) à la fin de la première entrevue/rencontre; (b) à la conclusion de leur groupe respectif; et (c) 3 mois après la fin de l’intervention, où les questionnaires seront postés avec une enveloppe de retour préaffranchie portant notre adresse (Recherche dans le domaine des soins palliatifs). Les questionnaires ayant été scientifiquement validés qu’auprèse d’une population anglophone, seule la version anglaise est disponible.

On demandera également aux participants de l’intervention de thérapies de groupe centrée sur le sens dans le deuil la permission de les contacter suite à la conclusion de l’intervention afin de participer à une entrevue de suivi. La participation à l’entrevue de suivi n’est pas obligatoire et fera l’objet d’une étude future. Les détails concernant cette étude future seront fournis lors de l’entrevue de suivi.

**Observation des séances**
Une adjointe de recherche sera présente pour observer les séances et prendre des notes détaillées. L’adjointe de recherche est liée par la confidentialité dans ce qu’elle observe et écrit, et cela ne sera partagé qu’avec l’équipe de recherche.

**Enregistrement audio des séances**
Les séances seront enregistrées par audio pour aider les meneurs et les chercheurs à mieux comprendre le fonctionnement du groupe. L’enregistrement audio sera transcrit textuellement et pourra être utilisé dans de futures études explorant le sens à trouver dans le deuil.

**Participation volontaire**
La participation à cette étude est entièrement volontaire, et vous pouvez vous en retirer en tout temps. Vous ne serez pas tenus de répondre aux questions qui vous mettent mal à l’aise que ce soit dans le cadre d’un questionnaire ou durant les thérapies de groupe. Dans le cas où un participant n’est pas en mesure d’être présent à une séance, il sera encouragé à en faire part lors de la séance ou de contacter Chris MacKinnon par téléphone le plus tôt possible. Une absence jugée raisonnable sera admise selon le jugement clinique des meneurs du groupe. Cependant, plus de deux absences sans explications au groupe ou au meneur du groupe pourront mener au retrait du participant. De plus, le retrait d’un participant serait également envisagé dans le cas où son absence entraînerait des effets néfastes pour le groupe.

**Risques et malaise**
Certaines personnes trouvent que discuter de leur expérience ravive des pensées, des sentiments ou des souvenirs déplaisants. Les meneurs du groupe seront ouverts à tous vos soucis et vos questions au cours de l’étude. Vous ne serez aucunelement forcés à partager des choses personnelles dont vous ne voulez pas parler. Si vous vivez une détresse significative au cours de cette intervention, on vous offrira du soutien supplémentaire sous forme d’une orientation vers le professionnel de la santé ou de la santé mentale le plus approprié. Enfin, parce que l’intervention centrée sur le sens est nouvelle, on ne peut pas prévoir tous les risques possibles.

**Avantages potentiels**
Nous ne sommes pas en mesure d’affirmer que vous bénéficierez d’avantages suite à la participation à cette étude. Cependant, les avantages potentiels de la participation peuvent comprendre le fait que votre adaptation à la présente perte sera facilitée, en partie parce que vous recevrez un soutien d’autres gens affectés de pareille façon. Vu que vos commentaires seront souvent sollicités, votre participation aidera à former une intervention qui pourrait aider d’autres gens également affectés par la perte. Enfin, votre participation pourra aider à guider de futurs conseillers, travailleurs sociaux et psychologues pour offrir des interventions thérapeutiques aux gens endeuillés.

Coût et remboursement
On ne vous offrira pas de compensation pour votre participation à cette étude. Il n’y a pas de coûts liés à votre participation à l’étude elle-même. On ne pense pas que votre participation crée de coûts supplémentaires pour vous.

Confidentialité
Toutes les données obtenues dans le cadre de cette étude seront strictement confidentielles et ne seront identifiées qu’avec un chiffre codé. Seuls les membres de l’équipe de recherche auront accès aux documents contenant vos renseignements personnels. Cette étude servira à compléter en partie le diplôme de doctorat de Chris MacKinnon en Psychologie de l’orientation à l’Université McGill. Votre nom ne sera pas associé avec les données dans les rapports, les présentations ou les publications qui découleront de cette étude. Les renseignements personnels recoltés ne seront utilisés que pour décrire les caractéristiques collectives de tous les participants à l’étude. Le comité d’éthique de l’Hôpital général juif pourra consulter les dossiers contenant vos renseignements personnels afin de s’assurer de la bonne gestion éthique du projet. Toutes les données seront conservées dans un classeur verrouillé ainsi que dans un appareil d’enregistrement numérique sécurisé et protégé par un mot de passe dans le bureau verrouillé de Chris MacKinnon, en Recherche dans le domaine des soins palliatifs à l’Hôpital général juif. Les données seront conservées pendant cinq ans après la publication des résultats de l’étude, puis seront détruites.

La confidentialité est un principe fondamental d’orientation et de psychologie. La complétion de l’intervention se fera en respectant le code de déontologie strict de l’Ordre des psychologues du Québec, que vous pouvez consulter au http://www.ordrepsy.qc.ca/fr/protection/code_deontologie.html. Dans des circonstances rares, les meneurs peuvent être tenus légalement de fournir certaines informations aux autorités responsables, en tenant compte des meilleurs intérêts du participant; par exemple, quand il y a un danger réel et imminent envers vous ou d’autres personnes. Les participants seront tenus de garder confidentiel les propos émis par les autres participants lors des séances.

Dans le cas où vous vous seriez retiré (ou auriez été retiré) de l’étude, les informations acquises jusqu’à votre retrait pourront être utilisées afin de protéger l’intégrité scientifique de l’étude.

