Presented by

jack hirose & ASSOCIATES INC.
Quality workshops & community resources

Sponsored by

Sunshine Coast Health Centre
A Non-12 Step Mental Health Program

Georgia Strait | WOMENS CLINIC

Live In-Person & Live Stream Conference

WHO SHOULD ATTEND

Clinical Professionals:
All mental health professionals including, but not limited to Clinical Counsellors, Psychologists, Psychotherapists, Social Workers, Nurses, Occupational Therapists, Hospice and Palliative Care Workers, Youth Workers, Mental Health Workers, Addiction Specialists, Marital & Family Therapists, Speech Language Pathologists, Vocational Rehabilitation Consultants, School Counsellors, Behaviour Specialists, Rehabilitation Consultants, Geriatric Specialists, and all professionals looking to enhance their therapeutic skills.

LIVE IN-PERSON

- Complimentary tea, coffee and assorted pastries
- On-site exhibitors

Please note, in-person registration does not include access to the live stream or recorded footage.

LIVE STREAM FROM HOME

This conference will be live streaming from Calgary, AB to online participants on November 13–15, 2024 from 8:30am – 4:00pm MT

Recorded footage and all course content will be available until December 16, 2024. Please allow 3–5 business days after the conference has ended for recorded footage to become available.

Live stream registration:
www.webinars.jackhirose.com

Please Post

The Many Pathways to Healing Conference

Clinical Interventions in the Treatment of Trauma, Grief & Loss

November 13–15, 2024
Wednesday to Friday
8:30am to 4:00pm

Calgary, AB
Best Western Premier Calgary Plaza Hotel
1316 33rd Street NE

A Conference Tailored to Mental Health Professionals at All Levels and Any Profession that Applies Behavioural and Developmental Science to Practice

November 13
An Integrated Approach to Trauma Treatment
John Arden
Ph.D.

November 14
Normative and Prolonged Grief
Christina Zampitella
Psy.D., FT

November 15
Acceptance and Commitment Therapy
Jennifer Patterson
Psy.D., LCPC

JACKHIROSE.COM | 1.800.456.5424

THE MANY PATHWAYS TO HEALING CONFERENCE: CLINICAL INTERVENTIONS IN THE TREATMENT OF TRAUMA, GRIEF & LOSS

Presented by Jack Hirose & Associates. Sponsored by Sunshine Coast Health Centre and Georgia Strait Women's Clinic

If you have any questions, please contact your on-site coordinator.

PLEASE REMEMBER:

- Wear your name badge every day.
- Turn off your cell phone.
- If you have pre-purchased lunch your tickets are in your name badge, please treat your tickets like cash.

EVALUATION FORM:

- Complete your evaluation form each day using the QR code below.

SCHEDULE:

This schedule may vary depending on the flow of the presentation and participant questions

7:30am – 8:30am	Sign-In
8:30am – 10:00am	Morning Workshops Begin
10:00am – 10:15am	Mid-Morning Break (Refreshments Provided)
10:15am – 11:45pm	Workshop in Session
11:45pm – 12:45pm	Lunch Break
	Sign-In (CPA Members Only)
12:45pm – 2:15pm	Afternoon Sessions Begin
2:15pm – 2:30pm	Mid-Afternoon Break (Refreshments Provided)
2:45pm – 4:00pm	Workshop in Session
4:00pm	Complete Evaluation Forms (Use QR Code Above) & Sign-Out (CPA Members Only)

CERTIFICATES:

- Digital certificates are available for download on the final day for multi-day attendees at: http://registration.jackhirose.com/certificates

CPA MEMBERS

- A new policy requires you to request a form from your on-site coordinator, which must be submitted directly to the association.
- Please sign in after lunch and sign out at the end of the day. Early departures result in the loss of CPA credits.
- Certificates will be updated with CPA credits after form verification (allow 2-4 weeks).

TABLE OF CONTENTS

An Integrated Approach to Treating Complex Trauma
Sheri Van Dijk, MSW, RSW
EMDR Certified & Consultant

1

Disclosure

No individuals who have the ability to control or influence the content of this webinar have a relevant financial relationship to disclose with ineligible companies, including but not limited to members of the Planning Committee, speakers, presenters, authors, and/or content reviewers.

"Many of the concepts I'm presenting today are from my books. I do benefit financially from royalty payments from the sale of these products."

2

Objectives

By the end of this workshop participants will learn:

- Some differences between PTSD, C-PTSD, and BPD
- The Triphasic approach to trauma treatment
- The basics of Polyvagal Theory and how to use this with clients
- Some skills to help ground and regulate clients, and to help prepare clients for trauma processing therapy
- How to screen for dissociation and understand its implications for therapy
- The Theory of Structural Dissociation of the Personality
- The basics of how to use a Parts approach in therapy

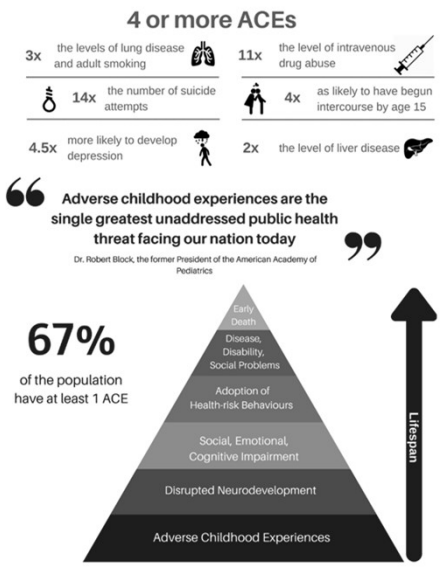
3

What is Trauma?

- Life-threatening trauma meeting the DSM-5 Criterion A definition for PTSD requires exposure (first-hand or vicariously) to actual or threatened death, serious injury, or sexual violence (often referred to as "Big T trauma").
- Experiences that don't meet this strict definition – such as emotional or verbal abuse, or neglect – (sometimes referred to as "small t trauma") may be perceived by an individual as equally or more life threatening than the Big T traumas.
- In EMDR's Adaptive Information Processing model, it's clear that if an experience undermines an individual's sense of self-worth or safety, inhibits their capacity to attribute or accept proper responsibility, or limits one's sense of control or choices in the here-and-now, then it is a trauma (Shapiro, 1997).
- "Trauma is in the eye of the beholder"!

4

The Adverse Childhood Experiences (ACE) study looked at the health and social consequences of seven traumatic childhood experiences in over 17,000 adults in the US (Felitti et al, 1995)



ACEs Measured:
- Parental separation, divorce, addiction, or incarceration
- Household mental illness or domestic violence
- Experiencing physical, sexual, or emotional abuse or neglect

5

Adverse Childhood Experiences (ACES)

- Green et al (2010) study findings suggest that early childhood adverse experiences could be related to up to 32% of psychopathology in adults, and up to 44% in children
- ACEs also increase the risk of early mortality; individuals with six or more ACEs:
  - Were found to have died 20 years earlier than those with no ACEs;
  - Were at a 1.7 times higher risk of death by age 75, and 2.4 times higher risk of death by age 65.

6

ACE Score Increases Suicide Attempt

1 of 100 people with 0 ACEs attempt suicide

10 of 100 people with 3 ACEs attempt suicide

20 of 100 people with 7 ACEs attempt suicide

7

Adverse Childhood Experiences (ACES)

- We need to remember that ACE scores don't account for positive experiences in early life that can help build resilience and protect a child from the effects of trauma (e.g. having a grandparent who loves you, a teacher or coach who understands and believes in you, a trusted friend you can confide in), which may mitigate the long-term effects of early trauma
- AND the initial ACEs study was composed of respondents who were predominantly white, middle-class, and well-educated. The Philadelphia ACEs (2012) project expanded on the original ACEs to look at an urban location with a racially and socio-economically diverse population, adding several events to capture a broader range of experiences…

(the response rate was small, at 1784 adults, or 67%)

8

Philadelphia Expanded ACE Questions look at Community-Level Adversity

Witness Violence	How often, if ever, did you see or hear someone being beaten up, stabbed, or shot in real life?
Felt Discrimination	While you were growing up...How often did you feel that you were treated badly or unfairly because of your race or ethnicity?
Adverse Neighborhood Experience	Did you feel safe in your neighborhood? Did you feel people in your neighborhood looked out for each other, stood up for each other, and could be trusted?
Bullied	How often were you bullied by a peer or classmate?
Lived in Foster Care	Were you ever in foster care?

9

Post-Traumatic Stress Disorder (PTSD): DSM-5 vs. ICD-11

- C-PTSD is not a diagnosis in the DSM-V-TR but has been included in the most recent edition of the WHO's ICD-11 (published in 2019, in-use as of 2022).
- DSM's "criterion A" for a **PTSD** diagnosis: ***The person was exposed to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence,*** either first-hand or vicariously:
  - Directly experiencing the traumatic event(s)
  - Witnessing, in person, the event(s) as it occurred to others
  - Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
  - Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).

*DSM criterion A may exclude a diagnosis of PTSD in many individuals

10

Post-Traumatic Stress Disorder (PTSD)

The ICD-11 formulation of PTSD requires ***exposure to an extremely threatening or horrific event or series of events***; and the experience of symptoms in each of the following clusters:

1. **Re-experiencing symptoms** such as intrusive thoughts, flashbacks, or nightmares.
2. **Avoidance symptoms**, such as avoiding places or situations that trigger memories of the traumatic event.
3. **Sense of threat**, such as hypervigilance and being easily startled.

To be diagnosed with PTSD, the symptoms persist for at least several weeks and cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

11

Complex PTSD

In 1988, Dr. Judith Herman of Harvard University suggested that a new diagnosis, "Complex PTSD" (CPTSD), was needed to describe the symptoms of long-term trauma.

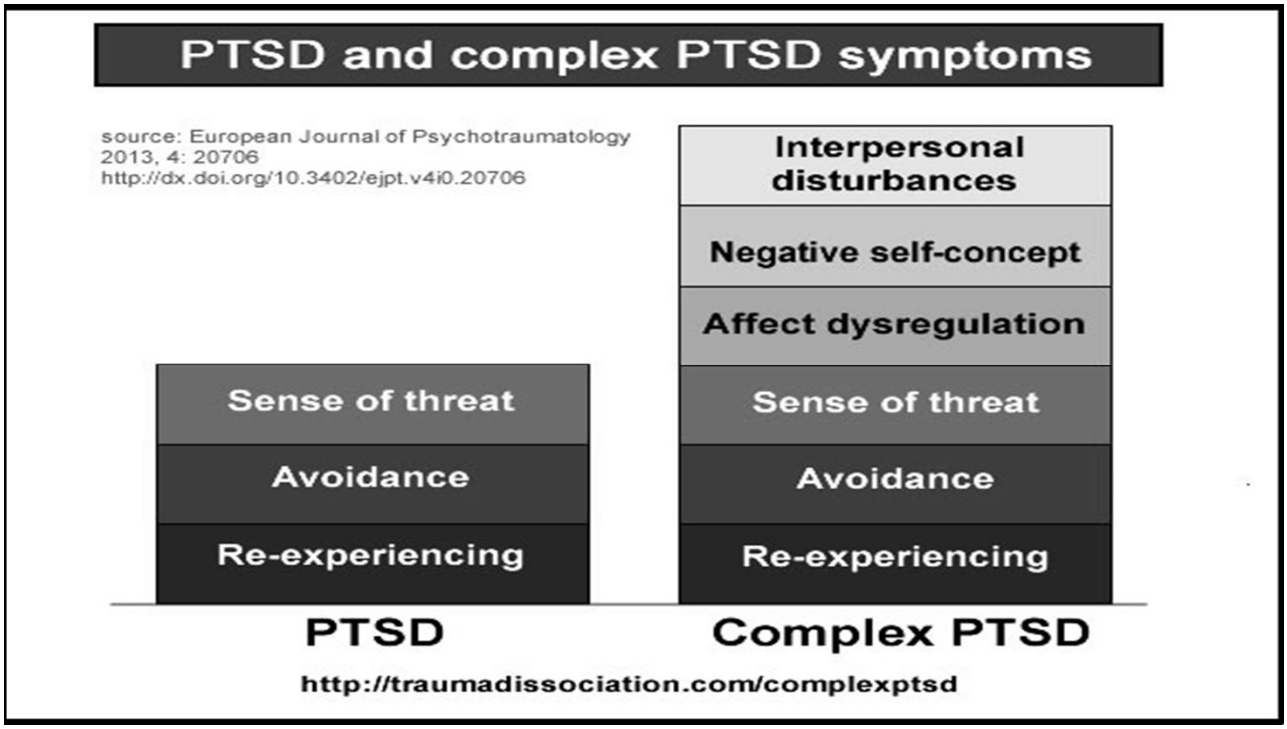
To receive a diagnosis of CPTSD all the features of PTSD must be present; in addition, there must be evidence of Disturbances of Self Organization (DSO) in three additional domains:

1. Problems of affect regulation (e.g. emotional reactivity such as explosive anger and violent outbursts, difficulties calming or soothing oneself after a stressor)

2. Persistent negative beliefs about oneself (e.g. beliefs about self as diminished, defeated or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic event)

3. Difficulties in sustaining relationships and feeling close to others (Relationships often suffer due to difficulties trusting others and the negative self-view; the individual may avoid relationships or develop unhealthy relationships similar to what they knew in the past)

12



13

Complex PTSD

In terms of the trauma itself:

- CPTSD usually results from multiple traumatic events, or when the exposure to trauma is prolonged (although chronic or repeated trauma is a risk factor, not a requirement, for CPTSD; and while it can be diagnosed after a single traumatic event, this is less likely);
- The stressors are typically of an interpersonal nature – that is, resulting from human mistreatment rather than acts of nature or accidents (e.g. childhood abuse, domestic violence, human trafficking, torture, kidnapping, racism, etc.)

14

PTSD, CPTSD and BPD as Different Disorders

- Evidence suggests that PTSD and CPTSD are distinct from, but often co-occur with BPD (Ford & Courtois, 2021; Cloitre et al, 2014; Frost et al, 2018; Knefel et al, 2016).
- Consistent with the idea that chronic or multiple trauma is a risk factor for CPTSD, studies have shown that childhood physical or sexual abuse, particularly within the family, is more strongly related to CPTSD than PTSD (Cloitre et al 2019); CPTSD is also associated with higher levels of psychiatric burden than PTSD, including greater depression and dissociation, and this burden increases when there is co-morbid BPD (Hyland et al, 2018; Cloitre et al, 2019)

15

Complex PTSD	Versus	BPD
Problems calming self & finding comfort when distressed; chronic emotional numbing; substance use; often over-regulated (emotional numbing, avoidance, dissociation). Anger, suicidal and self-injurious behavior occur occasionally.	- Emotion Dysregulation -	Recurrent suicidal behaviors, gestures, threats, and self-harming are more frequent; emotional lability; extreme, uncontrolled anger; profound emotional dyscontrol; typically underregulated
Stable, deeply negative; chronic sense of guilt, shame, worthlessness	- Sense of Self -	Highly unstable, polarized positive and negative perceptions of self Chronic sense of emptiness
Avoidance and detachment based on a fear of closeness; they may desire a relationship, but fear and shame prevents them from pursuing one.	- Relationships -	Pronounced reactive hostility in relationships; oscillating between idealizing and disparaging; intense fear of abandonment and behaviors to avoid this. Often an overwhelming need for closeness and demanding behaviors to fulfill this need.
**Required	- Traumatic Event -	**Not required; and some studies are showing that emotional abuse & neglect are more likely in BPD (Ford & Courtois, 2021)

16

Complex PTSD: Sorting out the Language

Developmental Trauma – proposed as a new diagnosis by van der Kolk & colleagues; this refers to trauma that takes place in childhood and/or adolescence, while the brain is still developing – essentially, C-PTSD for children; often involves attachment trauma.

- currently this is often mis-diagnosed as pediatric Bipolar Disorder, Oppositional Defiance Disorder, Conduct Disorder, and ADD/ADHD, and therefore treated with medications rather than addressing the trauma

Relational Trauma – refers to trauma that happens within a close relationship; this can happen in relationships in children or adults; when this occurs in developmental years it's also referred to as Attachment Trauma

Relational Trauma may lead to C-PTSD: for children, attachment is survival! So when attachment is damaged, lost, or inadequate, the child may experience the world as unsafe, without explicit memory or experiences of "trauma"

Traumatic Invalidation – can also lead to C-PTSD. When internal experiences are regularly invalidated by people in the environment; invalidation can be traumatic when it is severe, long lasting, and negatively affects your understanding of yourself and the world (Linehan, 2014). Examples of traumatic invalidation include emotional or verbal abuse, neglect, discrimination, being blamed or disbelieved when telling someone about a trauma you experienced

17

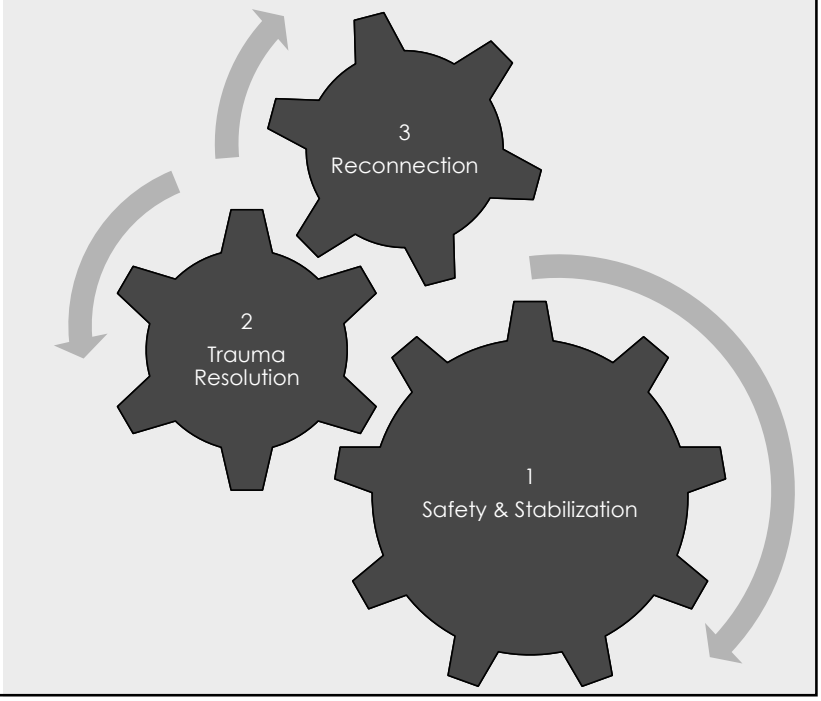
International Trauma Questionnaire

At present only one instrument is available that specifically assesses ICD-11 CPTSD, the International Trauma Questionnaire (Cloitre et al, 2018):

International Trauma Questionnaire: ITQ (traumameasuresglobal.com)

18

Triphasic Model of Treatment (Herman, 1992)



19

The Triphasic Approach to Treating Complex Trauma

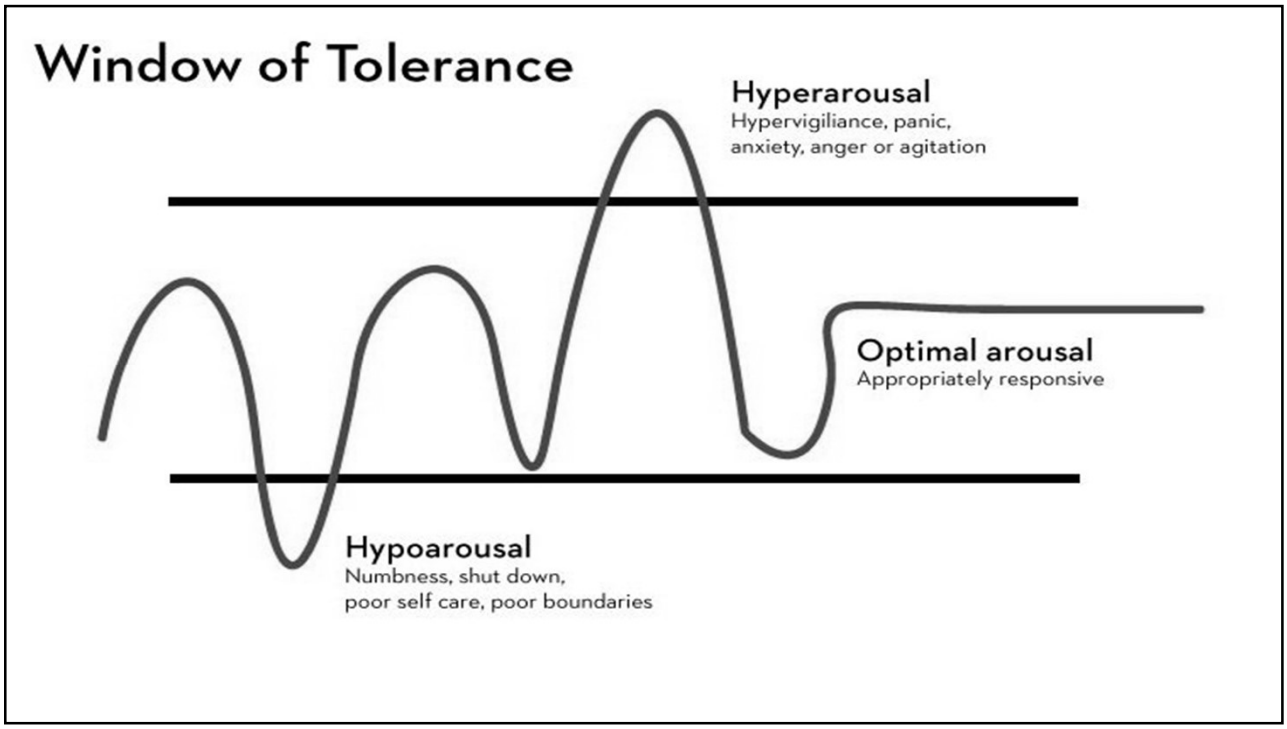
(based on Janet, 1907 & Judith Herman, 1992)