Questions et coordonnées
que participant à cette étude ou pour discuter de vos soucis au sujet des risques, vous pouvez contacter la commissaire locale des plaintes et de la qualité des services de l’Hôpital général juif, Rosemary Steinberg, au 514-340-8222 poste 5833.
Déclaration de consentement

J’ai lu ce formulaire de consentement et je donne volontairement mon accord pour participer à l’étude intitulée « L’élaboration et l’essai pilote d’une intervention de thérapies de groupe centrée sur le sens dans le deuil ». J’ai eu l’occasion de poser des questions, et on a répondu à chacune d’entre elles à ma satisfaction. Je pourrai garder une copie du formulaire de consentement pour mes propres dossiers. J’ai été informé que ma participation à cette étude est entièrement volontaire et que je peux refuser d’y participer ou m’en retirer à tout moment sans aucune conséquence. Je peux poser, maintenant ou plus tard, des questions au sujet de cette étude. J’ai été assuré que les dossiers liés à cette étude seront confidentiels et qu’aucun renseignement pouvant servir à m’identifier ne sera rendu public. Ce consentement est valide jusqu’à la fin de l’étude; cependant, je peux mettre fin à ma participation à cette étude en tout temps sans aucune pénalité. En signant ce formulaire de consentement, je n’abandonne aucun de mes droits légaux.

J’accepte de participer à l’entrevue de suivi.
Oui ☑ Non ☐ Initiales __________________

Par la présente, je consens à participer à l’étude.

______________________________  ______________________________  _____________
Participant                                  Signature                                  Date

______________________________  ______________________________  _____________
Co-meneur                                  Signature                                  Date

RESEARCH ETHICS
02 JUL 2010 APPROVAL
INITIALS
Informed Consent: Stage 2B: Fall 2011
The development and pilot testing of a meaning-centered group counselling intervention for bereavement.

Research Team

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Research Assistant/Observer
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Research Assistant
Laura Copeland, MSc
MA Student, Counselling Psychology, McGill University

Purpose of the Study
You are being asked to participate in a study which has the goal of assisting individuals in adapting to the death of a family member or friend. Before deciding to participate in this study, it is important that you clearly understand its requirements, risks, and benefits. The nature of this study will be explained to you in detail by the interviewer (Chris MacKinnon) in person. You are also invited to read this form carefully and ask any questions you have to the interviewer. You may take this form with you and discuss the study with anyone else before making your decision. If you decide to participate you will be asked to sign two copies of this form, one of which will be given to you. The present study is in partial fulfillment of Chris MacKinnon`s doctoral degree in Counselling Psychology at McGill University.
Description of Participation in the Study
The goal of the present study is to develop a group counselling intervention designed to allow participants to share their stories surrounding their loss. Approximately 32 participants will be invited to take part in a series of two groups, (a) led by either a trained volunteer with a social worker, or (b) a counsellor with a psychologist. All facilitators have expertise in the area of bereavement. Should you choose to participate in the study, you will be randomly assigned to one of two groups. One will be the standard Hope & Cope bereavement group and the other the meaning-centered group for bereavement.

The standard Hope & Cope bereavement group will be 8 bi-weekly sessions of 90 minutes. It is led by a volunteer with extensive training and experience in bereavement, and a social worker. The group follows a more conventional approach of grief support. Participants will be invited to share stories of their loved ones and encouraged to provide and receive support from the group.

The meaning-centered group for bereavement will include/involve 12 sessions of 90 minutes in duration. The goal of the group is to provide support to individuals who have experienced a loss. A series of tasks and themes, largely informed by an approach to grief counselling called meaning reconstruction will help structure the group sessions. Participants will also be encouraged to articulate their needs and desires in shaping the functioning of the group.

It is important for individuals to know that these groups are not teaching lectures. While at times there will be some education elements such as exploring the nature of grief and productive ways to cope, the groups are not a traditional class or course.

If you are interesting in participating in this study, one of the group leaders or the Research Assistant will phone you to set up an appointment for an initial individual meeting/interview. The goal of the interview is to consider together whether the study is most appropriate for you or to explore other options for support. This interview will be arranged at a time of convenience. You can ask questions you have about the study during this meeting. You will also be invited to respond to some short questions about your feelings and experiences of loss. The interview will take approximately one hour and 15 minutes, which includes the completion of approximately 7 questionnaires.

Following the interview and your acceptance to participate, you will be randomly assigned to either the standard Hope & Cope bereavement group or the meaning-centered group counselling intervention for bereavement. After you complete this interview, you will be provided details on dates, times, and locations of your specific group.

All participants (regardless of group) will also be asked to complete a series of questionnaires, that will take somewhere in the area of 30 minutes to complete, at three different times: (a) At the end of the first interview; (b) At the conclusion of their respective group in November; and (c) 3 months after the completion of the intervention in which the questionnaires will be mailed to you with a return envelope marked with the address of Palliative Care Research (postage paid). The questionnaires have only been scientifically validated with an English speaking population. As such, the questionnaires will only be available in English.
Permission will also be sought from participants in the meaning-centered group counselling to be contacted shortly after the conclusion of the intervention to participate in a follow-up interview. Participation in the follow-up interview is optional and is part of a separate study. The details concerning the follow-up study will be explained at the time of follow-up interview.

**Observation of Sessions**
A Research Assistant will be present to observe the sessions and take detailed notes. The Research Assistant is bound to confidentiality in what she observes and writes. Her observations will only be shared with the research team.

**Audio Recording of Sessions**
The sessions will be audio-recorded to help the leaders and researchers better understand the functioning of the group. The audio recordings will be transcribed verbatim and possibly used in future studies which explore finding meaning in grief.

**Voluntary Participation/ Withdrawal**
Participation in this study is purely voluntary and you can withdraw at any time. You do not have to answer any question, either on the questionnaires or during the group sessions that you do not feel comfortable with. Should a participant be unable to attend a given session they will be encouraged to indicate such as soon as possible in the group or contact Chris MacKinnon by phone to advise him. Reasonable absence by participants will be accommodated based on the clinical judgment of the leaders. However, more than two absences without explanation to the group or the leaders may result in participants’ discontinuation from the study.

**Risks and Discomfort**
Some people may find that discussing their experiences raises unpleasant feelings, memories or thoughts. The group leaders will be open to any concerns or questions you wish to express during the study. You will not be compelled in any way to share personal material you do not wish to share. If you experience any significant distress during the course of the intervention, additional support will be offered to you in the form of a referral to the most appropriate health or mental health practitioner. Finally, because the meaning-centered invention is new, we cannot foresee all possible risks.

**Potential Benefits**
We do not know if you will receive any benefits from participating in this study. However, potential benefits of participating in this study may include that you will find adapting to your present loss easier, in part due to receiving support from others similarly affected. Because your feedback will be regularly solicited, your participation will help shape an intervention that may benefit others similarly affected by loss. Finally, your participation may help guide future counsellors, social workers, and psychologists in providing therapeutic interventions to bereaved individuals.
Cost and Reimbursement
You will not be offered any compensation for your participation in this study. There are no costs related to participating in the study itself. We do not expect that your participation will create any additional costs for you.

Confidentiality
All data obtained during this study will be kept strictly confidential and will be identified only by a code number. Only the members of the research team will have access to the documents containing your personal information. Your name will not be associated with any of the information presented in the reports, presentations, or publications expected to result from the study. Personal information collected will be used only to describe the collective characteristics of all participants in the study. The Research Ethics Committee of the Jewish General Hospital may review the records containing your personal information in order to ensure the proper ethical management of the project. All data will be kept in a locked filing cabinet and a password-protected and secure digital storage device in the locked office of Chris MacKinnon in Palliative Care Research at the Jewish General Hospital. The information will be kept for five years after publication of the study results and then destroyed.

Confidentiality is a fundamental principle of counselling and psychology. The delivery of the intervention will adherence to the strict ethical code of L’Ordre des Psychologues du Quebec which is available for you to consult at http://www.ordrepsy.qc.ca/en/protection/code_ethics.html. In rare circumstances, the leaders may be legally required to release a limited amount of information to responsible authorities, with the participant’s best interests taken into consideration; for example, when there is real and imminent danger to yourself and/or others. Participants will also be asked to keep what they have heard from other participants in the group sessions confidential.

If you withdraw (or are withdrawn) from this study, any information collected up to the point of withdrawal for the purpose of this research may still be used in order to protect the scientific integrity of the study.

Questions and Contact Information:
If you have any questions or desire further information with respect to this study you may contact Chris MacKinnon at 514-340-8222 ext. 5697, Dr. Robin Cohen at 514-340-8222 ext 5676, or Dr. Nathan Smith, 514-398-3454. For information about your rights as a participant in the study, or concerns about risks, you may contact the Jewish General Hospital Local Commissioner of Complaints & Quality of Services, Rosemary Steinberg, at (514) 340-8222 ext. 5833.
Declaration of Consent

I have read this consent form and I voluntarily agree to participate in the study entitled “The development and pilot testing of a meaning-centered group counselling intervention for bereavement.” I have had the opportunity to ask questions and all my questions have been sufficiently answered to my satisfaction. I will be able to keep a copy of the consent form for my own records. I have been informed that my participation in this study is entirely voluntary and that I may refuse to participate or withdraw from this study at any time without consequence. I may ask now or in the future any questions about this study. I have been assured that records related to this study will be kept confidential and that no information about me will be released or printed that would disclose my personal identity. This consent is valid until the study is completed; however, I may discontinue my participation in this study at any time without penalty of any kind. By signing this consent form, I do not give up any of my legal rights.

I agree to be contacted to be given information regarding the follow-up interview.

Yes ☐ No ☐ Initials ______________

I hereby consent to participate in the study.

Participant ___________________ Signature _______________ Date __________

Co-Leader ___________________ Signature _______________ Date __________
Consentement éclairé: Stade 2B : Automne 2011

L’élaboration et l’essai pilote d’une intervention de thérapies de groupe centrée sur le sens dans le deuil.

Équipe de recherche

Étudiant/ Groupe co-facilitateur
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Co-meneuse du groupe
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Co-meneuse de l’intervention
Conseiller, Collège Champlain,
Pratique à titre indépendante

Adjointe à la recherche
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Département de psychologie de l’éducation et de l’orientation, Université McGill

Adjointe à la recherche
Laura Copeland
Adjointe à la recherche
Département de psychologie de l’éducation et de l’orientation, Université McGill

But de l’étude
On vous demande de participer à une étude dont le but est d’assister les gens à s’adapter à la mort d’un membre de la famille ou d’un ami. Avant de décider de participer à cette étude, il est important que vous compreniez clairement ses exigences, ses risques et ses avantages. La nature
de cette étude vous sera expliquée en détail par l’intervieweur (Chris MacKinnon) en personne. On vous invite également à lire ce formulaire attentivement et à poser toutes vos questions à l’intervieweur. Vous pouvez apporter ce formulaire avec vous et discuter de cette étude avec toute autre personne avant de prendre une décision. Si vous décidez de participer, on vous demandera de signer deux copies de ce formulaire, dont une vous sera remise.

**Description de la participation à l’étude**
Le but de l’étude est d’élaborer une intervention de thérapies de groupe conçue pour permettre aux participants de partager leur histoire relativement à leur perte. Approximativement 32 participants seront invités à prendre part à l’un des deux groupes dirigés soit par (a) un bénévole qualifié avec un travailleur social, soit par (b) un conseiller avec un psychologue. Tous les facilitateurs sont spécialisés dans le domaine du deuil. Si vous acceptez de participer à l’étude, on vous affectera de façon aléatoire à l’un des deux groupes : le premier est le groupe de deuil standard de L’espoir, c’est la vie, et le deuxième est le groupe centré sur le sens dans le deuil.

Le groupe de deuil standard de L’espoir, c’est la vie consistera en 8 séances de 90 minutes ayant lieu deux fois par semaines. Le groupe sera mené par un bénévole ayant une formation et une expérience approfondie dans le domaine relatif au deuil, ainsi que par un travailleur social. Le groupe suit une approche conventionnelle de soutien dans le deuil. Les participants seront invités à partager des histoires au sujet de leur proche décédé et seront encouragés à offrir du soutien aux autres ainsi qu’à accepter le leur.