(Keeping in mind that CPTSD is a newer diagnosis and so research is on-going regarding how best to treat it…)

Stage One: Safety and Stabilization: Focus is on helping clients identify the issues that brought them to therapy, learn to manage dysregulation, develop resources, and resolve any major internal conflicts in preparation for Stage 2 (trauma resolution)

- Develop and build the therapeutic alliance (expect this to take longer for a client with relational trauma!)
- Identify presenting issues and concerns, including risk factors, and medical or trauma-related symptoms that may interfere with successful treatment or contraindicate the use of particular interventions (such as EMDR), and that may need immediate attention (e.g. disordered eating)
- Take a thorough history, (not delving into details of trauma and keeping the client within their window of tolerance), and identify current and past sources of resilience

20



21

The Triphasic Approach to Treating Complex Trauma

(based on Janet, 1907 & Judith Herman, 1992)

Stage One: Safety and Stabilization:

History Taking:

- Remembering that there may not be an explicit memory of the trauma, but that *the body keeps the score*!
  - What were/are relationships like in the family of origin?
  - What's NOT being said? (e.g. a client who notes their parent was an alcoholic but then reports "childhood was great"; client might not know to report "no one was home at dinnertime so I had to make myself a sandwich when I was six"; new client)
  - e.g. From a Biosocial Theory perspective
  - e.g. From an Adaptive Information Processing (AIP) perspective
  - ***This should include screening for dissociation!*** e.g. The Dissociative Experiences Scale (DES and DES-T)

22

The Biosocial Theory
(Linehan, 1993)

Pervasive emotional dysregulation is the result of two main factors:

1. A biological predisposition to emotional vulnerability (high sensitivity) AND
2. A pervasively invalidating environment (e.g. the abusive home, the poor fit, the chaotic home)
   - Where the individual's internal experiences are regularly judged, punished, minimized, ignored, etc.

23

The Biosocial Theory
(Linehan, 1993)

Consequences of the emotionally vulnerable child growing up in the invalidating environment:

- The child doesn't learn to label or trust private experiences, including emotions; instead, they learn to search their environment for cues on how to think, feel, and act
- They therefore don't learn to modulate emotional arousal; or how to respond appropriately to distress
- "Problem Behaviors" are the result of unhealthy attempts to regulate emotions

24

The Adaptive Information Processing (AIP) Model

(Shapiro, 1995)

- Usually, we're able to heal from disturbing events we encounter; but sometimes things happen that overwhelm our ability to cope, resulting in the trauma becoming "stuck", or remaining "unprocessed" – unable to link up with more adaptive information
- From this perspective, we conceptualize the client's current symptoms based on the maladaptively stored information

25

The Triphasic Approach to Treating Complex Trauma

(based on Janet, 1907 & Judith Herman, 1992)

Stage One: Safety and Stabilization:

- Develop an initial plan for the subsequent treatment stages
- Provide psychoeducation about trauma and its effects (including the fact that talking about the trauma prematurely isn't typically helpful and sometimes causes more harm) – we'll come back to this with Polyvagal theory as well!

26

The Triphasic Approach to Treating Complex Trauma

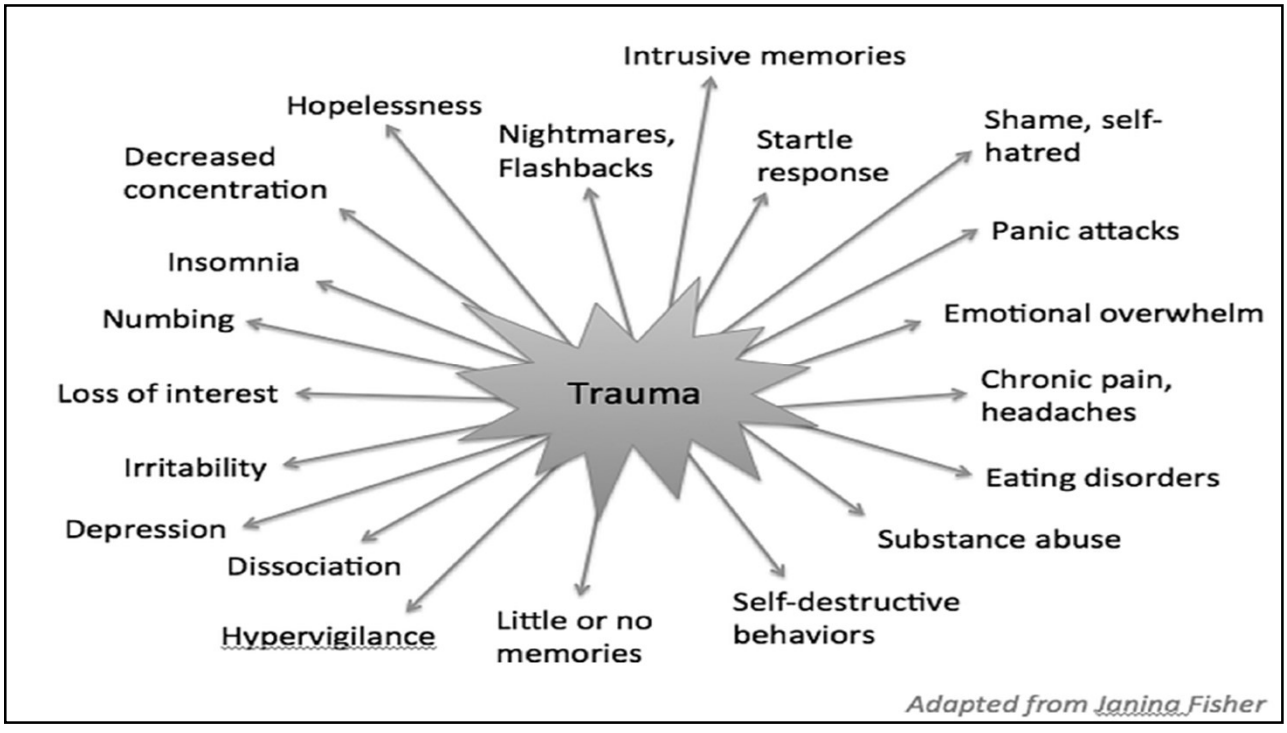
(based on Janet, 1907 & Judith Herman, 1992)

Stage One: Safety and Stabilization: Identifying Triggers

"When we remember a traumatic event or are triggered by some small cue in the here and now, our bodies automatically begin to mobilize for danger, not knowing that we're *remembering* threat rather than being threatened now" (Fisher, 2021, p. 96).

- This is because the amygdala - the part of the brain that responds to stress and triggers our active defenses – can't differentiate between past and present, so we feel as though the danger is happening *now*.
- Flashbacks and dissociation are obvious signs of being triggered, but signs can also be subtler, such as:
  - Feeling like you're not in control of your reaction
  - Having a reaction that seems more intense than what's warranted by the situation
  - Having a reaction different from how you would usually react
  - Becoming stuck in your reaction, unable to step back and access your internal wisdom
  - Feeling as though you're "not yourself", as though another part of you has taken over

27



28

The Triphasic Approach to Treating Complex Trauma

(based on Janet, 1907 & Judith Herman, 1992)

Stage One: Safety and Stabilization:

- Teach skills to increase stability (externally – e.g. housing, finances, relationships; as well as internally - emotion regulation, dissociation, self-care)
- "Bottom-Up" skills to re-regulate quickly (F-TIP Skills):
  - Forward Bend (PNS)
  - "TIP" the temperature of your face (mammalian dive reflex)

*****clients with anorexia and/or bulimia, who have low bp or take beta blockers cannot do this skill without first checking with their doctor!**

  - Intense exercise
  - Paced Breathing (PNS)
  - Paired Breathing: Progressive Muscle Relaxation + Paced Breathing
  - (Hyperventilation technique)

29

Mindfulness for CPTSD ("top-down")

Stage One: Safety and Stabilization:

- One study of an online mindfulness-based intervention demonstrated reduced CPTSD DSO symptoms, particularly negative self-concept and disturbances in relationships; reduced the PTSD symptom of sense of threat, and promoted positive mental health (Dumarkaite et al, 2021)
- Another study on mindfulness for PTSD: "findings suggest the mindfulness facet most relevant to PTSD may be nonjudging of inner experience" (Reffi et al, 2019)
- Aliche et al (2021) found that mindfulness reduced PTSD symptoms associated with experiential avoidance
- I believe everyone can benefit from mindfulness, AND we want to be cautious about how we're introducing mindfulness to someone with a trauma history – e.g. informal versus formal mindfulness; caution re: focus on body or breath; eyes open versus closed

30

Resourcing (Top-Down & Bottom-Up)

Stage One: Safety and Stabilization:

Secure (Calm, Healing, Peaceful) Place

Container

Protective Figure

Nurturing Figure

Wise Figure

New Parent

31

The Triphasic Approach to Treating Complex Trauma

(based on Janet, 1907 & Judith Herman, 1992)

Stage One: Safety and Stabilization:

- For clients who are highly dissociative, Stage 1 will also include understanding how the client's self-system is organized, obtaining on-going consent from all parts, orienting parts, and working on resolving conflicts between parts
- Psychoeducation (we all have parts!); for clients with very complicated internal systems, this may be a problem itself (red flag!)

32

The Triphasic Approach to Treating Trauma

Stage Two: Trauma Resolution: focuses on coming to terms with and resolving past, painful experiences and present triggers for that pain. Tasks include:

- Overcoming fears of the memory, triggers, and cognitions
- Accessing and resolving old, painful experiences
- Accessing and resolving present triggers that connect to the painful experience
- Depending on the treatment, an additional task in this stage may be restructuring trauma-based personal schemas (in EMDR therapy this happens naturally as a result of reprocessing dysfunctionally stored material)

**Not all clients will choose or be able to engage in Stage 2 work

33

Stage Two Treatments

- Eye Movement Desensitization and Reprocessing (EMDR)
- Deep Brain Reorienting (DBR)
- Ego-State Therapy
- **"Four Blinks":** Four Blinks Version of Flash: An Open Approach To Trauma Reprocessing – Rapid Memory Reconsolidation Resources (video)
- Internal Family Systems
- Prolonged Exposure/DBT-PE
- DBT-PTSD
- Cognitive Processing Therapy
- Somatic Experiencing
- Sensorimotor Therapy
- Trauma-Informed Stabilization Therapy

** again, research is on-going for CPTSD

34

The Triphasic Approach to Treating Trauma

Stage Three: Reconnection: focuses on integrating the changes within the self and in day-to-day life, consolidating gains, and (re-)connecting to a meaningful life.

- Addressing any existential, identity, and attachment-related issues (e.g. "Who am I, now that I'm no longer defined or held back by my trauma?")
- Developing a more consistent sense of mastery in life and self-sufficiency through learning skills for handling "ordinary" life difficulties
- Considering longer-term goals
- Achieving relief of any residual symptoms
- Concluding the therapeutic relationship ("what does it mean that we won't be working together any longer?", "will you be here if I need you in future?")
- (DBT Skills that I often use here: assertiveness, limit-setting, acceptance)

It's important to recognize that these stages of treatment don't exist separately from one another – clients will shift back and forth between stages at times

35

Polyvagal Theory (Stephen Porges, 1994)

Polyvagal Theory (PVT) is a popular approach to explaining how neurophysiology impacts our emotional states. It is evidence-based, but there is still debate about it.

- The Autonomic Nervous System (ANS) is a system that involves various organs from the brain to the colon; the Vagus Nerve links them all together.
- The job of the ANS is to keep us alive; it plays a central role in regulating emotions, behaviours, and the body's automatic reactions to social and environmental challenges, acting ***outside of our conscious awareness.***
- Historically we've known the ANS to have two distinct branches: the sympathetic (SNS - "fight or flight") and the parasympathetic (PNS - "rest and digest").
- PVT postulates that there are **two** branches (SNS and PNS), but **three pathways**: with the PNS being split between the Dorsal Vagal and the Ventral Vagal

36

Polyvagal Theory (Stephen Porges, 1994)

Neuroception:

- The term coined by Stephen Porges to refer to our unconscious perception (based on our senses) of safety or danger in the environment.
- The ANS constantly scans (6 times per second) inside your body, the environment outside your body, and what's happening between you and the people around you; it's the filter between us and the world
- Neuroception occurs deep underneath the conscious level of awareness – it's instant and automatic.
- How we neurocept is also influenced by what autonomic state we're in; our ANS is shaped by experiences, habitual responses, and patterns; and what we neurocept leads our ANS to respond in a certain way (active or dissociative defenses)

37

Polyvagal Theory (Stephen Porges, 1994)

- When a human neurocepts an unfamiliar or possibly dangerous stimulus, our brain orients to the stimulus; if it's determined to be safe or non-life-threatening, we return to a state of calm. If the stimulus is perceived to be harmful or dangerous, a defensive response from the ANS follows (**unconsciously**!)
- **Active** defenses are primitive, reflexive actions that include:
  - Crying for help
  - Flight
  - Or, if escape is not possible, Fight
- When active defenses are not possible, the next line of defense is **immobility**:
  - the hyper-aroused *freeze* response ("deer in the headlights"); or
  - the hypo-aroused response of *collapse/submit ("playing possum");* this submit response is the last mammalian defense prior to the onset of death, reducing ability to feel pain. In the context of day-to-day life, this shut-down can include dissociation, or collapsing into paralyzing experiences of depression, shame, or emotional and physical numbness

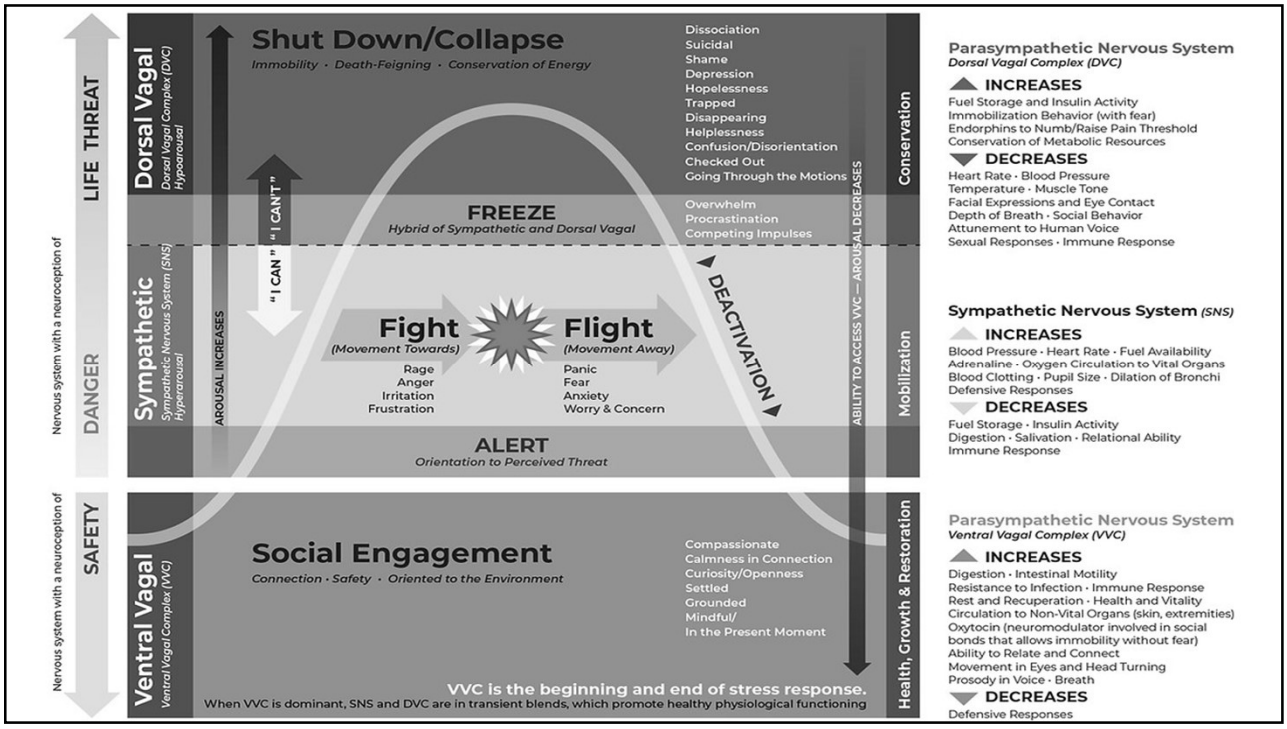
38

Polyvagal Theory (Stephen Porges, 1994)

Co-Regulation:

- The process by which a nervous system is reciprocally regulated (brought back to "safety") in the presence of a safe "other" (caregiver, parent, etc).
- Co-regulation is imperative to a person's ability to move into safe relationships and meaningful connections, and therefore to survival.
- We influence others around us through their neurocepting the signals we send.

39

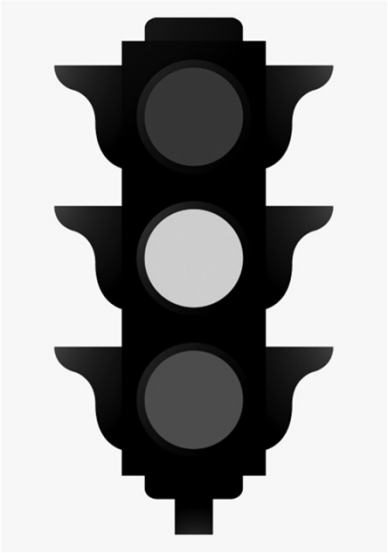


40

Ventral Vagal (Green Zone; WoT)

- Most recent in terms of evolutionary development
- Supports social engagement
- Heart rate slows (65-70bpm resting)
- Saliva & digestion are stimulated
- Facial muscles are activated
- Increased vocal prosody (versus monotone) and eye contact
- **Middle ear muscles are turned on, allowing us to better hear sounds in the mid-range, including the human voice**
- "Safety is a necessary prerequisite for strong social connections":

  Safety => Proximity => Contact => Bonds
- Everything isn't necessarily peaches and roses here, but we have access to our PFC!



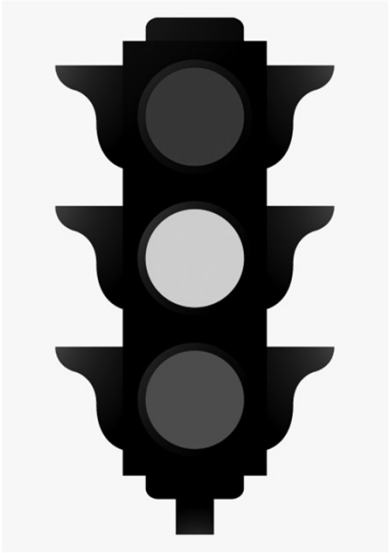
41

Green Zone

42

Sympathetic (Yellow Zone)

- Heart rate increases (110bmp = amygdala hijack)
- Pain tolerance increases
- Middle ear muscles turn off: better to hear extreme low and higher frequency sounds (predator sounds)
- Healthy individuals can bounce between Green & Yellow with ease (playfulness; healthy stress)
- Clinically: client with PTSD related to her husband's death; she's able to recall the events of his death within her WoT (tearful, anxious), but is able to stay in or return to the present and reconnect with me.