L’intervention de thérapies de groupe centrée sur le sens dans le deuil comprendra 12 séances de 90 minutes chacune. Le but du groupe est d’offrir un soutien aux gens qui vivent un deuil. On encouragera les participants à écouter et à partager des histoires au sujet de leur proche décédé. On les invitera à offrir du soutien aux autres et à accepter le leur, à discuter de comment la vie a changé et à explorer comment donner un sens à cette perte. Une série de tâches et de thèmes, surtout inspirée par une approche en thérapie du deuil nommée la reconstruction du sens, aidera à structurer les séances de groupe. On encouragera également les participants à articuler leurs besoins et leurs désirs pour façonner le fonctionnement du groupe.

Il est important pour les individus de savoir que ces groupes ne sont pas des leçons d’enseignement. Bien qu’il y ait parfois certains éléments éducatifs, tels qu’explorer la nature du chagrin lié au deuil, ainsi que les manières productives pour le surmonter, les groupes sont cependant différents d’une classe traditionnelle ou d’un cours.

Si la participation à l’étude vous intéresse, l’un des meneurs du groupe ou l’adjointe de recherche vous téléphonerà afin de fixer un rendez-vous pour une entrevue/rencontre individuelle initiale. Le but de l’entrevue est de décider ensemble si cette étude est appropriée pour vous et d’explorer d’autres options de soutien. Cette entrevue sera arrangée à un moment qui vous convient. Vous pouvez poser les questions que vous avez au sujet de cette étude lors de cette entrevue/rencontre. On vous invitera également à répondre à de courtes questions au sujet de vos sentiments et de vos expériences dans le deuil. La durée de l’entrevue sera approximativement une heure, incluant de 20 à 25 minutes pour remplir environ 7 questionnaires.
À la suite de l’entrevue, une fois que vous aurez accepté de participer, on vous affectera de façon aléatoire soit au groupe de deuil standard de L’espoir, c’est la vie, soit à l’intervention de thérapies de groupe centrée sur le sens dans le deuil. Des précisions à propos des dates, horaires et locations de votre groupe spécifique vous seront fournies. Des espaces de stationnement avec parcomètres sont également disponibles sur la rue et le stationnement de l’Hôpital Général Juif est gratuit en soirée.

Tous les participants, quel que soit le groupe dans lequel ils ont été sélectionnés, seront également invités à compléter une série de questionnaires qui prendront à peu près 30 minutes à compléter et cela à trois différentes reprises: (a) à la fin de la première entrevue/rencontre; (b) à la conclusion de leur groupe respectif; et (c) 3 mois après la fin de l’intervention, où les questionnaires seront postés avec une enveloppe de retour préaffranchie portant notre adresse (Recherche dans le domaine des soins palliatifs). Les questionnaires ayant été scientifiquement validés qu’auprès d’une population anglophone, seule la version anglaise est disponible.

On demandera également aux participants de l’intervention de thérapies de groupe centrée sur le sens dans le deuil la permission de les contacter suite à la conclusion de l’intervention afin de participer à une entrevue de suivi. La participation à l’entrevue de suivi n’est pas obligatoire et fera l’objet d’une étude future. Les détails concernant cette étude future seront fournis lors de l’entrevue de suivi.

**Observation des séances**
Une adjointe de recherche sera présente pour observer les séances et prendre des notes détaillées. L’adjointe de recherche est liée par la confidentialité dans ce qu’elle observe et écrit, et cela ne sera partagé qu’avec l’équipe de recherche.

**Enregistrement audio des séances**
Les séances seront enregistrées par audio pour aider les meneurs et les chercheurs à mieux comprendre le fonctionnement du groupe. L’enregistrement audio sera transcrit textuellement et pourra être utilisé dans de futures études explorant le sens à trouver dans le deuil.

**Participation volontaire**
La participation à cette étude est entièrement volontaire, et vous pouvez vous en retirer en tout temps. Vous ne serez pas tenus de répondre aux questions qui vous mettent mal à l’aise que ce soit dans le cadre d’un questionnaire ou durant les thérapies de groupe. Dans le cas où un participant n’est pas en mesure d’être présent à une séance, il sera encouragé à en faire part lors de la séance ou de contacter Chris MacKinnon par téléphone le plus tôt possible. Une absence jugée raisonnable sera admise selon le jugement clinique des meneurs du groupe. Cependant, plus de deux absences sans explications au groupe ou au meneur du groupe pourront mener au retrait du participant.

**Risques et malaise**
Certaines personnes trouvent que discuter de leur expérience ravive des pensées, des sentiments ou des souvenirs déplaisants. Les meneurs du groupe seront ouverts à tous vos soucis et vos questions au cours de l’étude. Vous ne serez aucunement forcé à partager des choses personnelles dont vous ne voulez pas parler. Si vous vivez une détresse significative au cours de
cette intervention, on vous offrira du soutien supplémentaire sous forme d’une orientation vers le professionnel de la santé ou de la santé mentale le plus approprié. Enfin, parce que l’intervention centrée sur le sens est nouvelle, on ne peut pas prévoir tous les risques possibles.

**Avantages potentiels**

Nous ne sommes pas en mesure d’affirmer que vous bénéficierez d’avantages suite à la participation à cette étude. Cependant, les avantages potentiels de la participation peuvent comprendre le fait que votre adaptation à la présente perte sera facilitée, en partie parce que vous recevrez un soutien d’autres gens affectés de pareille façon. Vu que vos commentaires seront souvent sollicités, votre participation aidera à former une intervention qui pourrait aider d’autres gens également affectés par la perte. Enfin, votre participation pourra aider à guider de futurs conseillers, travailleurs sociaux et psychologues pour offrir des interventions thérapeutiques aux gens endeuillés.

**Coût et remboursement**

On ne vous offrira pas de compensation pour votre participation à cette étude. Il n’y a pas de coûts liés à votre participation à l’étude elle-même. On ne pense pas que votre participation crée de coûts supplémentaires pour vous.

**Confidentialité**

Toutes les données obtenues dans le cadre de cette étude seront strictement confidentielles et ne seront identifiées qu’avec un chiffrage codé. Seuls les membres de l’équipe de recherche auront accès aux documents contenant vos renseignements personnels. Cette étude servira à compléter en partie le diplôme de doctorat de Chris MacKinnon en Psychologie de l’orientation à l’Université McGill. Votre nom ne sera pas associé avec les données dans les rapports, les présentations ou les publications qui découleront de cette étude. Les renseignements personnels recueillis ne seront utilisés que pour décrire les caractéristiques collectives de tous les participants à l’étude. Le comité d’éthique de l’Hôpital général juif pourra consulter les dossiers contenant vos renseignements personnels afin de s’assurer de la bonne gestion éthique du projet. Toutes les données seront conservées dans un classeur verrouillé ainsi que dans un appareil d’enregistrement numérique sécurisé et protégé par un mot de passe dans le bureau verrouillé de Chris MacKinnon, en Recherche dans le domaine des soins palliatifs à l’Hôpital général juif. Les données seront conservées pendant cinq ans après la publication des résultats de l’étude, puis seront détruites.

La confidentialité est un principe fondamental d’orientation et de psychologie. La complétion de l’intervention se fera en respectant le code de déontologie strict de l’Ordre des psychologues du Québec, que vous pouvez consulter au [http://www.ordrepsy.qc.ca/fr/protection/code_deontologie.html](http://www.ordrepsy.qc.ca/fr/protection/code_deontologie.html). Dans des circonstances rares, les meneurs peuvent être tenus légalement de fournir certaines informations aux autorités responsables, en tenant compte des meilleurs intérêts du participant; par exemple, quand il y a un danger réel et imminent envers vous ou d’autres personnes. Les participants seront tenus de garder confidentiel les propos émis par les autres participants lors des séances.

Dans le cas où vous vous seriez retiré (ou auriez été retiré) de l’étude, les informations acquises jusqu’à votre retrait pourront être utilisées afin de protéger l’intégrité scientifique de l’étude.
Questions et coordonnées
Déclaration de consentement

J’ai lu ce formulaire de consentement et je donne volontairement mon accord pour participer à l’étude intitulée « L’élaboration et l’essai pilote d’une intervention de thérapies de groupe centrée sur le sens dans le deuil ». J’ai eu l’occasion de poser des questions, et on a répondu à chacune d’entre elles à ma satisfaction. Je pourrai garder une copie du formulaire de consentement pour mes propres dossiers. J’ai été informé que ma participation à cette étude est entièrement volontaire et que je peux refuser d’y participer ou m’en retirer à tout moment sans aucune conséquence. Je peux poser, maintenant ou plus tard, des questions au sujet de cette étude. J’ai été assuré que les dossiers liés à cette étude seront confidentiels et qu’aucun renseignement pouvant servir à m’identifier ne sera rendu public. Ce consentement est valide jusqu’à la fin de l’étude; cependant, je peux mettre fin à ma participation à cette étude en tout temps sans aucune pénalité. En signant ce formulaire de consentement, je n’abandonne aucun de mes droits légaux.

J’accepte de participer à l’entrevue de suivi.
Oui ☐  Non ☐  Initiales __________________

Par la présente, je consens à participer à l’étude.

Participant __________________ Signature __________________ Date __________________

Co-meneur __________________ Signature __________________ Date __________________
Appendix E

PRE-SCREENING PROTOCOL

(Adapted from Keefler 2005). When possible, interview conducted jointly by two facilitators or with a facilitator and the research assistant.

Identifying Information

Date: ...............................................................
Study Identification Number: ...................................
Name of Participant: ...........................................

Contact Information:
Mailing Address....................................................
........................................................................
........................................................................
A phone message can be left at....................................................
Email (optional) ....................................................

Source of Referral (if any) ............................................

General Functioning
How do you manage to cope with stress, now and in the past?

Initial Grief Assessment

- Can your briefly describe the loss you experienced? What was your relationship to the deceased? How would you describe the nature of your relationship? (e.g., strong, loving, difficult, unresolved).

History of Mental Health Difficulties

- Do you have any history of seeking mental health services in the past? What was it related to? What was the nature and duration of treatment? (e.g., 15 week Cognitive-Behavioural Therapy).
- Are you currently being followed by a mental health practitioner? For how long and what modality?
- Severity: The disruption in the participant’s present functioning and degree of distress.
- Duration/Frequency: The frequency of the problem and its duration.
- Meaning: Includes the meanings and beliefs that the participant attaches to the problem that may perpetuate the problem.
- Past Solutions: Solutions participant has already tried in resolving her/his grief or previous problems.
• Contributing Factors: Any current factors that contribute to the perpetuation of the problem (e.g., cultural, environmental, life cycle, discrimination or systemic variables related to the problem)?
• Have you ever, or are you currently taking any form of medication (e.g., antidepressants, anti-anxiety, anti-psychotics)?

Complicated Grief Assessment:
• Please describe any difficulties you have had in adapting to the loss.
• Severity: The disruption in the participant’s functioning and degree of distress.
• Duration/Frequency: The frequency of the problem(s) and its/their duration.
• Meaning: Includes the meanings and beliefs that the participant attaches to the problem that may perpetuate the problem.
• Past Solutions: Solutions the participant has already tried in resolving her/his grief or previous problems.
• Contributing Factors: Any current factors that contribute to the perpetuation of problem (e.g., cultural, environmental, life cycle, discrimination or systemic variables related to the problem)?
• Do you have any symptoms about which you have questions?
• How hopeful are you that you will be able to recover from this loss?