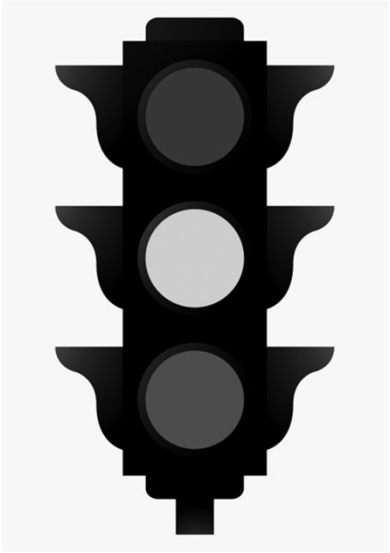
43

Yellow Zone

44

Dorsal Vagal (Red Zone):

- Oldest system, associated with reptilian brain; path of last resort!
- Supports defensive immobilization and "shutdown" behaviours
- Heart rate decreases (60 and below)
- Death feigning - DISSOCIATION
- Understanding the Red Zone helps us to better understand Trauma
- Clinically: client gets highjacked by a memory and dissociates into trance



45

Red Zone

46

PVT: The Story of Trauma Survivors

- Individuals stuck in the dorsal vagal state may carry a story of loneliness, shame, depression, suicidal and self-harming thoughts and behaviors, and dissociation.
- Stuck in the sympathetic state, individuals with unhealed trauma may carry a story of anxiety, mistrust, and difficulties managing emotions
- When survivors are in the ventral vagal state, they're able to let go of these stories and become more connected with and attuned to others.

47

Personal Profile (Deb Dana)

For each of the three zones:

1. I am…(e.g. at peace; cautious; shut-down)
2. The World is…(e.g. calm; overwhelming; terrifying)
3. What word best describes the state for you? (e.g. Chill; Defcon 1; Gone)
4. What are things you can do to help you stay in Green on your own? And with others?
5. What things can you do on your own and with others to help move you out of Yellow and Red? (it takes 20 minutes for us to move back into Green when in full fight/flight)

- Name (the state) to tame it…Understanding the state reduces the shame!
- Trauma isn't psychological, it's physiological

48

Polyvagal Theory (Stephen Porges, 1994)

Ways of stimulating the Vagus Nerve:

1. (Forward Bend)
2. (Paced Breathing)
3. Stimulate the salivary glands
4. Mindfulness meditation
5. Physical exercise
6. Cold water immersion (with caution)
7. Hum, sing, chant, talk or shout, laugh, gargle (the vagus nerve is connected to the vocal chords)
8. Massage

(Safe and Sound Protocol (SSP))

49

Polyvagal Theory (Stephen Porges, 1994)

Criticisms of PVT:

- The model contains vague concepts that can't be tested as a scientific theory
- It over-simplifies the complexities of human emotions and reactions, ignoring the heterogeneity of internal experiences and discounting individual temperament and personality
- The evolutionary ideas are also disputed

50

Diagnoses from a PVT Perspective (Ford & Courtois, 2021)

- PTSD = ***freeze*** response (Yellow Zone): orienting response to scan the environment for stressors and for ways to avoid harm or signs of potential threat (i.e. avoidance based on intrusive re-experiencing of trauma memories)
- CPTSD DSO Symptoms = ***flight*** response (Yellow/Red Zone): unmodulated distress (i.e. difficulty in self-calming, guilt, and sense of worthlessness); and conscious and unconscious attempts to avoid further harm (i.e. emotional numbing and relational detachment). Therefore, CPTSD might be understood as the maladaptive persistence of an initially adaptive stress response that progresses from hypervigilance (i.e., PTSD) to shut-down (i.e., DSO).
- BPD = ***fight*** response (Yellow Zone) when executive control capabilities aren't sufficient to sustain PTSD's freeze/hypervigilance or CPTSD's flight/detachment

51

Polyvagal Theory (Stephen Porges, 1994)

Resources:

- https://www.youtube.com/watch?v=ZdIQRxwT1I0&t=2s
- https://www.bing.com/videos/search?q=seth+porges+polyvagal+theory+on+youtube&view=detail&mid=BC9D971A7BED21C47BCFBC9D971A7BED21C47BCF&FORM=VIRE

52

Dissociation: What is it?

"Dissociation is the essence of trauma" *(Van der Kolk, 2014)*

- We still lack consensus on a definition! ISSTD Definition: ***Involves the total or partial loss of awareness or knowledge, inner body sensation, five-sense perception, emotions, thoughts, perceptions, memories, impulses, and/or sense of self***

Examples:

- a client reports loss of feeling in her hands after she mentioned to me in session that her hands had been badly injured when she was a child;
- during assessment a client mentions they have "no memory" of their life before age 10;
- a client starts describing how she worries she's going to find her son dead from suicide, but expresses no emotion;
- a client informed me that her brother, who had sexually abused her when they were growing up, was supposed to come for a visit at Christmas-time, but when I asked about this two weeks later, she had no memory of the visit.

53

Dissociation: What is it?

- **Not all dissociation is problematic, or a sign that trauma has occurred! -** e.g. daydreaming, highway hypnosis, absorption in a book or movie
- Dissociation becomes problematic when it occurs frequently, is activated in inappropriate circumstances, interferes with daily life functioning, or involves the symptom of identify alteration (and we need to consider the client's perspective of this experience – culture, spiritual/religious beliefs, etc.).

54

Dissociation: What is it?

- Peritraumatic dissociation (PD) is dissociation that takes place at or around the time of a distressing event; it helps us to survive ("the escape when there is no escape" – Putnam, 1997)
  - It's an instinctive, automatic distancing from unbearable pain; or a way of maintaining attachments
  - It allows overwhelming experiences to be split off from and held outside of conscious awareness
- A history of attachment trauma and/or neglect appears to increase the likelihood of PD in the face of traumatic experience; and PD predicts pathological response to trauma (Lanius et al, 2014)
- Dissociation is greater with "betrayal trauma", when a caregiver is an abuser, fails to protect a child from an abuser and/or has an alliance with the abuser (Courtois & Ford, 2009)

55

Key Dissociative Symptoms

Dissociative symptoms commonly occur in many disorders other than dissociative disorders, including PTSD/CPTSD, eating disorders, panic disorder, major depressive disorder, and borderline personality disorder

1. **Depersonalization** – the sense of being disconnected from, or "not in" your body, feeling as though you're an outside observer of your own mental processes, body, or actions
2. **Derealization** – persistent or recurrent experiences of the world seeming unreal or dreamlike, foggy, or distant

(DP/DR are more general symptoms of posttraumatic symptoms, but can also be present in more severe forms – such as dissociative disorders)

56

Key Dissociative Symptoms

3. **Identity Confusion** – feeling as though you don't have a good sense of who you are, what your values are, what you like and dislike, and so on.

4. **Identity Alteration** – At its extreme, this is where a person has DID, and shifts to a different part (or self-state) that may not know where they are, how old they are, and so on. But this can also happen in less extreme ways: like feeling as though there's a different part of you acting at times, and that part doesn't feel like the real you.

(these are the result of more fully-formed self-states resulting from traumatic experiences)

5. **Amnesia** – an inability to recall autobiographical information of various kinds

(amnesia is highly disruptive to an individual's sense of continuity, and ability to be present, aware, and in control; amnesia is therefore recognized as the fullest expression of pathological dissociation, and a defining characteristic of DID).

57

Dissociative Symptoms

Paul Dell notes that, "the phenomena of pathological dissociation are recurrent, jarring, involuntary intrusions into executive (cognitive) functioning and sense of self" (2009); and developed a taxonomy of dissociative symptoms organized into three sets of criteria:

1. General posttraumatic dissociative symptoms – occur not only in dissociative disorders, but in other disorders as well, such as PTSD, panic disorder, conversion disorder, major depression, BPD:
    1. General memory problems – may include day to day experiences like forgetfulness; as well as difficulties with remote memory
    2. Depersonalization
    3. Derealization

58

Dissociative Symptoms

4. Somatoform (conversion) symptoms - bodily experiences and symptoms that have no medical basis; these may affect vision, hearing, sight, smell taste, body sensations and functions, or physical abilities, and are often a partial re-experiencing of the traumatic event

5. Trance - an altered state of consciousness that occurs spontaneously. The person loses conscious contact with what is going on around them and may not respond to attempts to gain their attention (e.g. staring into space, thinking of "nothing", or "going away" in their own mind)

6. Flashbacks - sudden, intrusive memories, pictures, tastes or body sensations, emotions, or nightmares of traumatic events; during a flashback the individual may lose contact with the present moment

59

Flashbacks

- DSM-5 and ICD-11 both recognize flashbacks as existing on a continuum:
  - at one end is total absorption in the traumatic memory, with a complete loss of awareness of the current environment;
  - at the other end of the continuum is a vivid, intrusive memory of the traumatic event in which the person doesn't lose contact with their current surroundings but has a sense that the event is happening again in the here and now.
- This helps differentiate PTSD from other conditions (e.g. major depression) in which there may be intrusive memories of distressing events, but these are experienced as belonging to the past.

60

Dissociative Symptoms

2. Partially-Dissociated intrusions of another self-state into executive functioning and sense of self: symptoms are registered as generated from outside of conscious intention (though not external to the person), and experienced as intrusive or disruptive (for example, hearing child voices, puzzlement about oneself, internal conflicts)

3. Fully-Dissociated Actions of another self-state: the individual experiences amnesia for periods of minutes to days (or more), precipitated by distress for one or more self-states (may include time loss, where the individual discovers they can't account for a period of time; a sense of "coming to"; fugue (suddenly discovering they're somewhere, without memory of going); finding evidence of recent actions, etc.).

61

You Might Not See It!

- Dissociation can be difficult to observe
- Clients might not be aware of the problems – the nature of dissociation is that it is protective!
- Western medicine has "dissociated dissociation!" – clinicians often haven't been trained in dissociation, what to look for, and how to screen
- Other, "more important" treatment targets (e.g. suicidality, self-harming, eating disorders, substance abuse) might distract us from seeing dissociation or inquiring further

62

The Dissociative Disorders

There are five dissociative disorders in the DSM-V-TR:

1. Dissociative Identity Disorder (DID)

2. Depersonalization/Derealization Disorder (DPDR)

3. Dissociative Amnesia (difficulty recalling important information about yourself and your life)

4. Unspecified Dissociative Disorder (used when the symptoms fit the general category of a dissociative disorder but are not specific enough or there's not enough information yet to be classified as a dissociative disorder)

5. Other Specified Dissociative Disorder (OSDD) – where a person experiences dissociative symptoms but does not meet the full criteria for any other dissociative disorder; may be diagnosed when there is an identifiable cause that is not typical of other dissociative disorders.

- There are four common presentations of OSDD:
- **mixed dissociative symptoms**: disturbances of identity without amnesia
- **identity disturbances due to chronic and extreme persuasion**: disturbances of identity due to brainwashing, being involved with a cult, or being subjected to torture
- **dissociative reactions to stress**: dissociation as a result of stressful events that last a few hours to less than one month
- **dissociative trance:** an uncontrollable loss of awareness of their surroundings

63

Ego-State Therapy/Parts Work

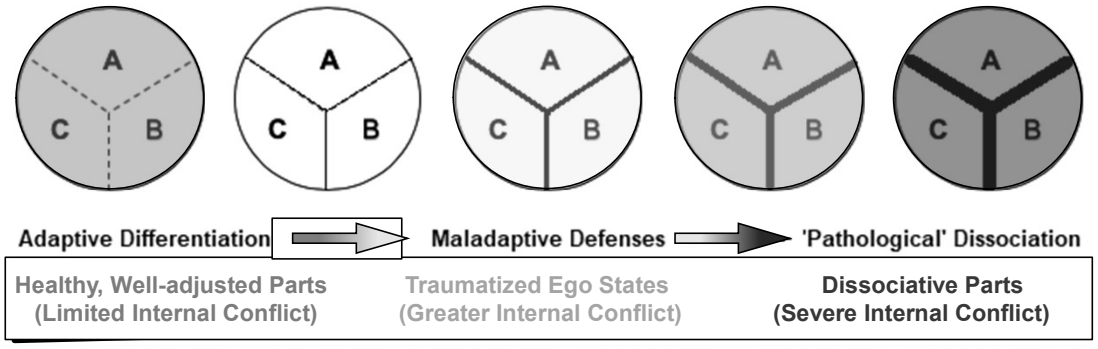
Ways of conceptualizing Self-States/Ego States/Parts:

(yes, they are PART of YOU!)

- Parts are "disconnected containers of implicit memory, driven by instinctive subcortical animal defense responses…a part is the child you once were at a certain age, or the child you had to be in certain situations…it's the little You" (Fisher, 2017)
- Parts are memory networks - bundles of neuronal connections that hold consistent patterns of information that belong to specific ages or situations from childhood
- They're autonomic states (e.g. "my freeze part", or "my fight part")
- Parts are neural networks that know what to expect about the world, and therefore how to respond

64

The Ego State Continuum: From Differentiation to Dissociation
(based on Watkins & Watkins, 1997)



International Society for the Study of Trauma and Dissociation | The Center for Advanced Studies in Trauma & Dissociation

65

Ego-State Therapy/Parts Work

Ego states can develop in three ways (Watkins & Watkins, 1997):

1. Through normative, healthy differentiation (for example, as I learned and trained to be a psychotherapist, I developed my Therapist part).
2. By unconsciously internalizing certain qualities of others, such as beliefs, values, and behaviors ("**Introjects**"). This commonly happens with children and parents – for example, if your parents always ensured you said *please* and *thank you* as a child, as an adult you may judge people who don't say *please* and *thank you* as impolite. Your parents' value has been internalized as your own.

66

Ego-State Therapy/Parts Work

Ego states can develop in three ways (Watkins & Watkins, 1997):

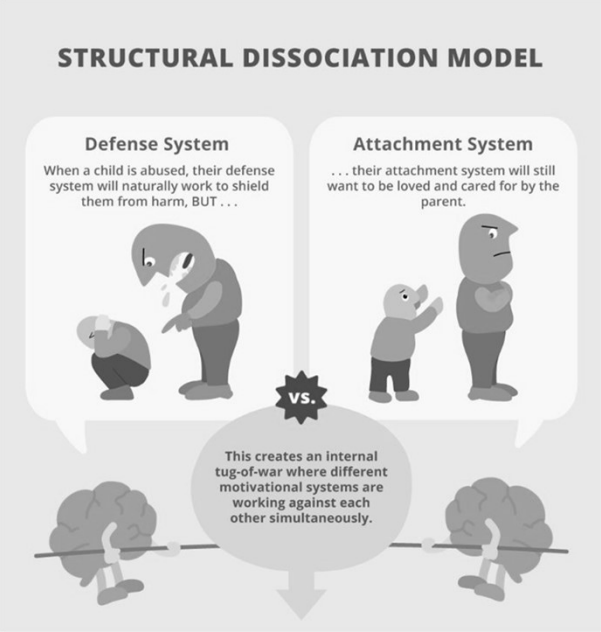
3. As a reaction to trauma: experiencing a traumatic event can lead to the formation of parts associated with those events: Peritraumatic Dissociation is associated with the release of endogenous opioids and endo-cannabinoids that alter communication between lower and higher brain structures (Lanius et al, 2014), creating isolated ego states

- e.g.: a child who is verbally and emotionally abused by a male caregiver develops a part that's triggered when they interact with male authority figures. When a trauma part is activated, you may re-experience emotions, thoughts, and physical sensations associated with the original trauma.

67

Theory of Structural Dissociation of the Personality

When an infant/child (who has not yet developed an integrated personality) is traumatized and receives insufficient soothing, calming, and modeling of emotion regulation, the child may not develop a healthy, integrated personality system of ego-states; instead, the personality divides on "fault-lines" – it becomes structurally dissociated.



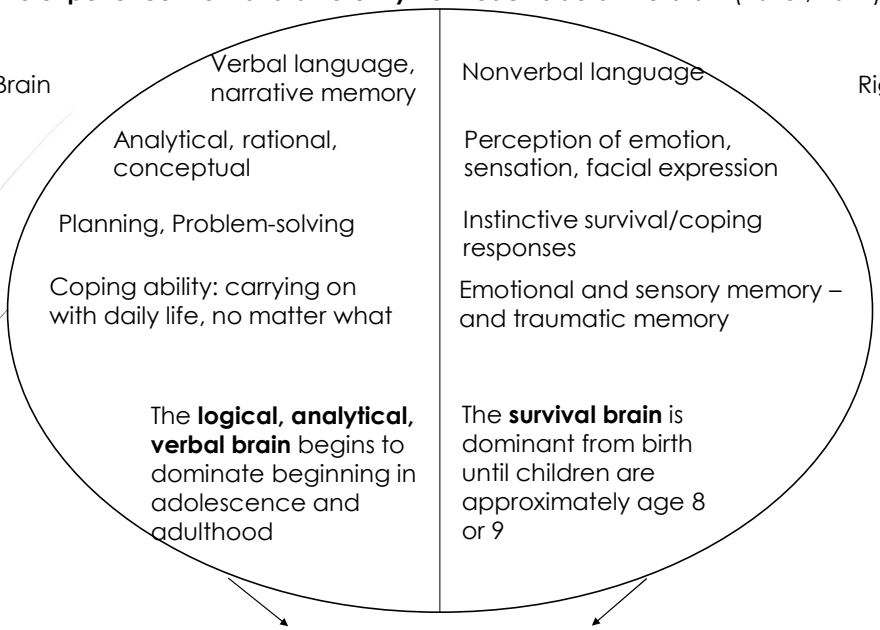
68

Theory of Structural Dissociation of the Personality

Video

69

We experience the world differently from each side of the brain (Fisher, 2022)



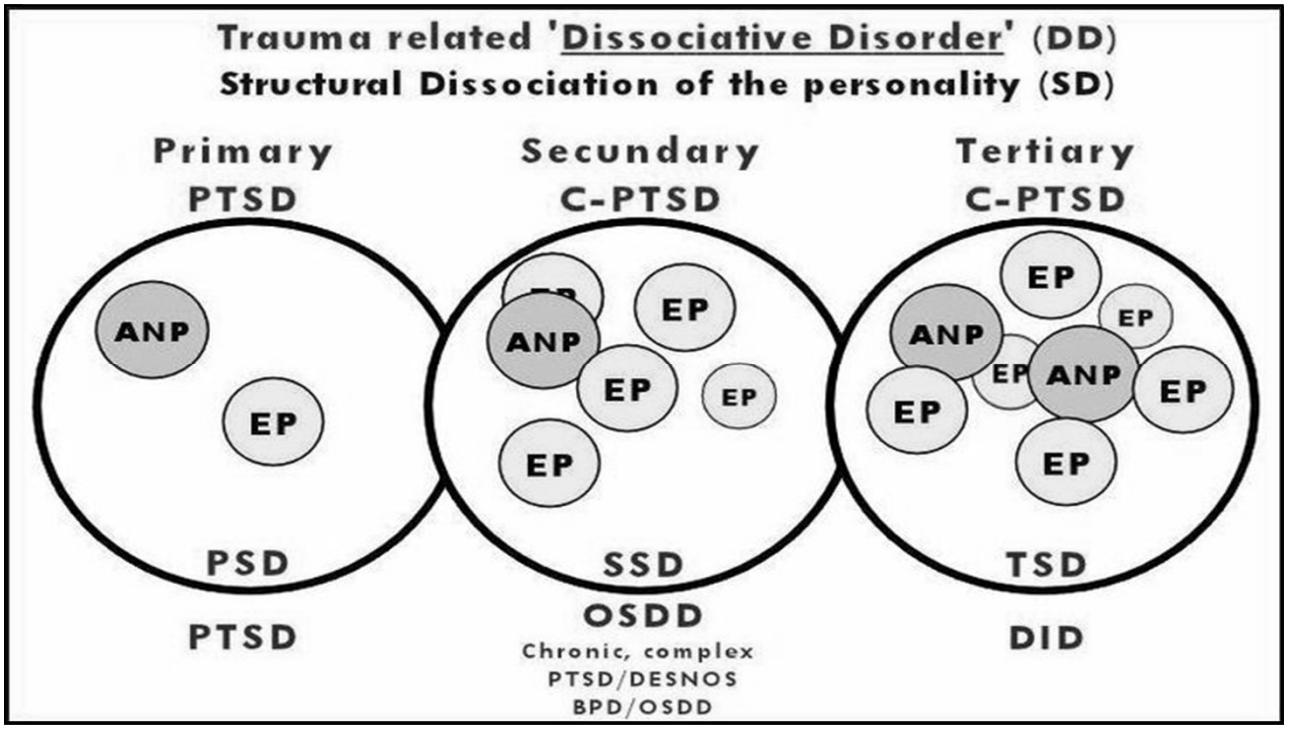
70

Theory of Structural Dissociation of the Personality (SDP)

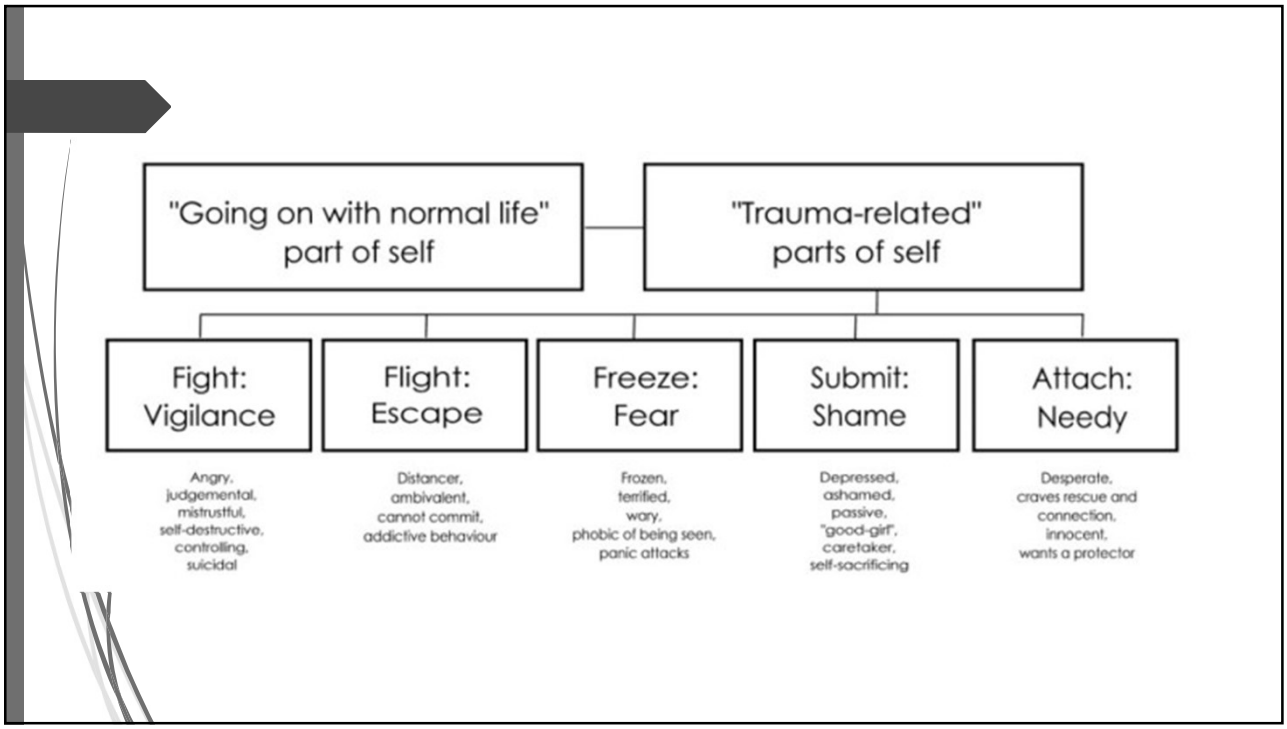
(van der Hart O., Nijenhuis E., and Steele, K., 2006).

- No single model of dissociation has yet to be established as "fact".
- According to SDP, self-states (Parts) develop as a means of adapting to extreme or chronic stress, such as childhood abuse or neglect; these dissociative structures are based on action systems
- The "Apparently Normal Part" (ANP) of the personality is focused on going on with normal life (PFC)
- "Emotional Parts" (EP's) are triggered by implicit or explicit reminders of traumatic events and are often characterized by intense painful emotions (Limbic System);
  - It's important to understand that the job of the EP is to protect, even if that's not readily apparent (e.g. a 30 year-old client has suicidal thoughts related to a 12 year-old part that started as a means of feeling in control when he lived at home with his controlling father)
- The ANP and EP's can interact in complex and conflicting ways, leading to difficulties with self-identity, emotion regulation, and relationships.

71



72



73

SDP: Examples of Parts

Fight: Cory recalls first thinking of suicide when he was 12 years old. He had a very controlling father who didn't understand his depression, and who pushed Cory to do better in school, play more sports, take on more responsibilities, and so on, until Cory finally found escape through fantasizing about taking his life. Now Cory is 30 years old and finds himself thinking about suicide when he feels like he has no control, even though he knows he's an adult and has choices he didn't have as a child.

Flight: Karmen recently left her marriage to an abusive and controlling partner. She had been using drugs for a long time to manage her emotions; but having finally gotten clean from these, she now finds herself alternating between restricting food and bingeing. She doesn't want to do these things but feels like she has no control over herself.

Freeze: Jhavid reports constant feelings of anxiety, and daily panic attacks. Bullied in school for being the only person of color, and growing up with three older brothers who teased him relentlessly for being more sensitive, Jhavid still feels like nowhere is safe.

74

SDP: Examples of Parts

Submit: Marval recalled her mother always yelling at her when she was a child, and even at age 55, she constantly feels like she's doing something wrong. She goes out of her way to try to please others and make them like her, even when that means regularly putting aside her own needs and wants. She also has a habit of over-apologizing, constantly feeling ashamed and not good enough.

Attach: Sam was seeing their new therapist, Shayne, once a week and felt very connected to him, but Sam found they had a strong need to reach out to Shayne between sessions. Sam was reaching out multiple times a day by email or text, and when Shayne told Sam he would only respond to them once a day moving forward, Sam felt very hurt and alone.

75

Structural Dissociation: What to Look For In Adults

(From *Healing the Fragmented Selves of Trauma Survivors, Fisher, 2017*)

1. Signs of internal conflict: e.g. functioning well at work but struggling in personal relationships; acting out a disorganized attachment—a desperate attach part fearing abandonment followed by a fight part pushing away those who try to get close; a client who reconnected with me to return to therapy but keeps missing or being late for appointments.
2. Treatment History: Often multiple previous treatments with little progress; past treatment may be described as "rocky" or ending badly
3. Somatic symptoms: e.g. high tolerance for pain, or an unusual pain sensitivity, headaches, eye blinking or drooping, narcoleptic symptoms, other physical symptoms with no diagnosable medical cause
4. Atypical or non-responsiveness to psychopharmacological medications

76

Structural Dissociation: What to Look For In Adults

(From *Healing the Fragmented Selves of Trauma Survivors, Fisher, 2017*)

5. Regressive behavior or thinking: e.g. body language or voice of a young child, shorter sentences, themes relating to separation, caring, and fairness; client is more likely to feel empathically failed when not well understood.

6. Patterns of indecision or "self-sabotage": Ambivalence = conflict between parts with different objectives.

7. Memory gaps and time loss: Difficulty remembering therapy sessions, how time was spent in a day, conversations, getting lost while driving someplace familiar.

8. Patterns of self-destructive and addictive behavior: Fight and flight parts seeking to avoid pain from traumatic past.

**It's the Going On With Normal Life part that's seeking therapy

77

Red Flags for Dissociation (ISSTD, 2024)

Your client may experience problematic dissociation if they:

- Report a childhood history of abuse or neglect
- Provide vague, inconsistent, contradictory, or poor chronological history
- Notice times where they experience loss of well-rehearsed skills and knowledge

78

Red Flags for Dissociation (ISSTD, 2024)

Your client may experience problematic dissociation if they have had times when:

- They acted as if they were a child, or like a completely different person
- They found objects in their possession that they don't recall acquiring and that don't make sense for them
- They referred to themselves by a different name
- They noticed distinct changes in their hand-writing
- They experience rapid mood changes without apparent reason
- They heard voices or "loud thoughts" (usually inside the head)

79

Hearing Voices

- Although now recognized as a feature of PTSD (in the DSM-5 and ICD-11), the symptom of hearing thoughts as voices is rarely acknowledged; but hearing voices isn't uncommon in PTSD and especially CPTSD (Anketell et al, 2010). In this study, hearing voices was correlated with increased dissociative symptoms.
- A study by Shinn et al, 2020 concluded that hearing voices is not equivalent to having a psychotic disorder; and that "the experience of voice hearing may potentially be the rule rather than the exception in trauma spectrum disorders" (p. 14).

80

Red Flags for Dissociation (ISSTD, 2024)

Your client may experience problematic dissociation if in session you observe your client:

- "Switching" – distinct changes in voice, speech, behavior, movement, or appearance
- Referring to self as "we", or in third person ("he/she/they")
- Answering basic questions with puzzled, ambivalent, or conflicting responses
- Reacting strongly to questions about dissociation
- Blinking repeatedly, keeping eyes closed for no apparent reason, or exhibiting "eye rolling"
- Struggling to track from one session to the next

81

Red Flags for Dissociation (ISSTD, 2024)

Your client may experience problematic dissociation if in session you observe in YOURSELF:

- Feeling confused, or ungrounded: as dissociation disrupts your client's linear thinking and emotional congruity, they may move from one topic to another, or from one emotional state to another, and you find yourself struggling to follow what's happening for them
- Feeling sleepy – your mirror neurons may be picking up on your client being partially absent
- Having a sense of not knowing the client; wondering "who came to therapy last week?" – if your client presents quite differently, with different clothing/hair style, mannerisms, vocabulary, attitude, manner of relating to you, goals for therapy, etc.
- Questioning your memory – the client may have gaps in their memory for previous sessions, and may deny or be unaware of this, suggesting or leaving you questioning if you're mis-remembering

82

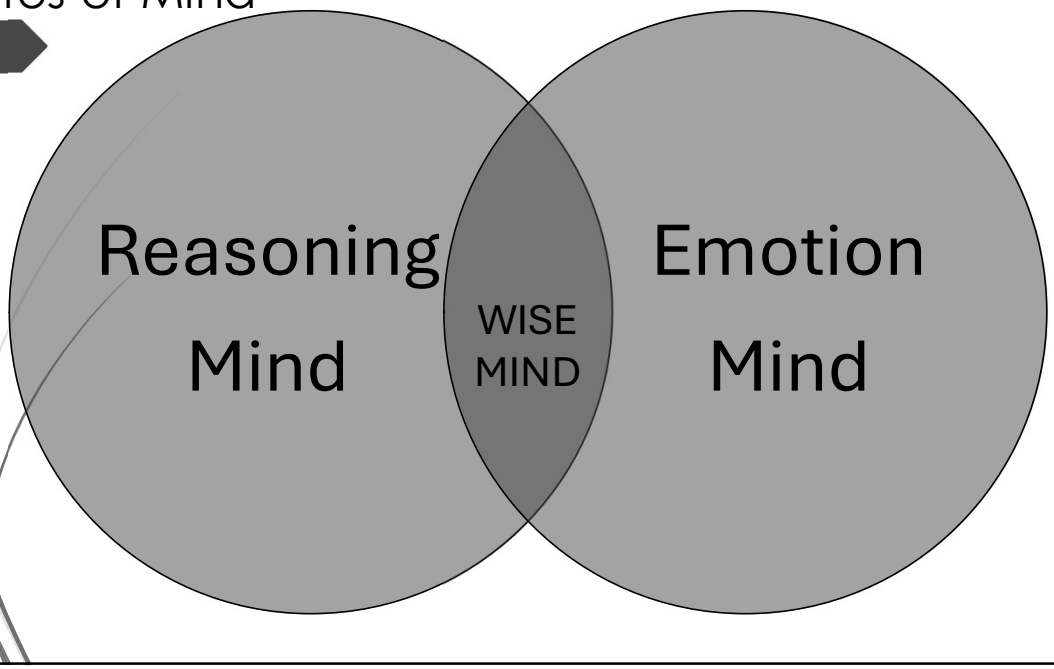
Ego-State Therapy/Parts Work

The Adult Wise Self

- Neither the *going on with normal life part* nor the *trauma parts* are fully integrated, so we want to help our client learn to access their Adult Wise Self/Wise Mind (in IFS this is known as Self or Self Energy)
- I draw on DBT's States of Mind for this:
  - Emotion Mind & Reasoning Mind = Trauma Parts and going on with normal life parts
  - Wise Mind: Emotions + Logic + Intuition (which includes values)

83

States of Mind



84

Core Mindfulness Skills: States of Mind

Reasoning Mind (might be EP or ANP):

- Logical, practical, intellectual, rational, straight-forward thinking
- No emotions involved (or very minimal)
- E.g. making a grocery list; following instructions to bake a cake; balancing your chequebook (as long as there's no anxiety involved!)

85

Core Mindfulness Skills: States of Mind

Emotion Mind (EP):

- You know you're in emotion mind when your *emotions* are controlling your *behaviors*
- E.g. you're feeling anxious so you avoid; your mood is depressed so you withdraw and isolate yourself; you feel angry and you lash out at the people around you
- Emotion mind also includes pleasant emotions

86

Core Mindfulness Skills: States of Mind

Wise Mind:

- It's not that RM and EM are *bad,* and we want to get rid of them; rather, we want to be able to find a balance more often: this is Wise Mind
- Wise Mind = RM + EM + Intuition
- You're in WM when you're thinking about the consequences of your behavior and *choosing* how you want to act rather than reacting.

**WM is fully integrated, having access to all information in the system

87

Core Mindfulness Skills: States of Mind

Differences between EM and WM:

- Both involve an element of emotion, so clients often confuse the two
- In EM, the feelings are more intense, and are *controlling behavior*; there's usually an uncertainty and going back and forth between two choices
- In WM, there's a feeling of peace or calmness ("rightness") about a decision
- EM can often "trick" us into thinking it's WM – we have to *go within*; this usually takes practice

88

Core Mindfulness Skills: States of Mind

Exercises to help clients get to Wise Mind:

- "What does your Wise Mind tell you?"
- Turning inward exercises – e.g. Stone flake on a lake; going down a spiral staircase within yourself
- Breathing exercise: breathing in "Wise", out "Mind"

89

Core Mindfulness Skills: States of Mind

Often just identifying what state of mind is there can help someone take a step back if they're in EM or RM

Help increase awareness of these states by having clients notice regularly ("short cut")

Mindfulness and many of the DBT skills will help people access WM

90

Ego-State Therapy/Parts Work

Working with Parts:

- ***It's important for parts to know that we're not trying to get rid of them!!!***
- Instead, the focus is on helping the client get to know their internal system and helping the system work together more effectively (Stage One of Herman's Model)
- Brain scan research on clients with DID has demonstrated an association between the ANP and the PFC; while none of the trauma-related parts' brain scans show cortical activity (Fisher, 2017)
- Therapies: Ego-State Therapy, Internal Family Systems, Trauma-Informed Stabilization Treatment

91

Strategies: The Meeting Place (Video)

- The client chooses a place they'll be meeting with their parts; this can be based in reality, or fictional, and can be an indoor or outdoor space; have the client close their eyes if possible and imagine this place in as much detail as possible (client describes their meeting place; elicit as much details using as many senses as possible)
- Have the client create a door in their meeting place
- Instruct the client: "When you're ready, unlock the door, open it up, and invite in any parts that would like to join us".
  - Attending the Meeting Place is voluntary for parts; parts may come in but not want to participate in any way, which is fine.
  - Let the client know that parts may appear as other versions of themselves; but they may also appear as unfamiliar: they may be a gender different from the gender the client identifies with; they might be animals or inanimate objects; they may be insubstantial and so are more "felt" than "seen"
  - When the client indicates that parts have come in: "Before we start, I want to let all parts know that this is a safe place, where no one is allowed to hurt anyone else. The meeting place is a place where we're working on getting to know one another, and increasing communication between everyone. Is everyone in agreement?"
- You can then open up dialogue (e.g. do any of the parts have anything they'd like to share, or questions they'd like to ask?)
- Other ways of encouraging communication with parts: collage, drawing, non-dominant hand drawing, Sand Tray

92

Blending With Parts

- When a part takes over and is controlling thoughts, emotions, physical sensations, and body functions, the client has become blended with the part (Schwartz, 1995); they can't tell the difference between their experience and that of the part.
- Blending with a part isn't inherently "bad" – it can be helpful when a part takes over to navigate a specific situation where that parts' skills are required.
  - e.g. a parent who's a doctor – isn't it better for the Doctor part to take over when their child is injured, to deal with the immediate crisis, rather than having the worried Parent part in charge?
- In a healthy system the part will unblend, stepping aside for the wise self to take the wheel again once that need is resolved; when this doesn't happen in a natural and fluid way – as is often the case for individuals with CPTSD – it becomes problematic.

93

How to Unblend

Step One: Assume that any painful or overwhelming thoughts and emotions are communications from parts (Fisher, 2017).

Step Two: Rather than referring to parts' experiences as *yours*, refer to them as belonging to the part (*There's a part of me that feels angry*). Notice what happens when you describe *the parts'* experience – often people note a calmness, reduction in tension, or sense of relief as the part feels validated.

Step Three: See if you can create some space between yourself and the part, so you still feel the parts' feelings, but less intensely, and you're able to feel yourself at the same time. A change in your body position (like a forward bend!), paced breathing, or looking at your hands to remind yourself of your current age can help; and continue to use parts language: *That part of me is feeling…* or *that part of me is thinking*.

94

How to Unblend

Step Four: From your wise mind, consider what the part needs:

- if this was your child, your friend, or your partner, what would you say or do for them?
- depending on the age of the part, you might ask, *What do you need to help you feel less (angry, afraid, ashamed, etc.) right now?*
- if this is a young part, asking might not be appropriate – a 5 year-old can't usually articulate what they need! So, ask yourself, *If this was a 5 year-old child with me right now, feeling afraid, what would I do or say?*
- then, try it: imagine yourself having that conversation with your 16 year-old self; or feel yourself hugging that 5 year-old child.
- notice if the part responds: if you don't get a positive response, you can try again – maybe the part hears your words but doesn't feel them; or perhaps this part struggles to trust and it will take time to build a relationship with them. If the part is responsive, notice how it feels for you that the part feels soothed, reassured, a little calmer, or whatever their experience was.

95

Strategies: Mindful Noticing & Internal Dialogue

- What do you notice happening inside right now?
- If you turn inward right now, are you able to identify what part is responding?
- What does that part need? Can you check in with that part (if appropriate)? Based on what you know about_____, can you think of something that part might find helpful? (e.g. "Based on what you know about 5 year old kids, what do you think would help that young part right now?")
- Parts often need ***validation***, reassurance, orienting to time and place
- As you (validate that part, hug that part, assure that part you're going to continue to check in with them…) How is that part responding?
- What's it like to sense that part feeling… (e.g. reassured by your words)?
- If client really struggles: imagine you have a 5 year old sitting with you right now; would it be okay to tell them they should just get over this? What would you want to say or do for them instead? Some clients may need even more distancing (e.g. The Bonnyville Intervention)
- "How do you feel towards (that part, that physical sensation, etc)?" – activates PFC "witnessing mind" and encourages a perspective of "separate from and in relationship with" (Taylor-Shore)

96

Strategies: Grounding & Orienting Strategies

Grounding:

- Ice pack
- "Big Toes Little Toes"
- Tell me 3 things you see that are… (red, round, etc.)
- Look at your hands; are these 5 year-old hands, or are they 40 year-old hands?
- Having the client stand up and face the door: reach for the door handle; are you the height of a 5 year-old, or of a 40 year-old?
- Can that part of you feel how long your body is? Are they able to sense that this isn't a 5 year-old body, but a 40 year-old body?
- Tell me where you live now? And who do you live with? And where did you live when the (abuse/bad things) were happening?

97

Resourcing (Top-Down & Bottom-Up)

Secure (Calm, Healing, Peaceful) Place

Container

Protective Figure

Nurturing Figure

Wise Figure

New Parent

98

Dissociative Experiences Scale (DES)

Average DES Scores in research	
General Adult Population	5.4
Anxiety Disorders	7.0
Affective Disorders	9.35
Eating Disorders	15.8
Late Adolescence	16.6
Schizophrenia	15.4
Borderline Personality Disorder	19.2
Posttraumatic Stress Disorder	31
Dissociative Disorder Not Otherwise Specified	36
Dissociative Identity Disorder (MPD)	48

http://traumadissociation.com/downloads/information/dissociativeexperiencesscale-ii.pdf

99

Assessment Tools for Dissociation

- Cambridge DPDR Scale
  https://www.wspce.org/couples/Cambridge%20Depersonalization%20Scale-chart-scoring%20version.pdf
- Multidimensional Inventory of Dissociation (MID)
  https://www.mid-assessment.com/

100

Client Story: Gabrielle (DES & MID Example)

101

Ending In Safety

Be sure to always end the session in safety, with your client grounded in the present.