Assessment of Ability to Function in a Group
• Motivation: The participant’s motivation to participate in group counselling focused on grief according to participant and interviewer.
• Have you ever been part of a support group, group psychotherapy, or any other groups? If yes, please describe when, the duration, and the nature.
• How comfortable and willing would you be to share some of your experiences of loss with others similarly affected?
• What are your hopes/expectations of the group?
• What kind of support are you seeking from the group?
• Are there any difficulties you anticipate in participating in a group?

Final decision to invite participant to group:
Yes:...........................No:...........................

If not appropriate, participant referred to: ...........................

1 = Hope & Cope Individual Support
2 = Hospital
3 = Psychiatric Evaluation
4 = Addiction Centre
5 = Private Practitioner
6 = Other (please describe)
Appendix F

DEMOGRAPHIC FORM

Please complete the following Demographic Form, placing a checkmark beside the appropriate box where needed.

Date of recent death-related loss: ________________________________

Relationship of the deceased to you: ________________________________

Other significant death-related loss in your life:

<table>
<thead>
<tr>
<th>Relationship to you (e.g., Sibling)</th>
<th>Year of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What is your spiritual/religious orientation (if any)?

<table>
<thead>
<tr>
<th>Judaism</th>
<th>Hinduism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Islam</td>
<td>Indigenous</td>
</tr>
<tr>
<td>Buddhism</td>
<td>Confucianism</td>
</tr>
<tr>
<td>Christianity</td>
<td>Sikhism</td>
</tr>
<tr>
<td>Secular/Nonreligious/Atheist</td>
<td>Agnostic</td>
</tr>
<tr>
<td>Other (Please Specify):</td>
<td></td>
</tr>
</tbody>
</table>

What is your sexual orientation?

<table>
<thead>
<tr>
<th>Lesbian</th>
<th>Heterosexual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gay</td>
<td>Other (please specify):</td>
</tr>
<tr>
<td>Bisexual</td>
<td></td>
</tr>
</tbody>
</table>

What is your gender?

<table>
<thead>
<tr>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Transgender</td>
</tr>
</tbody>
</table>

What is your age? ______

What is your ethnic background/nationality? ________________________________

What is your net family income?

<table>
<thead>
<tr>
<th>Below $10,000</th>
<th>$10,001-$20,000</th>
<th>$20,000 - $30,000</th>
<th>$30,000 - $40,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>$40,000 - $50,000</td>
<td>$50,000 - $60,000</td>
<td>$60,000 - $70,000</td>
<td>$70,000 - $80,000</td>
</tr>
<tr>
<td>$80,000 - $90,000</td>
<td>$90,000 - $100,000</td>
<td>$100,000 - $110,000</td>
<td>$110,000 - $120,000</td>
</tr>
<tr>
<td>$120,000 – $130,000</td>
<td>$140,000 - $150,000</td>
<td>$150,000 and up</td>
<td></td>
</tr>
</tbody>
</table>
What is your highest level of education?

<table>
<thead>
<tr>
<th>Qualification</th>
<th>Degree Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than High School</td>
<td>High School or Equivalent</td>
</tr>
<tr>
<td>College/CEGEP Degree</td>
<td>Professional Degree</td>
</tr>
<tr>
<td>Bachelor’s Degree</td>
<td>Master’s Degree</td>
</tr>
<tr>
<td>Doctoral Degree</td>
<td>Post-Doctoral Training</td>
</tr>
</tbody>
</table>

What is your civil status?

<table>
<thead>
<tr>
<th>Status</th>
<th>Other: (Please specify):</th>
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</thead>
<tbody>
<tr>
<td>Widowed</td>
<td>Divorced</td>
</tr>
<tr>
<td>Separated</td>
<td>Common Law</td>
</tr>
<tr>
<td>Single</td>
<td>Married/ civil union</td>
</tr>
<tr>
<td>In a relationship, living apart</td>
<td>Other: (Please specify):</td>
</tr>
</tbody>
</table>
Appendix G

PARTICIPANT TRACKING FORM

Participant Study Identification Number:.........................................

Pre-screening Interview

<table>
<thead>
<tr>
<th>Date</th>
<th>PG-13 Score</th>
<th>Completed Outcome Measures (Y/N)</th>
<th>Invited to Group (Y/N)</th>
<th>Referred to:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

Assignment Details (Stage 2 Only)

<table>
<thead>
<tr>
<th>MBGC</th>
<th>Treatment as Usual</th>
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<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Session by Session Attendance Form

<table>
<thead>
<tr>
<th>Session Number</th>
<th>Date (YR/M/D)</th>
<th>Attendance (Y/N)</th>
<th>Session Number</th>
<th>Date (YR/M/D)</th>
<th>Attendance (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 1</td>
<td></td>
<td></td>
<td>Session 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Session 2</td>
<td></td>
<td></td>
<td>Session 8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Session 3</td>
<td></td>
<td></td>
<td>Session 9</td>
<td></td>
<td></td>
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<tr>
<td>Session 4</td>
<td></td>
<td></td>
<td>Session 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Session 5</td>
<td></td>
<td></td>
<td>Session 11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Session 6</td>
<td></td>
<td></td>
<td>Session 12</td>
<td></td>
<td></td>
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</tbody>
</table>

Completed Outcome Measures

<table>
<thead>
<tr>
<th>Time 1</th>
<th>Time 2</th>
<th>Time 3 (Stage 2 Only)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

Withdrew from Study:

<table>
<thead>
<tr>
<th>Date</th>
<th>Reasons for withdrawal</th>
<th>Referred to:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Co-Leader:  
Stage/Group: 1/1  2/1  2/2  
Date: 

<table>
<thead>
<tr>
<th>Significant Themes of the Session/ Meaning-Reconstruction Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specific Member Observations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group Dynamic Observations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objectives for next session/ Items to be followed up</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>
Appendix I

OBSERVATION PROTOCOL

*Completed by the research assistant during and after each session and checked for notable disagreements with the two co-leader notes.*

Date………………………………
Session #…………………………
Stage/Block: e.g., Stage 2 Block 2 (Experimental) ………………………………………
Study Identification Numbers of Group Members Present……………………………………
Study Identification Numbers of Absentees………………………………………………

<table>
<thead>
<tr>
<th>What were the main themes for the sessions?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Which group members participated the most? What observations might explain this?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Which group members participated the least? What observations might explain this?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What aspects/themes/activities of the session did participants appear to respond well to and what is the basis for this judgment?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What aspects/themes/activities of the session did participants appear not to respond well to and what is the basis for this judgment?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>What implicit or explicit interpersonal processes/dynamics were observed in the session?</th>
</tr>
</thead>
</table>
(individuals not talking, passive messages, lack of eye contact, turning towards or away)

Comment or describe any notable non-verbal behaviour of the group members and the therapists.