Kluft's "Rule of Thirds" for therapy with clients with C-PTSD:

1. Checking in, catching up, reviewing any homework, making a plan for the session
2. Doing the deeper healing work
3. Closing the session: closure, stabilization, homework and planning for the upcoming time between sessions

102

103

The Complexities of Complex PTSD: References

1. Anketell, C, Dorahy, MJ, Shannon, M, et al. (2010) An exploratory analysis of voice hearing in chronic PTSD: potential associated mechanisms. Journal of Trauma & Dissociation, 11: 93–107.

2. Chinenye Joseph Aliche, Chuka Mike Ifeagwazi, Philip Chukwuemeka Mefoh, John E. Eze & Johnbosco Chika Chukwuorji (2021) Experiential avoidance mediates the relations between mindfulness and PTSD symptoms severity in terrorist attack survivors, Nordic Psychology, 73:2, 191-207, DOI: 10.1080/19012276.2020.1852953

3. Cloitre, M, Garvert, DW, Weiss, B, et al. (2014) Distinguishing PTSD, complex PTSD, and borderline personality disorder: a latent class analysis. European Journal of Psychotraumatology, 5: doi 10.3402/ejpt.v5.25097.

4. Cloitre, M, Hyland, P, Bisson, JI, et al. (2019) ICD-11 PTSD and complex PTSD in the United States: a population-based study. Journal of Traumatic Stress, in press.

5. Dana, D. 2018. The Polyvagal Theory in Therapy: Engaging the rhythm of regulation. New York: W W Norton & Co.

6. Dell, P.F. (2009). Understanding Dissociation. In P.F. Dell & J.A. O'Neil (Eds), *Dissociation and the Dissociative Disorders: DSM-V and beyond* (p. 709-825). New York: Routledge.

7. Dumarkaite, A., Truskauskaite-Kuneviciene, I., Andersson, G. et al. Effects of Mindfulness-Based Internet Intervention on ICD-11 Posttraumatic Stress Disorder and Complex Posttraumatic Stress Disorder Symptoms: a Pilot Randomized Controlled Trial. Mindfulness 12, 2754–2766 (2021). https://doi.org/10.1007/s12671-021-01739-w

8. Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, Marks JS. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. Am J Prev Med. 1998 May;14(4):245-58. doi: 10.1016/s0749-3797(98)00017-8. PMID: 9635069.

9. Fisher, J. (2017). Healing the Fragmented Selves of Trauma Survivors: Overcoming Internal Self-Alienation. New York: Routledge.

10. Ford, J.D., Courtois, C.A. Complex PTSD and borderline personality disorder. *bord personal disord emot dysregul* **8**, 16 (2021). https://doi.org/10.1186/s40479-021-00155-9

11. Fraser, G. A. (1991). The Dissociative Table Technique: A strategy for working with ego states in dissociative disorders and ego-state therapy. Dissociation: Progress in the Dissociative Disorders, 4(4), 205–213.

12. Frost, R, Hyland, P, Shevlin, M et al. (2018) Distinguishing Complex PTSD from Borderline Personality Disorder among individuals with a history of sexual trauma: a latent class analysis. European Journal of Trauma and Dissociation, doi 10.1016/j.ejtd.2018.08.004

13. Green JG, McLaughlin KA, Berglund PA, Gruber MJ, Sampson NA, Zaslavsky AM, Kessler RC. Childhood adversities and adult psychiatric disorders in the national comorbidity survey replication I: associations with first onset of DSM-IV disorders. Arch Gen Psychiatry. 2010 Feb;67(2):113-23. doi: 10.1001/archgenpsychiatry.2009.186. PMID: 20124111; PMCID: PMC2822662.

14. Herman, J. (1992). Trauma and recovery. New York City: Basic Books.

15. Hyland, P, Shevlin, M, Fyvie, C, et al. (2018) Posttraumatic stress disorder and complex posttraumatic stress disorder in DSM-5 and ICD-11: clinical and behavioral correlates. Journal of Traumatic Stress, 31: 174–80.

16. Karatzias, T, Murphy, P, Cloitre, M, et al. (2019) Psychological interventions for ICD-11 complex PTSD symptoms: systematic review and meta-analysis. Psychological Medicine, Mar 12: doi 0.1017/S0033291719000436

17. Knefel, M, Tran, US, Lueger-Schuster, B (2016) The association of posttraumatic stress disorder, complex posttraumatic stress disorder, and borderline personality disorder from a network analytical perspective. Journal of Anxiety Disorders, 43: 70–8

18. Linehan, M. M. 2014. *DBT Skills Training Manual. 2nd ed.* New York: Guilford Press.

19. Parnell, Laurel. (2013). Attachment-Focused EMDR: Healing Relational Trauma 1st Edition. New York City: W. W. Norton & Company.

20. Porges, Stephen W. (1995). "Orienting in a defensive world: Mammalian modifications of our evolutionary heritage. A Polyvagal Theory". Psychophysiology. 32 (4): 301–318.

21. Reffi, A., Pinciotti, C., Darnell, B., Orcutt H. (2019). Trait mindfulness and PTSD symptom clusters: Considering the influence of emotion dysregulation. Personality and Individual Differences, Volume 137: 62 – 70.

22. Schwartz, R. C. (1995). Internal family systems therapy. New York: Guilford Press.

23. Shinn AK, Wolff JD, Hwang M, Lebois LAM, Robinson MA, Winternitz SR, Öngür D, Ressler KJ, Kaufman ML. Assessing Voice Hearing in Trauma Spectrum Disorders: A Comparison of Two Measures and a Review of the Literature. Front Psychiatry. 2020 Feb 24;10:1011. doi: 10.3389/fpsyt.2019.01011. PMID: 32153431; PMCID: PMC7050446.

24. van der Hart O., Nijenhuis E., and Steele, K. (2006). The Haunted Self: Structural Dissociation and the Treatment of Chronic Traumatization. New York City: W. W. Norton & Company.

25. van der Kolk, B.A. (2014) The Body Keeps the Score. New York: Viking of Penguin Group.

26. Van Dijk, S. (2022). The DBT Workbook for Emotional Relief. Oakland: New Harbinger Publications.

Normative and Prolonged Grief Disorder: Proven and Effective Interventions to Help Your Clients Process Grief and Loss

Dr. Christina Zampitella, FT

Objectives

- **One** — Define and differentiate both normative and prolonged grief
- **Two** — Identify and work effectively with individuals who experience disenfranchised losses
- **Three** — Describe how stage models of the grieving process are outdated and learn new theories of the grieving process
- **Four** — Discuss and describe how bereavement is addressed in the DSM-V-TR/ICD
- **Five** — Use a case study to learn how to make differential diagnoses to ensure the use of appropriate interventions
- **Six** — Learn multiple, creative, and proven techniques to support bereaved clients

Outline

I. Definitions
   a. Normative
   b. Prolonged grief

II. Risk factors for prolonged grief disorder

III. Disenfranchised grief

15-minute break

IV. Grief theories
   a. Older theories
   b. Modern theories

V. Cultural and spiritual considerations

60 Minute Break for Lunch

Outline

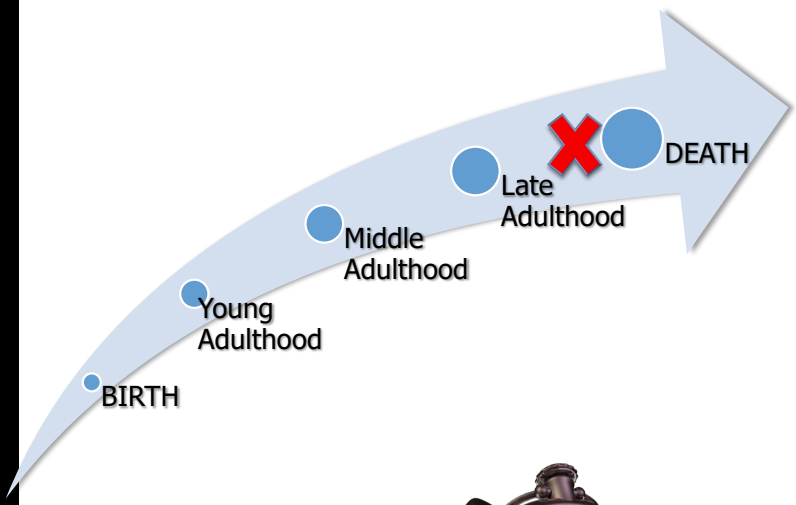
VI. DSM-V-TR/ICD and differential diagnoses

VII. Assessment – Gathering information
   * Case Study

15-minute break

VIII. Treatment planning for uncomplicated bereavement

IX. Interventions
   * Interactive activity


BIRTH
Young Adulthood
Middle Adulthood
Late Adulthood
DEATH


BUNGEE
SKYDIVING
MY BUCKET LIST

What is "grievable?"
What is a Loss?

We experience a sense of loss when someone or something, very dear to us, has been taken from our lives. This loss leaves a sense of emptiness and deprivation.

Loss is an experience of our own human condition. And…we experience different types of losses throughout our lives.

What are some examples of non-death related losses?

Grief: Isn't it Always Complicated?

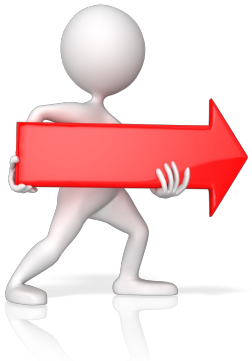
- **Yes, but not in the clinical sense!**
- **Reduction of grief reactions, separation distress, and intensity over time, with allowances for exacerbation (sudden transitory upsurge of grief - STUG) and *non-linear grieving processes***
- **Growing acceptance of reality of the death/loss and its implications. Gradual adaption and integration to new life without deceased**
- **Continued bond with deceased – a different relationship (if culturally appropriate)**
- **Life goals redefined**
- **Gradual return and reinvestment of new interests, activities, relationships, etc.**
- **"If only" thoughts diminish**
- **Meaning reconstruction/post-traumatic growth**

(Harris & Winokuer, 2016; Jamison, 2009; Neimeyer, 2016; Neimeyer, et al., 2019; Rando, 1993; Shear, et al. 2011; Worden, 2018)

Normative Grief

Acute Grief

- Shortly after loss
- Intense yearning, longing, sorrow
- All-encompassing, painful emotional, physical, cognitive, spiritual, and interpersonal reactions
- Natural adaptive reaction



Integrated Grief

- Lasting form of grief
- Feelings and behaviors are integrated into a "new" normal
- Reality of loss is accepted
- Bittersweet memories
- Grief does not dominate
- New interests

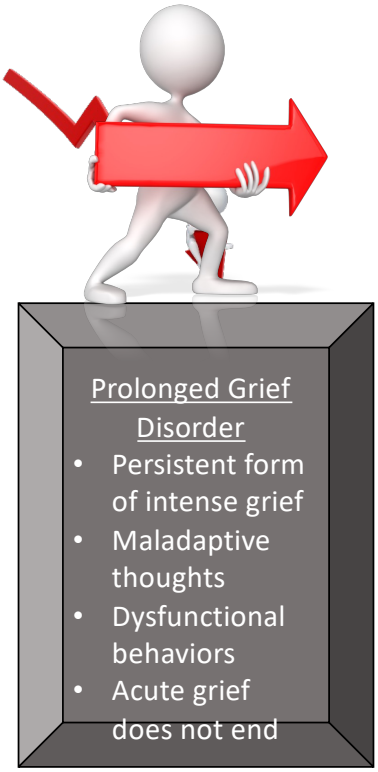
(Doka & Tucci, 2017; Simon, et al., 2011)

7 Domains of Grief Responses

When Grief Goes Awry

Acute Grief

- Shortly after loss
- Intense yearning, longing, sorrow
- All-encompassing, painful emotional, physical, cognitive, spiritual, and interpersonal reactions
- Natural adaptive reaction



Prolonged Grief Disorder

- Persistent form of intense grief
- Maladaptive thoughts
- Dysfunctional behaviors
- Acute grief does not end

Integrated Grief

- Lasting form of grief
- Feelings and behaviors are integrated into a "new" normal
- Reality of loss is accepted
- Bittersweet memories
- Grief does not dominate

(Doka & Tucci, 2017; Simon, et al., 2011)

The Missing Piece - PGD

Not a form of depression – it is more trauma based

Pathological and unique enough to have its own diagnostic disorder (PGD)

Psychobiological dysfunction of the brain, reduced heart rate, impaired autobiographical memory, and problem-solving

(Horwitz, et al., 2009; Shear et al., 2011; Zisook et al.,

Characterized by severe separation distress, dysfunctional thoughts, feelings or behaviors related to the loss that complicate the grieving process and prevent the griever from adapting to the loss, not acknowledging the reality of the loss, not reconnecting with others, and not moving forward with aspirational goals.

Prolonged Grief and DERAILERS (Shear)

- **D**ifficulty letting go of doubts that you did enough for person who died
- **E**mbracing ideas about grief that make you want to change or control it
- **R**uminating about ways that the death was unfair or wrong
- **A**nger and bitterness you can't resolve or let go of
- "**I**f only" thoughts about imagined alternative scenarios
- **L**ack of faith in the possibility of a promising future
- **E**xcessive efforts to avoid grief and/or reminders of the loss
- **R**esistance to letting others help, feeling hurt and alone
- **S**urvivor guilt; it feels wrong or uncomfortable to be happy or satisfied

(Shear, 2020)

These are *normal* responses to loss, especially at the beginning of the grieving process. But if unrelenting, *could* lead to prolonged grief.

Risk Factors

I. Personal psychological vulnerability
   a. Pre-loss or co-morbid psychological disorders
   b. Extreme separation distress
   c. Non-integrated previous losses
   d. Low self-esteem
   e. Worry/anxiety
   f. High negative cognitions
   g. Poor coping skills
   h. Trauma history
   i. Tendency to avoid
   j. Intolerance of uncertainty
   k. High emotionality
   l. Women more than men

(Tofthagen, et al., 2017)

Risk Factors

II. Circumstances of death
a. Untimely
b. Unexpected
c. Violent/traumatic
d. Feels preventable
e. Stigmatized
f. Drug overdose

III. Context in which the death occurs
a. Low social support/ problematic
b. Disenfranchisement
c. Concurrent stressors
d. Multiple losses

(Neimeyer, 2024; Tofthagen, et al., 2017)

Risk Factors

IV. Relationship dynamics
a. Dependent relationship
b. Loss of child/spouse
c. Insecure attachment style

(Tofthagen, et al., 2017)

Disenfranchised Grief

When a bereaved individual or group of individuals are denied the right to grieve, the social support essential to integrating loss, and deprived of the social validation in order to heal

(Doka, 2002)

Significance of relationship is rejected, minimized, or not recognized

Loss is not recognized because it is non-human, abstract, or inanimate

Griever is not recognized as being capable of forming significant relationships or recognizing the loss (griever is excluded)

Circumstance of death or loss is stigmatized

Grieving style is unacceptable

(Attig, 2004; Doka, 2002)

Theories of Grief

Stage Models

I. Bowlby and Parkes' (1970)
   4 stage model
   A. Shock-numbness
   B. Yearning-searching
   C. Disorganization
   D. Reorganization

Kübler-Ross' Stage Model of *Dying*

II. Elisabeth Kübler-Ross' (1969) five stage model
   A. Denial
   B. Anger
   C. Bargaining
   D. Depression
   E. Acceptance
   F. (Meaning Making) – new stage added by David Kessler (2020)

Stage Model Criticisms

- People do not move through stages in a fixed, linear progression. They are useful in describing *some* of commonly found reactions
- Little room for individual, family, religious, societal, cultural, and contextual factors (e.g., not everyone experiences anger/bargaining)
- Cannot apply theory of dying (Kubler-Ross) of terminal illness to theory of grieving process. This theory of dying process has now been discredited as well
- May unintentionally imply a fixed process that the individual should be at a particular place on a continuum despite intervening variables. Actually, the "stages" are more like defense mechanisms/responses and even those are simplistic
- Lack of empirical support, absence of clear research concepts, and not culturally sensitive. 200 interviews of terminally ill middle-aged people

(Corr, 2021; Friedman & James, 2008;Kelley, 2010: Metzger, 1979; Schultz & Adermna, 1974)

"The attempt to expand this model [Kubler-Ross'] to what experts have learned is unjustified, potentially dangerous, and contrary to what experts have learned about loss, grief, and bereavement during the past 30 to 40 years…attempts to employ the five stages of grief (whatever they are thought to mean) in either education or practice should be promptly abandoned and never resuscitated."

~ Charles Corr

Phase Theories

- Models are more pliable than stage models
- Allows for symptoms of one phase to overlap the symptoms of the next—or even regress to a previous phase
- Bowlby and Parkes' model is sometimes put into this category because it is a more flexible stage model

Sanders' Phase Model

- Sanders' five-phase model states phases can co-exist, with one or more being more intense than others at different times
- Each phase has psychological, cognitive, and physical symptoms
- Recognizes individual nature of grief
- Individuals have choices in grief. Not just passive coping with little control

(Doka, 2005-2006; Sanders, 1999)

Sanders' Phase Model

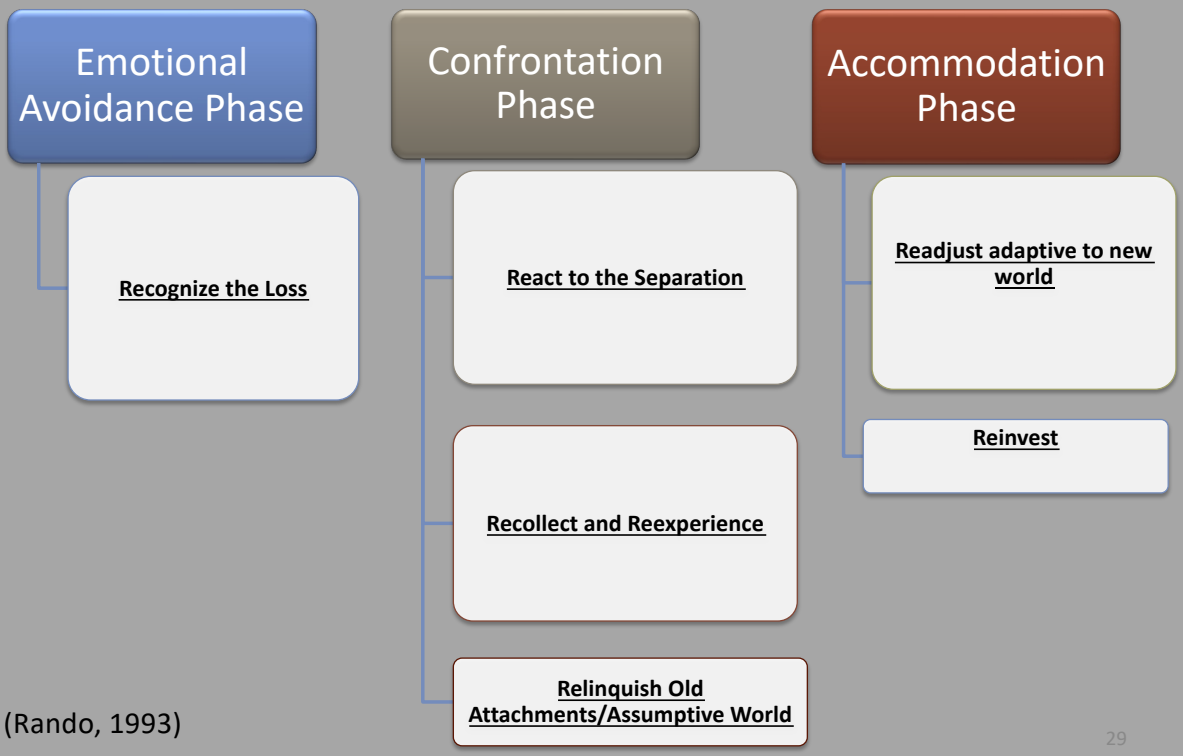
1. Shock
2. Awareness of the loss
3. Conservation-withdraw
4. Healing – The Turning In Point
5. Renewal

** Sanders was developing a sixth phase called Fulfillment, but she died before her work was finished. Doka (2006) published her work for her. **

6. Fulfillment

(Doka, 2005-2006; Sanders, 1999)

Rando's Six R's of Mourning



(Rando, 1993)

Worden's Task Model

Worden's (2018) Tasks of Mourning approach

A. States stages and phases implies mourner *passes through* grieving

B. Completing tasks refers to the concept of the mourner can *actively* do something about his/her process

C. Tasks do not need to be accomplished in a particular order, but within definitions of each, some ordering is suggested

(Worden, 2018)

Worden's Task Model

1. Accept the reality of the loss

2. Work through the pain of grief

3. Adjust to an environment in which the deceased is gone
   I. Three types of adjustments
      a. External – everyday functioning
      b. Internal – sense of self
      c. Spiritual - sense of world, values, and fundamental beliefs, meaning making, existential issues

4. Relocate the dead person, relationship, etc. within one's life and find ways to memorialize the person

"To find a way to remember the deceased in the midst of embarking on the rest of one's journey through life" (Worden, 2018, p.51)

(Worden, 2018)

Neimeyer's Meaning Reconstruction Model

- Constructivist, narrative approach model that is an active process of meaning reconstruction
- Loss assaults assumptive world:
    1. In day-to-day functioning
    2. Values and priorities
    3. Identity
    4. Social and interpersonal relationships
    5. Spiritual, religious, or philosophical views
- Holds that loss disrupts self-narratives and sets individual into a quest for meaning making

(Neimeyer, 2001; 2016)

Neimeyer's Meaning Reconstruction Model

Three activities to reconstruct meaning

1. Sense making – Comprehending the loss; find benign explanation (e.g., spiritual reason)
2. Benefit finding – "Silver lining" (e.g., increased empathy)
3. Identity change – Reconstruct self, especially when response to loss is adaptive

(Neimeyer, 2001; 2016)

Neimeyer's Meaning Reconstruction Model

- Identity seen as successful narrative achievement established through stories we tell ourselves and others ("live in stories, not statistics") where meaning is woven in
- Author our own stories - reflect, interpret, and reinterpret what happened
- Emphasizes idiosyncratic nature in each griever's reactions – each person writes his/her own story
- Therapist comes from place of "not knowing"

(Gillies & Neimeyer, 2006)

"Perhaps the most important contribution to the current conceptualization of grief reactions is the recognition of the uniqueness of the grieving process to each individual and family. The empirical literature has not supported the concept of linear stages or phases in mourning. Bereaved individuals often experience contrasting emotions at the same time and oscillate between them. Instead of focusing on ensuring individuals are grieving the *correct* way, the emphasis now is on recognizing the multiple variables that affect the grieving process, as well as the particular individual style of expressing grief. Thus the main goal of grief and bereavement care is to support the individual's unique and personal grieving process without a preconceived notion of how that process should present or develop."

~ Strada, 2016

Cross-Cultural Bereavement

- Have prescribed norms of what is considered an appropriate emotional expression to loss and expectations of behavior during/after loss
- Mourning rituals, traditions, and taboos culturally prescribed
- Contingent upon gender roles, religious beliefs, nature of the relationship, nature of the death
- Behavior exhibited varies considerably from culture to culture…and even sub-cultures within a predominant culture.

Cross-Cultural Bereavement

- Influences what is considered appropriate support and interventions
- Affects how deceased is thought of (e.g., to be beneficial to the bereaved or not to be spoken of)

Grief Within Cultural Framework

- Expression and continue bonds regulated (policing)
- Subtly or overtly
- Tied to gender roles
- Differences in loss-orientation and restoration-oriented coping (e.g., Chinese lean towards restoration)
- Expression norms on a continuum, influenced by if death is a community event (e.g., India) vs. those that are more private (e.g., Britain)

(Klass & Chow, 2011; Laungani & Young, 1997)

Grief Within Cultural Framework

- Handling of body, laying out body, transportation to cemetery/crematorium, arrangement for funeral services, if body can/cannot be cremated, who performs which rituals - all related to norms and practices
- How openly death, dying, and grief is discussed is culturally bound
- Prescribes what constitutes death. Dichotomous event? Gradations?
- How long death is "spread out." How long person remains earthbound. where they can be "found" (e.g., nowhere, shrine, cemetery, etc.)
- Secondary rituals helps mark steps in responsibilities in grief (e.g., end of obligation to mourn and move forward)

(Laungani & Young, 1997; Parkes, 1997)

Clinical Considerations

- No absolute guidelines for specific cultures.
- Westerners often apply their norms, customs, etc. as being "normal." Give as much acceptance to other cultures as we do ours
- Length, rules, and expectations of mourning varies by culture.
- Theories, resolution of grief, and techniques culturally bound
- Events and loss have universal components, but responses and what are considered symptoms are expressed within the specific culture context that may or may not fit clinician's expected symptoms
- What is considered "help" is different cross-culturally
- Client may defer to clinician's definition of abnormal grief and acquiesce (clinician as police)
- Attend to judgments about grief responses in one's own family and communities. Cultural self-awareness necessary
- Attend to restoration or loss orientation differences

(Klass & Chow, in Neimeyer et al., 2011; Parkes, 1997; Stamm, et al., 2004)

Religion and Spirituality: Definitions

Religion

- "An institutionalized pattern of beliefs, behaviors, and experiences, oriented toward spiritual concerns and shared by a community and transmitted over time in traditions" (Canda & Furman, 1999, p. 73)

Spirituality

- "An innate human need to find meaning and purpose in life and to have a relationship with something outside of, and larger than, oneself" (Moremen, 2005, p. 310)
- To seek an answer to the question, "How can you make sense out of a world which does not seem to be intrinsically reasonable?"
- How one's soul experiences connection with that which is greater than oneself

(Burke & Neimeyer, 2014; Canda & Furman, 1999; Chapple, et al., 2011; Currier, et al., 2013; Kelley & Chan, 2012; Krieglstein, 2006; Moremen, 2005; Wortman & Park, 2008)

Spirituality of Grieving

- Bereavement can be catalyst for spiritual growth - creates imbalances that must be addressed
- Forced to engage in efforts to create meaning to reintegrate and find balance. Leads to personal transformation
- Spiritual needs can fluctuate throughout the mourning process
- Affected by one's individual development and cultural modes of expression
- Can give hope, comfort, strength, inner resources, and support

Religion, Spirituality, and Grief

- "Global conceptualizations of religion do not adequately capture the complete nature of religion in people's lives" (Wortman & Park, 2008, p. 703)
- Provides perspectives on death
- Loss may lead to fundamental shifts in belief systems – with changed, increased, or deceased faith
- Provides framework and coping resources (e.g., clergy, community, rites and rituals, prayers, behaviors, ceremonies, structure)
- Resource for understanding/coping with loss
- May support meaning making
- Religious coping, private religious practices, and organizational religious activity is factored into post-traumatic growth (PTG)
- Grief can deepen spiritual beliefs and enhance PTG, most especially with violent loss survivors
- Can help reframe loss; be a form of solace; help interpret events differently
- Engaging with beliefs and spiritual leaders can support this process
- May provide comfort and guidance regarding existence beyond physical existence
- Secure attachment to one's Higher Power (one who is consistently available and responsive) predicts positive religious coping, meaning making, stress-related growth, and reduces depression and anxiety (belief in benevolent Higher Power)

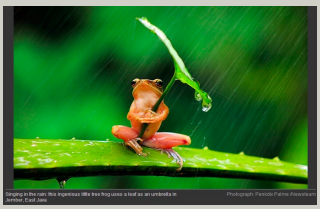
(Burke & Neimeyer, 2014; Chapple, et al., 2011; Currier, et al., 2013; Kelley & Chan, 2012; Wortman & Park, 2008)

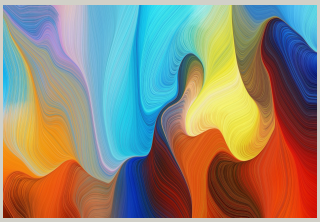
Clinical Considerations

- Explore how clients draw on beliefs and spiritual convictions to navigate grieving process. Be a companion in exploration, not offer definitive answers
- Deal with difficult topics courageously and honestly. Do not shy away
- Explore and reinforce those beliefs, remembering they are a source of strength
- Be aware and attend to the spiritual crisis that may occur as a result of the loss
- Be open to exploring the various ways that religious beliefs encourage guidance in finding meaning in suffering; support hope and compassion
- Welcome client to share post-death encounters (i.e., extraordinary experiences)
- Be willing to hear experiences and beliefs foreign to you
- Become more familiar with religious and spiritual traditions
- "Develop the necessary comfort and skill to deal with client's spiritual concerns in ways most helpful to the client" (Tedeschi & Calhoun, 2006, p. 111)
- Remember religious beliefs may not always be helpful, and may lead to self-blame and other painful feelings and experiences

(Burke & Neimeyer, 2014; Chapple, et al., 2011; Currier, et al., 2013; Tedeschi & Calhoun, 2006)

Enjoy Your Lunch!






DSM/ICD and Differential Diagnoses

Adjustment Disorders

Criterion A	• Development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s)
Criterion B	• Causes significant impairments in social, occupational, or other important areas of functioning
Criterion C	• Does not meet criteria for another disorder or exacerbation of current disorder
Criterion D	• Does not represent normal bereavement
Criterion E	• Once stressor or consequences have terminated, symptoms do not persist for more than an additional 6 months

Criteria for Prolonged Grief Disorder

Criterion A	• The death, at least 12 months ago, of a person who was close to the bereaved individual (for children and adolescents, at least 6 months ago).
Criterion B **Since the death, the development of a persistent grief response characterized by one or both of the following symptoms, which have been present most days to a clinically significant degree. In addition, the symptom(s) have occurred nearly every day for at least the last month:**	• Intense yearning/longing for the deceased person • Preoccupation with thoughts or memories of the deceased person (in children and adolescents, preoccupation may focus on circumstances of the death)
Criterion C **Since the death, at least 3 of the following symptoms have been present most days to a clinically significant degree. In addition, the symptoms have occurred nearly every day for at least the last month:**	• Identity disruption (e.g., feeling as though part of oneself has died) since the death • Marked sense of disbelief about the death • Avoidance of reminders that the person is dead (in children and adolescents, may be characterized by efforts to avoid reminders)

(APA, 2022)

Criteria for Prolonged Grief Disorder

Criterion C (Cont'd)	• Intense emotional pain (e.g., anger, bitterness, sorrow) related to the death • Difficulty reintegrating into one's relationships and activities after the death (e.g., problems engaging with friends, pursing interests, or planning for the future) • Emotional numbness (absence or marked reduction of emotional experience as a result of the death) • Feeling that life is meaningless as a result of the death • Intense loneliness as a result of the death
Criterion D	• The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning
Criterion E	• The duration and severity of the bereavement reaction clearly exceeds expected social, cultural or religious norms for the individual's culture and context

(APA, 2022)

Criteria for Prolonged Grief Disorder

Criterion F	• The symptoms are not better explained by a major depressive disorder, posttraumatic stress disorder, or another mental disorder, or attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition

(APA, 2022)

Prolonged Grief Disorder in ICD-11

Follows death of partner, parent, child, or other person close to the deceased

At least one if the following	• Persistent and pervasive longing for the deceased • Persistent and pervasive preoccupation with the deceased
Accompanied by intense emotional pain	• Examples include sadness, guilt, anger, denial, blame • Difficulty accepting death • Feeling one has lost part of one's self • Inability to experience positive mood • Difficulty engaging with social or other activities
Time and Impairment	• More than 6 months following loss • Clearly exceeding expected cultural, social, or religious norms • Significant impairment in personal, family, occupational, and other important areas of functioning

DSM-V-TR/ICD-10-CM

On October 1, 2024, EHR systems changed DSM-V-TR codes to match ICD-10-CM codes.

So, how does this impact mental health diagnosing?

The Z code of 63.4 is no longer the name used for uncomplicated bereavement in the EHR because in the ICD-10-CM, the Z Code 63.4 is for disappearance and death of a family member. *However*, it is listed as such:

Disappearance and death of family member

- Assumed death of family member
- Bereavement

Therefore, continue to use this code for uncomplicated bereavement. NO OTHER Z CODE FITS!

Bereavement vs. MDD

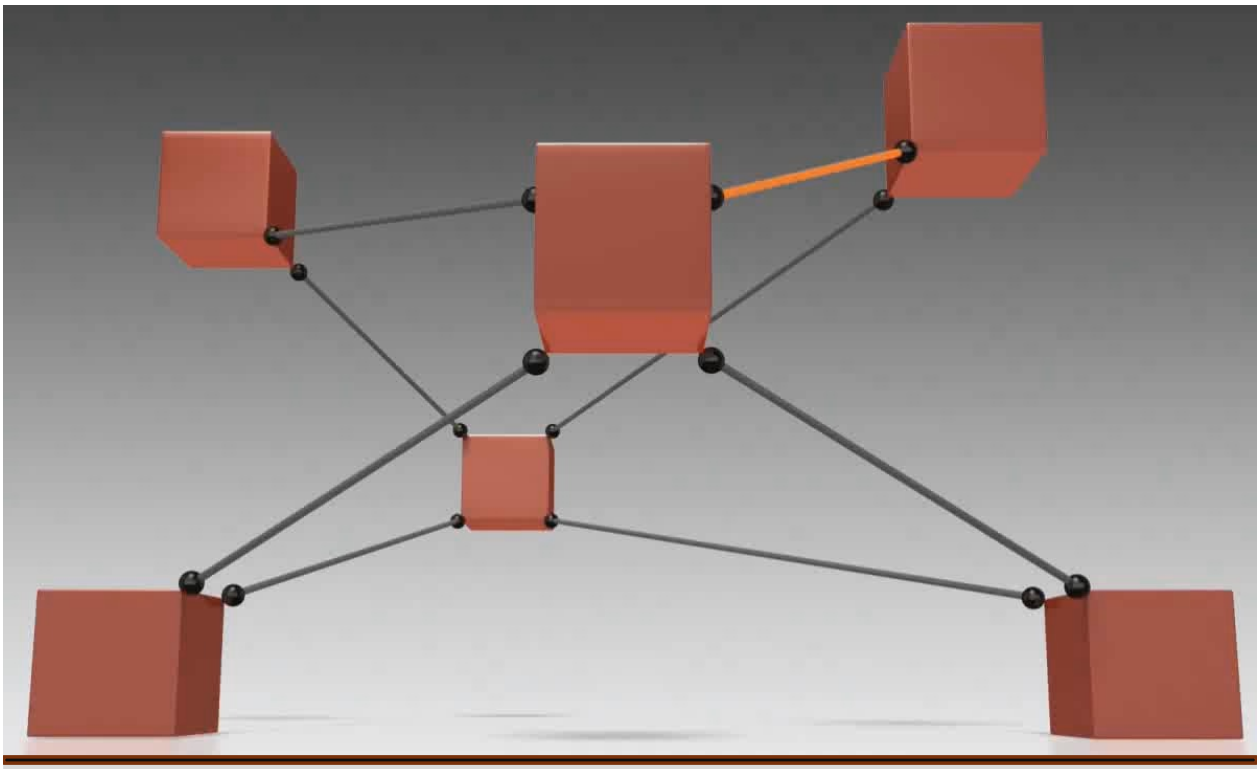
Characteristic	*Bereavement*	*Major depressive episode*
Pattern	Waves or pangs of grief associated with thoughts or reminders of the deceased that are likely to spread further apart over time	Negative emotions experienced continually over time
Predominant affect	Emptiness and loss accompanied by occasional pleasant emotions	Pervasive depressed mood and the inability to anticipate happiness or pleasure
Self-esteem	Typically preserved, but if self-derogatory thoughts are present they usually involve perceived failings in relationship to the deceased (e.g., not visiting the deceased more often, failing to communicate their love enough to the deceased)	Critical toward self, feelings of worthlessness, and self-loathing
Sociability	Maintains connections with family and friends who have ability to console	Withdraws from others physically and emotionally and has difficulty being consoled
Thoughts	Preoccupation with thoughts and memories of the deceased; tends to be hopeful	Self-critical or pessimistic thoughts; tends to be hopeless
Thoughts of death or suicide	Thoughts of death and dying focused on the deceased and perhaps reuniting with the deceased	Explicit suicidal thoughts related to feelings of worthlessness, a belief that one is undeserving of life, or a sense that one is no longer able to cope with the pain of depression
Triggers	Depressed mood triggered by thoughts or reminders of the deceased	Depressed mood not tied to specific thoughts or preoccupations

(Kavan, 2014)

What Does the "Note" Say?

- In distinguishing grief from a major depressive episode (MDE), it is useful to consider that in grief the predominant affect is feelings of emptiness and loss, while in a MDE it is persistent depressed mood and the inability to anticipate happiness or pleasure. The dysphoria in grief is likely to decrease in intensity over days to weeks and occurs in waves, the so-called pangs of grief. These waves tend to be associated with thoughts or reminders of the deceased. The depressed mood of a MDE is more persistent and not tied to specific thoughts or preoccupations. The pain of grief may be accompanied by positive emotions and humor that are uncharacteristic of the pervasive unhappiness and misery characteristic of a MDE. The thought content associated with grief generally features a preoccupation with thoughts and memories of the deceased rather than the self-critical or pessimistic ruminations seen in a MDE. In grief, self-esteem is generally preserved, whereas in a MDE feelings of worthlessness and self-loathing are common. If self-derogatory ideation is present in grief, it typically involved perceived failings via-a-via the deceased (e.g., not visiting frequently enough, not telling the deceased how much he or she was loved). If a bereaved individual thinks about death and dying, such thoughts are generally focused on the deceased and possibly about "joining" the deceased, whereas in a MDE such thoughts are focused on ending one's own life because of feeling worthless, undeserving of life, or unable to cope with the pain of depression. (APA, 2022, p.142)