Were there any critical incidents in the session? (e.g., significant self-disclosure, affective reaction, conflict/rupture, sudden shift in focus?) What observations might explain this?

Were any group members absent and what was the effect on the group process?

Were there any notable obstacles to the evolving group process?

Was there any evidence of sub-grouping, scapegoating, marginalized members, or other un-therapeutic processes?

How did group members respond to the interventions of the therapist(s)? Were some interventions more or less effective?

What steps did a/some group member(s) or the group as a whole take in advancing the group process? For example, towards the goal of meaning reconstruction?

What feedback—implicit, explicit, or implied—did group members communicate about
the functioning of the group, group members, or group dynamics?

| Did a/some group member(s) appear to benefit more than others? What is the basis of this observation? |
| Did a/some group member(s) appear not to benefit as much as others? What is the basis of this observation? |
| Overall, was this a useful session for group members/group-as-a-whole? What observations might explain this? |
| Other observations of research and clinical significance? |
Appendix J

IN-SESSION PARTICIPANT FEEDBACK GUIDELINES

Duration 5 to 10 minutes at conclusion of sessions 3, 6, and 9 with entire group.

- Are there any barriers you perceived in the group? For example, were there any times that you felt unsafe or uncomfortable participating?
- Do you feel you understand a little better how to start making sense or meaning of your loss following your participation in the group so far?
- What do you think helps people make sense (make meaning) of death-related loss?
- What suggestions for improvement do you have regarding the intervention?
- What suggestions for improvement do you have regarding the co-leaders of the group?
- What would you like to see happen in the group in the next few sessions?
Appendix K

FOLLOW-UP INTERVIEW PROTOCOL

Semi-structured interview guide.

- Looking back on the bereavement group, would you say you are better off now than before, the same, or worse? Please elaborate.
- Were there any barriers you perceived while in the group? For example, were there any times that you felt unsafe or uncomfortable participating?
- Do you feel you have been better able to make sense or meaning of your loss following your participation in the group?
- What do you think helps people make sense (make meaning) of death-related loss?
- Describe your role in the group? For example, were you more or less active than others? Did this role feel familiar in any way? (previous learning experiences of being in groups)
- Did the task of meaning reconstruction assist you in adapting to your loss? What aspects of meaning reconstruction were most helpful? What aspects of meaning reconstruction were least helpful?
- What suggestions for improvement do you have regarding the intervention?
- What suggestions for improvement do you have regarding the co-leaders of the group?
- If there was anything you could change about your experience in the group, what might it be?
- Do you have any regrets about participating in the group?
- Would you recommend this group to someone else in a similar situation?
- Did you seek out any outside support while you were a member of the group?
- What are your plans for the future? Are you going to seek out further assistance?
- What was your impression of the questionnaires? Were any of the questions inappropriate? Was the time to complete the questionnaires appropriate?
Appendix L

RESEARCH REPORT FORM

To be completed weekly by MacKinnon and circulated prior to weekly research team meeting.

Present Date………………………………. Session Date……………………………..
Session Number………………………………

<table>
<thead>
<tr>
<th>Significant Findings: Participant Tracking Form</th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>--</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Significant Findings: Observation Protocol</th>
<th>Evolution over time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Significant Findings: Post-Session Notes</th>
<th>Evolution over time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Significant Findings: Comparing the Observation Protocol with the Post-Session Notes</th>
<th>Convergent Themes</th>
<th>Divergent Themes</th>
<th>Evolution over time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Significant Findings: In-Session Participant Feedback (Only Sessions 3, 6, 9 and 12)

<table>
<thead>
<tr>
<th>Convergent Themes</th>
<th>Divergent Themes</th>
<th>Evolution over time</th>
</tr>
</thead>
</table>

### Significant Findings: Treatment Fidelity and Integrity Thematic Checklist

<table>
<thead>
<tr>
<th>Convergent Findings</th>
<th>Divergent Themes</th>
<th>Evolution over time</th>
</tr>
</thead>
</table>

### Significant Segments: Audio Recording

<table>
<thead>
<tr>
<th>Time:</th>
<th>Theme(s)</th>
<th>Please note:</th>
</tr>
</thead>
</table>

### Other topics of clinical or research significance
<table>
<thead>
<tr>
<th>Difficulties or problems using this form</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Adaptations and Changes to the Intervention</th>
</tr>
</thead>
</table>
Appendix M

RECRUITMENT POSTERS

Bereavement Support Group

A professionally facilitated bereavement group offering support from others in re-adjusting to your life after a loss is scheduled to begin in the Fall 2010. If interested, please contact:

Christopher MacKinnon, MA, Psychologist
Doctoral Candidate, Department of Educational and Counselling Psychology, McGill University
Palliative Care Research, Jewish General Hospital
514-340-8222 ext. 5697
echristopher.mackinnon@mail.mcgill.ca

Research Director: Dr. Robin Cohen

A clinical-research study in collaboration with:

Jewish General Hospital  McGill
Groupe de soutien pour personnes vivant un deuil

Un groupe de soutien pour personnes vivant un deuil mené par des professionnels est offert à l’automne 2010. Si vous êtes intéressé à obtenir du soutien de personnes vivant un deuil afin de réajuster votre vie après une perte, prière de contacter:

Christopher MacKinnon, MA, Psychologue
Candidat au doctorat
Département de psychologie de l’orientation, Université McGill
Recherche en soins palliatifs, Hôpital général juif
514-340-8222 ext. 5697
christopher.mackinnon@mail.mcgill.ca

Directeur de recherche: Dr. Robin Cohen

Une étude clinique en collaboration avec...