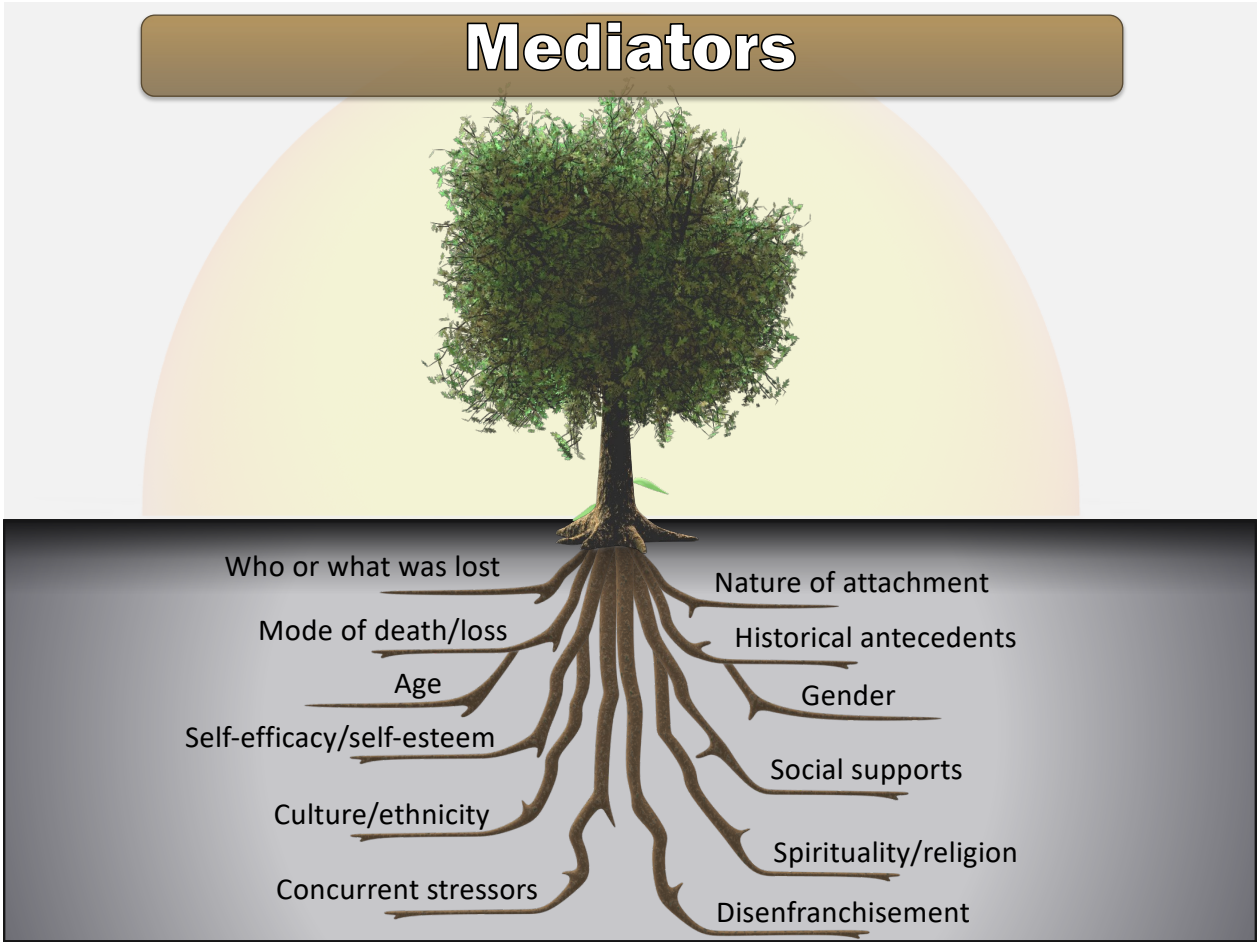
Differential Diagnosis of prolonged grief disorder, major depressive disorder, and post-traumatic stress disorder			
Characteristic	**Prolonged Grief Disorder**	**Major Depressive Disorder**	**Post-Traumatic Stress Disorder**
Affective Symptoms			
Depressed mood	Prominent; focused on loss; diagnostic criterion	Prominent; diagnostic criterion	May be present
Disbelief about death	Prominent; focused on loss; diagnostic criterion	Not usually present	May be present
Anhedonia	Not usually present	Prominent and pervasive; diagnostic criterion	Prominent and pervasive; diagnostic criterion
Anxiety	May be present; focused on separation anxiety	May be present	Prominent and pervasive; diagnostic criterion; focused on fear of recurrent danger
Yearning and Longing	Prominent and pervasive; diagnostic criterion	Not usually present	Not usually present
Guilt	Common; diagnostic criterion; related to regrets with deceased	Usually present; related to feelings of being undeserving and worthless	Prominent and pervasive; diagnostic criterion; usually focused on event or aftermath
Cognitive and Behavioral Symptoms			
Difficulty concentrating	Not usually present	Common; diagnostic criterion	Common; diagnostic criterion
Preoccupying thoughts	Common; Focused on thoughts and memories of the deceased; diagnostic criterion	May be present, focused on negative thoughts about self, other, the world	Negative, exaggerated, distorted thoughts related to the event; diagnostic criterion
Recurrent preoccupying images or thoughts	Common; focused on thoughts/memories of deceased; diagnostic criterion	May be present	Common; focused on event; associated with fear; diagnostic criterion
Avoidance of reminders of loss	Common; focused on reminders of the finality if the death; diagnostic criterion	May be present, but usually focused on social withdrawal	Common; focused on loss of safety or reminders of the event; diagnostic criterion
Loss of meaningful life	May feel meaningless without deceased; diagnostic criterion	May be present	May be present
Seeking proximity to the deceased	Common; diagnostic criterion	Not usually present	Not usually present



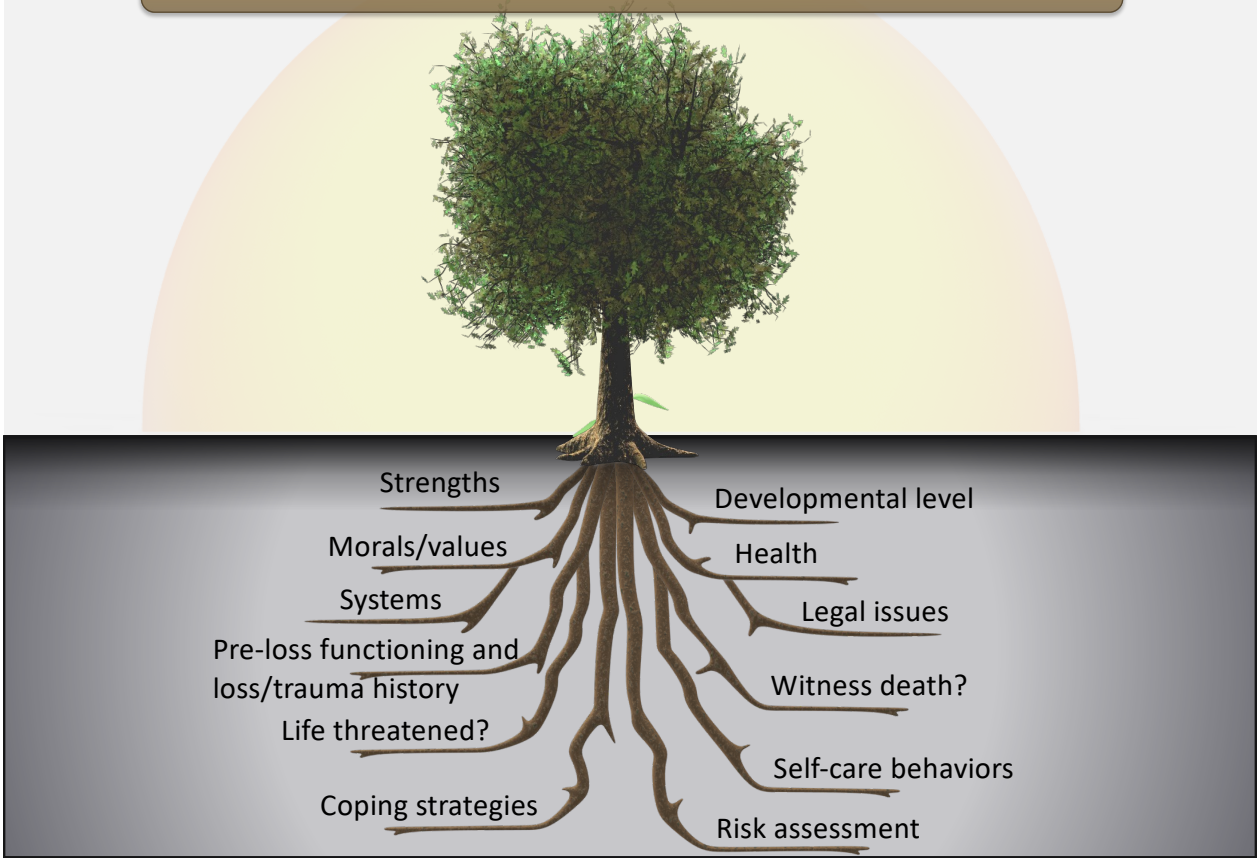
Assessment

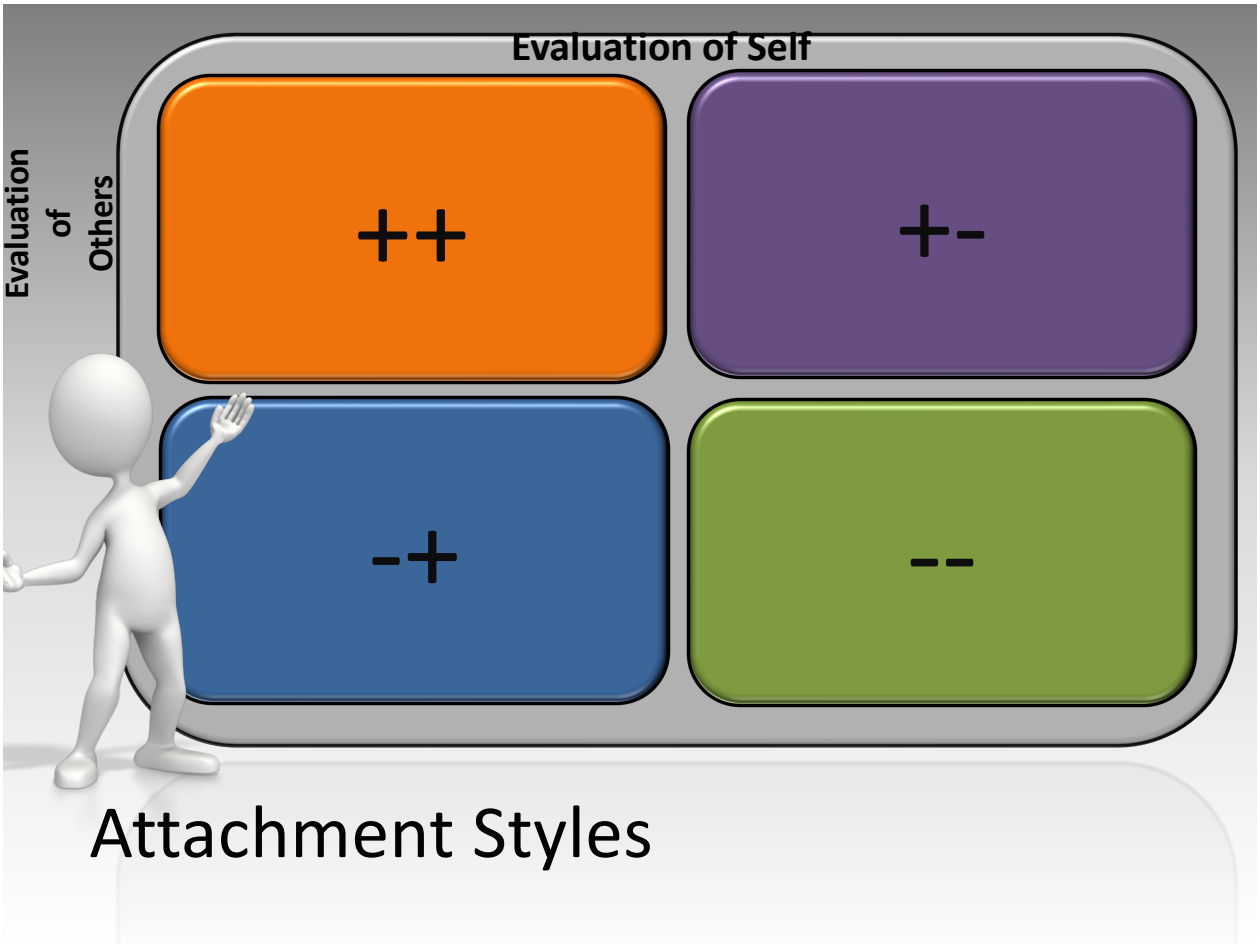
Gathering information

Mediators



Mediators





Attachment Styles

Secure	2
3	4

Comfortable with intimacy and autonomy

High self-esteem

Coherent and cohesive

Flexible

Relocates bond

Oscillates

1

Preoccupied/ Anxious

3

4

Preoccupied with relationship

Low self-esteem

Unable to cope constructively

Stuck in emotional response

High risk of PGD

1

2

Dismissive/ Avoidant

4

Dismissing of relationships and intimacy

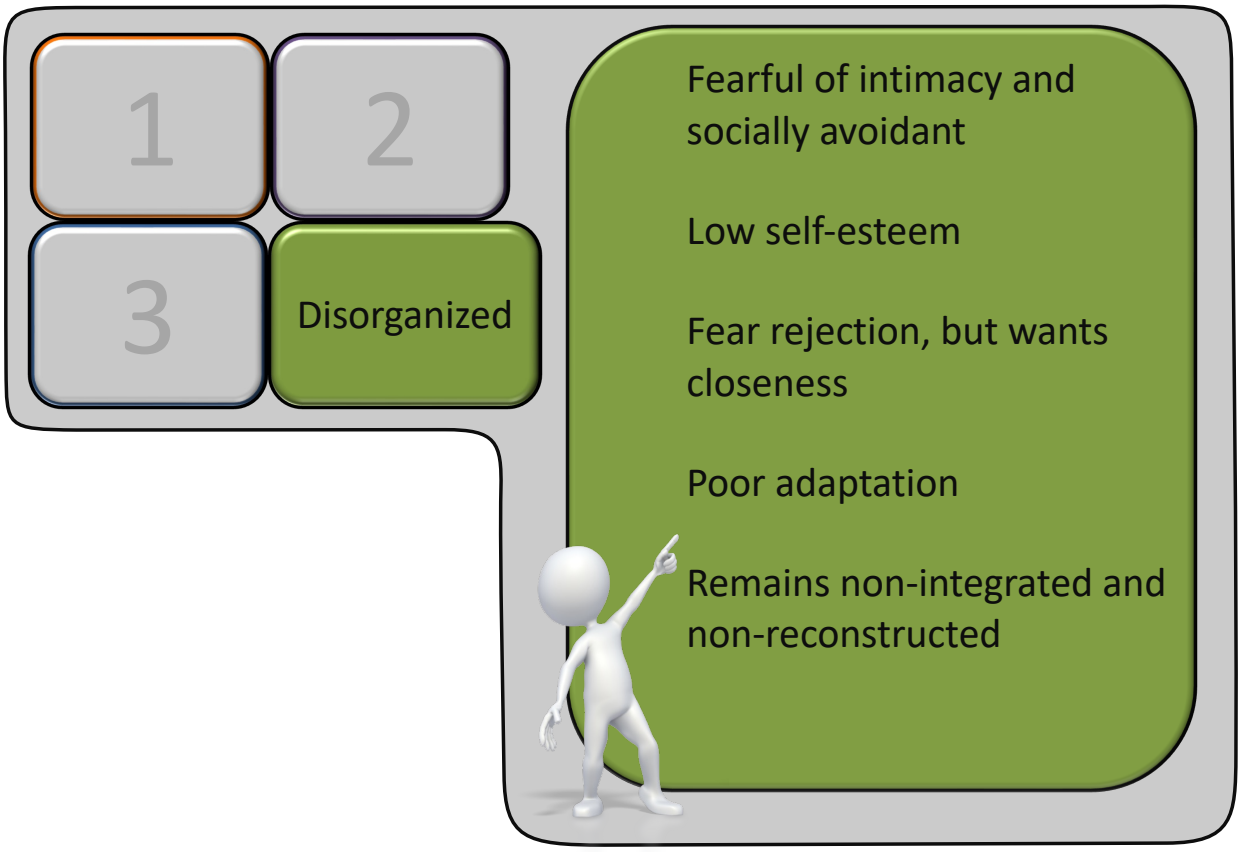
High self-esteem

Lack of trust

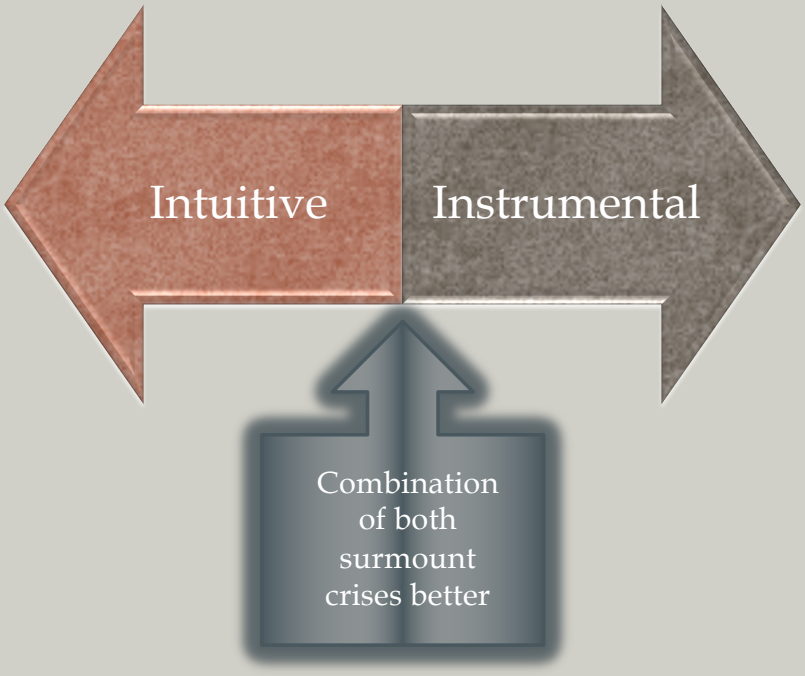
Independent

Avoids emotions

Restoration focused



Martin & Doka's Adaptive Grieving Styles



(Doka, 2011)

Formal Assessment Measures

- Do not just use scale or questionnaire. Study research, focus, and appropriateness
- Choices should be tailored
- May be used throughout the course of treatment.
- Many in public domain, but some require purchase and training

Stengths Assessment Measure

Strengths

https://www.viacharacter.org/survey/account/register

Intake Questionnaires

1. **Grief and Mourning Status Interview and Inventory (GAMSII) (Rando)**

Offers:

a. Part I: Basic demographic information

b. Part II: Main parts of history, MSE, and premorbid characteristics

c. Part III: Structured interview with loss-related topic areas based on Rando's 6 R's mourning processes

GAMSII and accompanying chapter provided in handout for this certification

(Permission granted by Therese Rando)

(Rando, 1993)

Intake Questionnaires

1. **Two-Track Bereavement Questionnaire on Life Following Loss (Rubin, Nadav, & Malkinson)**

Self-report assesses response to loss over time. Constructed in accordance with the Two-Track Model of Bereavement.

Offers:

a. Track I: Biopsychosocial functioning

a. Track II: Ongoing relationship to memories, images, thoughts, and feeling states associated with the deceased.

(Rubin, Nadav, & Malkinson, 2009)

Prolonged Grief Measure

PG-13: Inventory of Prolonged Grief - R (Prigerson et al.)

https://endoflife.weill.cornell.edu/sites/default/files/pg-13.pdf

Complicated Spiritual Grief Measure

3. Inventory of Complicated Spiritual Grief 2.0 (Burke, et al.)

"a spiritual crisis during bereavement that compromises the griever's sense of relationship to God and/or the faith community, such that he or she struggles to reestablish spiritual equilibrium following the loss" (Burke, et al., 2021)

Measures:

a. Insecurity with God

b. Estrangement from spiritual community

c. Disruption in religious practices

https://www.tandfonline.com/loi/udst20

Sarah's Case

Sarah is a 43-year-old, divorced, heterosexual, cisgendered, Italian American, Christina female who resides in Philadelphia, PA with her two children, Sabastian (8 years old) and Katie (6 years old). Sarah and her ex-husband, Jason, lost their 3-year-old son, Jacob, to cancer 2 years ago after a 6-month battle with lymphoma. His death significantly impacted their relationship, eventually leading to the end of their 10-year marriage. They share equal, joint custody of their surviving children.

While Jacob was sick, Sarah resigned from her 7-year position as an office manager at a law firm to care for Jacob, taking him to and from the hospital, staying with him when he was inpatient, and so on. Sarah and Jason were bedside with Jacob when he died (which Sarah felt was traumatic for her). Sarah felt relieved that the hospital pastor was present when Jacob died, even though Jason felt differently about her presence. Sabastian and Katie were not informed of many details surrounding Jacob's illness as their parents felt they "would not understand what was happening anyway and we don't want this to be harder on them as it already is."

Sarah's Case

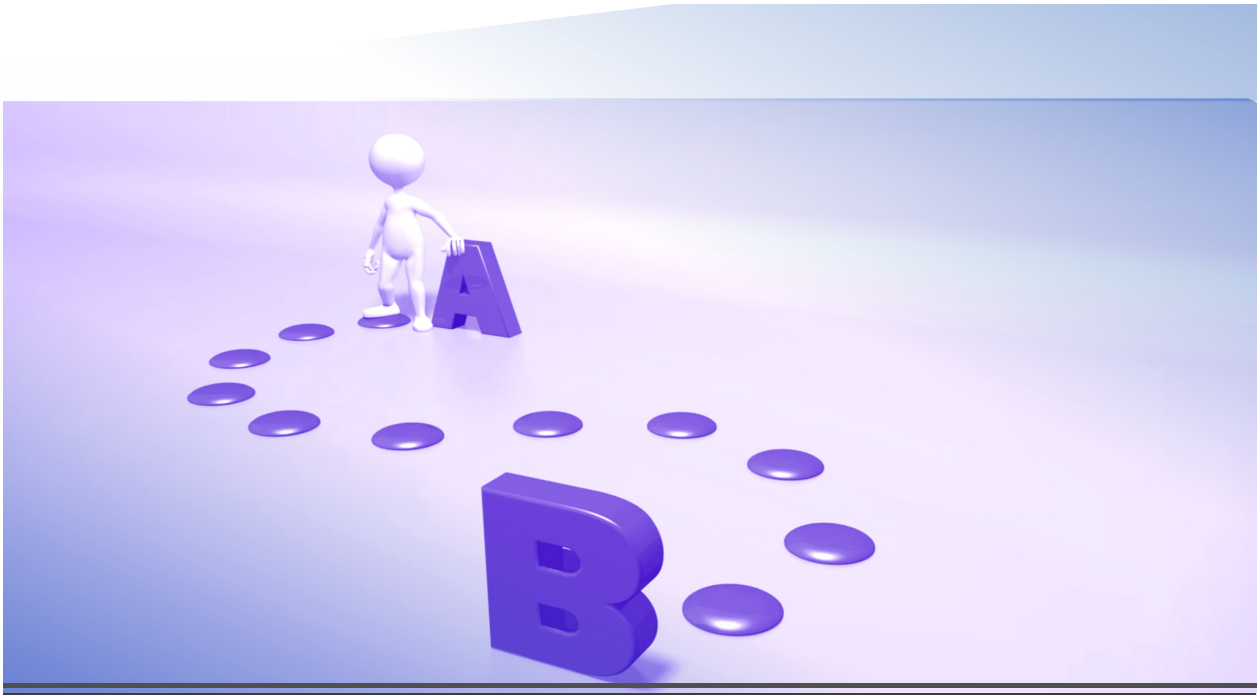
The family's income was severely impacted, and they lost their secondary insurance which led to high medical bills that she and her ex-husband are still trying to pay off.