Hôpital général juif
Bereavement Support Group

A professionally facilitated bereavement group offering support from others in re-adjusting to your life after a loss is scheduled to begin in the Winter of 2011. If interested, please contact:

Christopher MacKinnon, MA, Psychologist
Doctoral Candidate, Department of Educational and Counselling Psychology, McGill University
Palliative Care Research, Jewish General Hospital
514-340-8222 ext. 5697
christopher.mackinnon@mail.mcgill.ca

Research Director: Dr. S. Robin Cohen & Dr. Nathan G. Smith

A clinical-research study in collaboration with...
Groupe de soutien pour personnes vivant un deuil

Un groupe de soutien pour personnes vivant un deuil, animé par des professionnels, est offert à l’hiver 2011. Si vous êtes présentement en deuil et pensez pouvoir bénéficier de soutien pour vous adapter à une nouvelle vie suite à la perte, prière de contacter:

Christopher MacKinnon, MA, Psychologue
Candidat au doctorat
Département de psychologie de l’orientation, Université McGill
Recherche en soins palliatifs, Hôpital général juif
514-340-8222 ext. 5697
christopher.mackinnon@mail.mcgill.ca

Directeur de recherche: Dr. S. Robin Cohen & Dr. Nathan G. Smith

Une étude clinique en collaboration avec...

Hôpital général juif  McGill  CIHR RSC
Groupe de soutien pour personnes vivant un deuil

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Christopher MacKinnon, MA, Psychologue
Candidat au doctorat
Département de psychologie de l'orientation, Université McGill
Recherche en soins palliatifs, Hôpital général juif
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christopher.mackinnon@mail.mcgill.ca

Directeur de recherche: Dr. S. Robin Cohen & Dr. Nathan G. Smith

Une étude clinique en collaboration avec...

Hôpital général juif
McGill
CIHR

Christopher MacKinnon
christopher.mackinnon@mail.mcgill.ca
514-340-8222 x 5697

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christopher.mackinnon@mail.mcgill.ca
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Bereavement Support Group
Fall 2011

A professionally facilitated bereavement group, offering support from others in re-adjusting to your life after a loss, is scheduled to begin in the Fall of 2011. If interested, please contact:

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A clinical-research study in collaboration with...
Appendix N

FLOWCHART OF INTERVENTION RESEARCH PROCEDURES STAGE 1

Jewish General Hospital ethics approval granted.

Participants who self-selected and meet the inclusion criteria are contacted by researcher (minimum needed: 12).

Certain individuals were not interested in participating after hearing over the phone the requirements of the study (e.g., time of group meetings; travelling to meeting location etc.)

Individual meetings with potential participants for pre-screening. Written informed consent obtained. Psychosocial assessment. PG-13 if appropriate. Time 1 questionnaires and demographic information collected.

In cases where the intervention is deemed appropriate for participants, they will be invited to the group.

In cases where the intervention is deemed inappropriate for the participant, they will be given an appropriate referral.

Meaning-based group counselling (MBGC) for bereavement.

Weekly research reports generated based on qualitative analysis of audio recordings of sessions; Post-session intervention team meetings; Research Assistant observations; Co-leader session notes.

Research Team meetings to finalize modifications.

Modification and adaptation during the course of the intervention.

Conclusion of MBGC: Time 2 questionnaires administered.

Follow-up interviews with participants.

Qualitative analysis of interviews.

Counter-indications: Failure to benefit and/or increase in psychological distress following MBGC.

Do not proceed to Stage 2 of the Study.

Participants indicate general improvement in psychological...
Appendix O

FLOWCHART OF INTERVENTION RESEARCH PROCEDURES STAGE 2

Participants who self-refer and meet the inclusion criteria will be contacted (minimum needed: 24).

Certain individuals were not interested in participating after hearing over the phone the requirements of the study (e.g., time of group meetings; travelling to meeting location etc.)

Individual meetings with potential participants for pre-screening. Written informed consent obtained. Psychosocial assessment. PG-13 if appropriate. Time 1 questionnaires and demographic information collected.

In cases where the intervention is deemed inappropriate for participants, they will be given an appropriate referral.

In cases where the intervention is deemed appropriate for participants, randomization to one of two treatment arms.

**Experimental Arm**
MBGC: 2 groups of $n = 6-8$.

Conclusion of the interventions: Time 2 questionnaires administered.

Follow-up interviews with MBGC participants. Follow-up questionnaires mailed 3 months later.

MBGC participants indicate general improvement in psychological wellbeing. Suggestions for improvements and refinements only if necessary. Feasibility assessed.

**Control Arm**
Treatment as Usual: 2 groups of $n = 6-8$.

Conclusion of the interventions: Time 2 questionnaires administered.

Follow-up questionnaires mailed 3 months later.
Appendix P

ADDITIONAL INFORMATION AT FOLLOW-UP

Please answer the following three questions:

1. Did you seek out any outside professional support (e.g., psychological counselling) during the course of the group? (Circle one)

   YES/NO

   If yes, please describe: ____________________________________________

2. Did you begin or stop taking any medication related to your mental health (e.g., antidepressants) during the course of the group? (Circle one)

   • BEGAN TAKING
   • STOPPED TAKING
   • NEVER TOOK
   • HAVE CONTINUED A PRESCRIBED TREATMENT PLAN PRIOR TO AND FOLLOWING COMPLETION OF THE GROUP

3. Did you speak with any members of the other bereavement group at the Hope & Cope Wellness center during the course of your group? (Circle one)

   YES/NO