After the divorce, Sarah presented to therapy endorsing the following symptoms: intense yearning for Jacob, deep guilt for "not being able to keep him alive," anger and shock at her higher power and ex-husband, preoccupation with thoughts of Jacob and his dying process, feeling as if part of her has died, being socially isolated and not engaging in activities she used to enjoy, refuses to drive past the hospital, and has begun to believe if she were to die then her children would be better off and maybe she would be reunited with Jacob.

QUESTIONS:

1. What diagnosis would you give Sarah?
2. What mediators are you assessing? How do you think they are impacting Sarah's grieving process?
3. What information still needs to be collected?
4. How do you feel about how the surviving children were treated?

Questions?? Comments?



Treatment Planning

Counseling vs. Therapy

Counseling

~ facilitate normative grief to healthy integration

Therapy

~ uses specialized techniques that help with abnormal or prolonged grief reactions

~ helps resolve conflicts of separation, avoidance, and adaptation

~ trauma work (developmental, acute, etc.)

Treatment Plan: Uncomplicated Grief

- Walk along side, do not lead
- Fingerprint analogy - flexible
- Must consider attachment style
- Natural, adaptive, non-pathological
- Maintain process
- Grief facilitation

Treatment Plan: Uncomplicated Grief

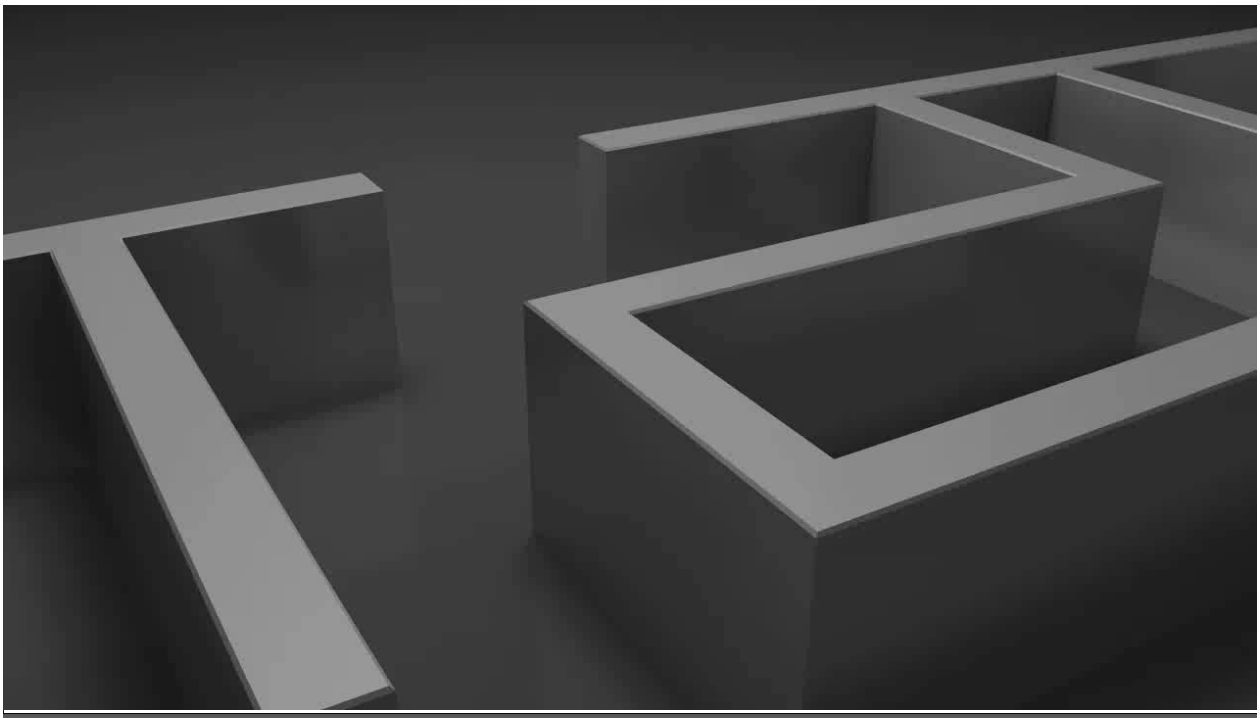
1. Accept reality and permanence of death
2. Experience painful emotions of the death
3. Recognize and resolve ambivalent feelings
4. Adjust to changes in everyday life
5. Identify and preserve positive memories of deceased
6. Redefine relationship with deceased as one of memory
7. Develop new relationships and deepen existing ones
8. Make meaning from the loss
9. Foster enhanced problem-solving and conflict resolution

(Cohen, et al., 2001: Worden , 2018)

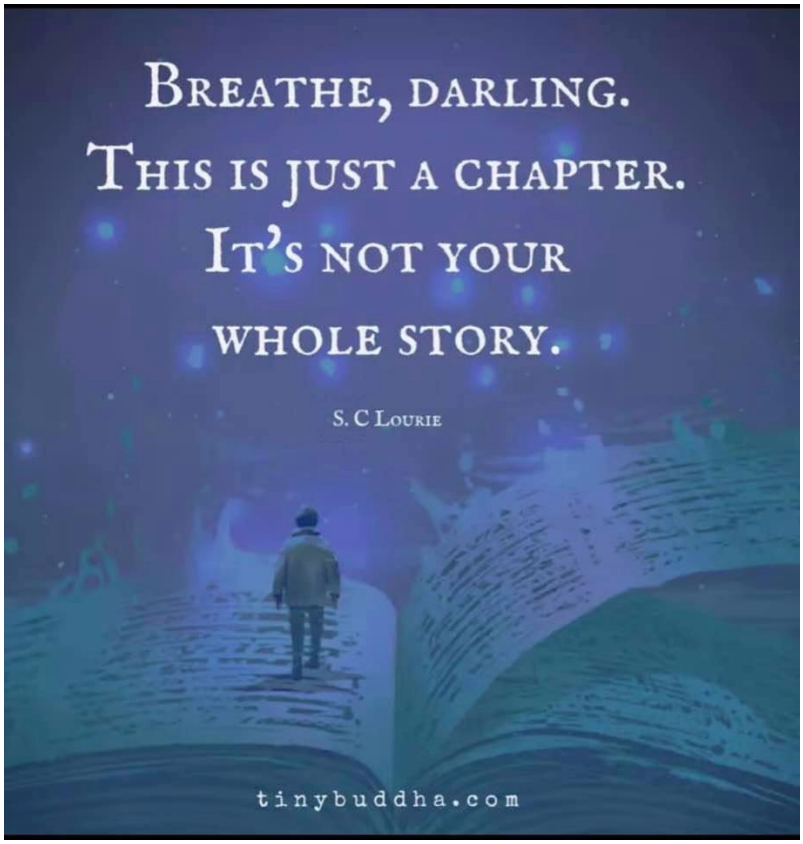
Treatment Plan: Meaning Reconstruction

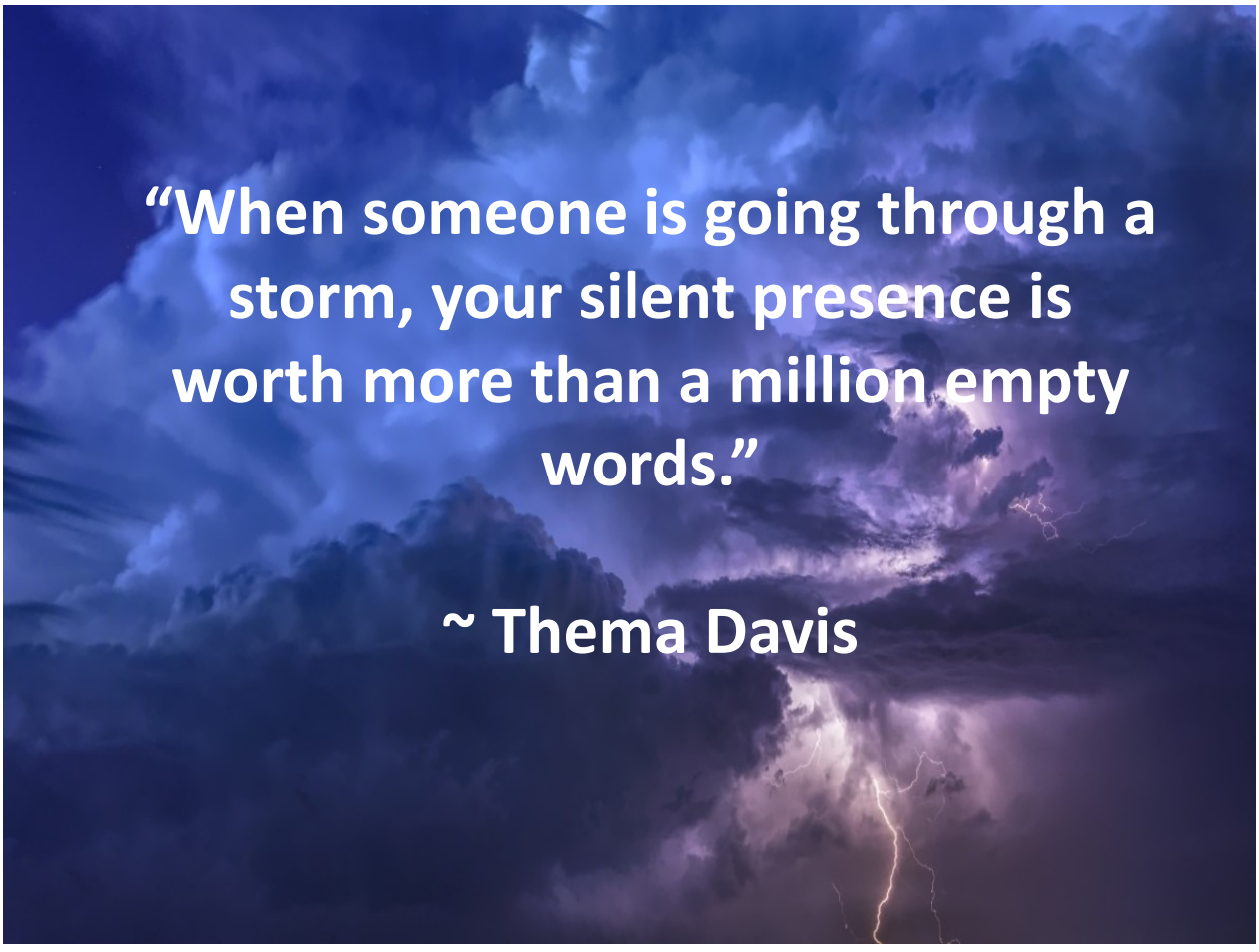
- Process event story, its implications, and make sense of it (interventions go here)
- Access the back story of relationship to restore a sense of grounding and security (interventions go here too!)
- Resolve unfinished business (and MORE interventions!)
- Re-attach in a new way
- Integrate deceased's absence in a way the preserves the attachment

(Neimeyer, 2018)

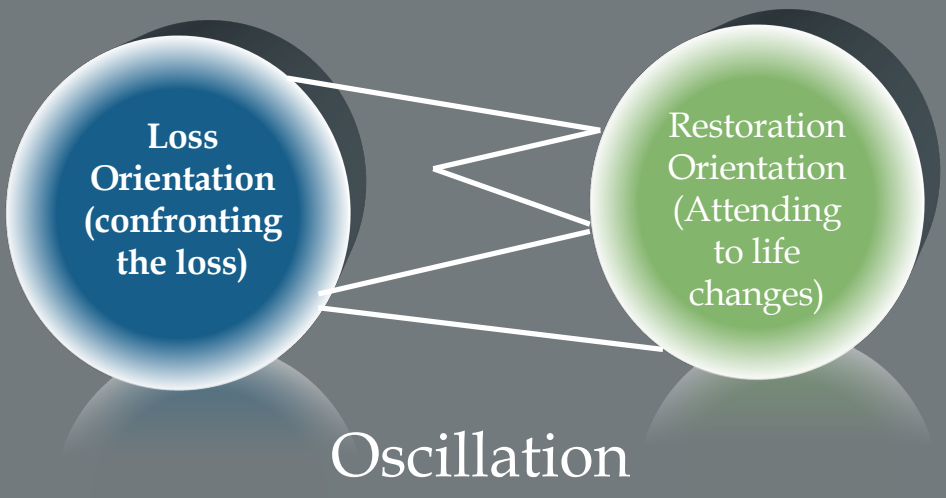


Interventions


BREATHE, DARLING.
THIS IS JUST A CHAPTER.
IT'S NOT YOUR
WHOLE STORY.
S. C LOURIE
tinybuddha.com


"When someone is going through a storm, your silent presence is worth more than a million empty words."
~ Thema Davis

Dual Process Model of COPING



(Stroebe & Schut, 1999)

Medications

To Use or Not Use? THAT is a GOOD Question!

Key symptoms (i.e., profound separation distress, preoccupation with the death, meaninglessness in the absence of the loved one) are not analogous to depression, but have more in common with anxiety

PGD has different neural profiles when compared to MDD or PTSD. (e.g., nucleus accumbens activated in PGD, but not depression or PTSD)

Neurobiology of PGD involves same circuitry as reward pathway ("reward dysfunction disorder")

Current research focusing on addiction approach; drugs that work on dopamine receptors and competes against opioid receptors

Does not touch core symptomology, may provide more energy to engage in self-help

May ameliorate symptoms of depression and anxiety, but NOT grief

Tricyclic antidepressants and benzodiazepines not been proven effective for PGD

Naltrexone, which is currently used to treat alcohol and opioid dependence, being studied

Could prevent professionals, social support, and clients to pursue others forms of support and coping that are as effective as medications

Bui, et al., 2012; Gang, et al., 2021; Neimeyer, 2021)

Restorative Retelling

- Narrative Process
- Three narratives:

1. External narrative (event focused)
   "What happened?"
2. Internal narrative (emotion-focused view)
   "What's happening in you?"
3. Reflexive narrative (meaning focused)
   "What are you making of what is going on here?"

Goal is to weave all together to create a stronger "through line." Make sense of themselves and the event

(Neimeyer, 2024; Neimeyer, 2016)

Restorative Retelling

- Three steps

1. Bracing – modulation and support (in and outside session; before session ends)
2. Pacing – *GO SLOW*, dose (leave 15 minutes before end of session to stop and process)
3. Facing – Victim > navigator, witnessing, seeking empowerment

Retell for 15 minutes starting when death was imminent or announced

Reconstructing and relearning as the person is now with more resources that can be used to bear the pain

"The only thing we can do is change the past by assigning different meanings." Restoration happens in this reconstruction

(Neimeyer, 2016)


Linking Objects

Journaling

Journaling - Guidelines

- Focus on loss that is most upsetting/traumatic
- Write about aspects of experience discussed least adequately with others
- Write from standpoint of deepest thoughts and feelings, then shift to event
- Do not worry about grammar, spelling, penmanship
- 20 minutes, 4 days
- Schedule transitional activity

(Neimeyer, 2016)

Journaling - Precautions

- Secure privacy
- Postpone journaling until stable instead of directly after loss if needed
- Share (with consent) after relationship is secure with therapist

(Neimeyer, 2016)

If-Onlys and Shoulds

- Examine or experiment with ruminative thoughts – do not dismiss
- Empty chair (self)
- Reconstruction by focusing on deceased (deceased) e.g., "What do you feel that person would think and feel?"
- "What would be there if the ___ was not?" (others)
- Legacy work (event)

(Neimeyer, Pitcho-Prelorentzos, & Mahat-Shamir, 2021)

Mindfulness and Meditation

- Non-judgmental attention to emotions, thoughts, and inner experiences in the present moment
- Acceptance and openness to moment-by-moment experience
- Observing without overwhelming reactions
- Avoid making assumptions
- Through multiple modalities:
    1. Sitting meditation
    2. Body scan
    3. Visualization
    4. Progressive relaxation
    5. Guided imagery
    6. Walking meditation

"Mindfulness cultivates a compassionate attitude, which in turn safeguards against the pernicious effects of negative feelings such as guilt and self criticism, and facilitates well-being" **(Hollis-Walker & Colosimo, 2011, p. 226)**

(Sedighimornani, Rimes, & Verplanken, 2019)

Correspondence with deceased

Photonarratives

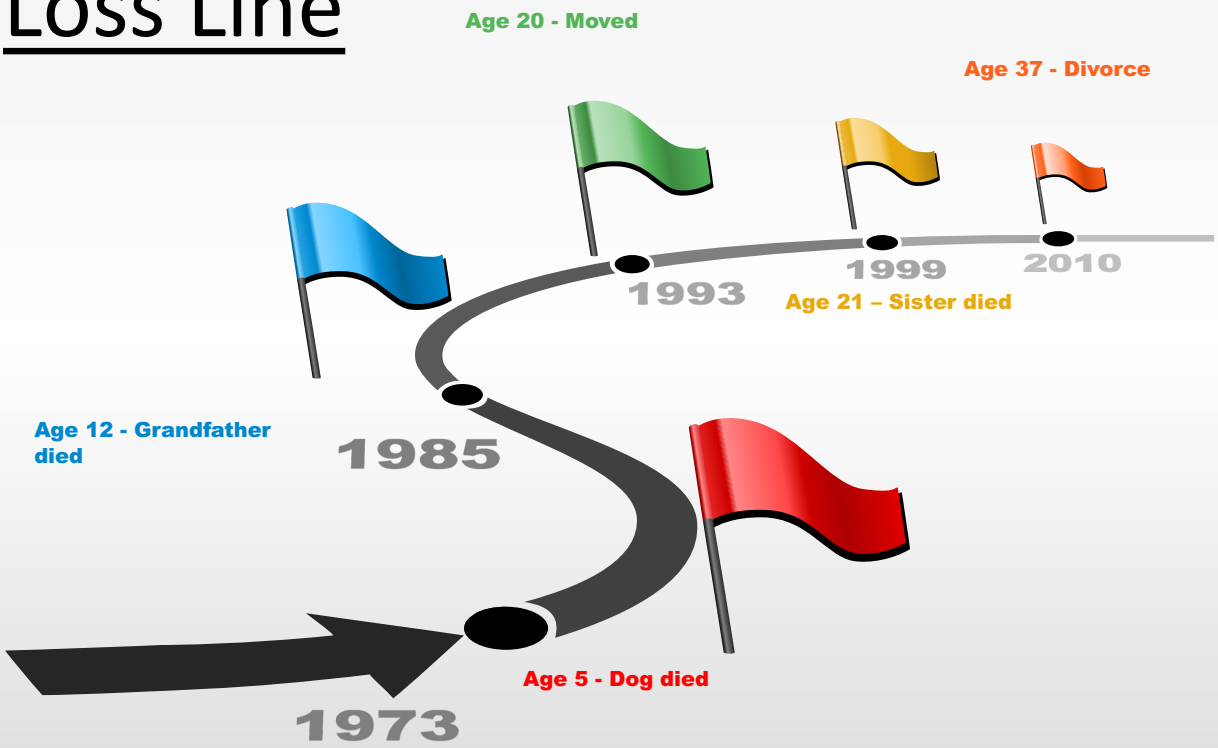
Photographs/Family Albums

Life Imprint

1. Person whose imprint I want to trace _____
2. This person has had the following impact on:
3. The imprints I'd like to affirm and develop are: ____
4. The imprints I would most like to relinquish or change are: ____

(Neimeyer, 2016)

Loss Line



Music Interventions

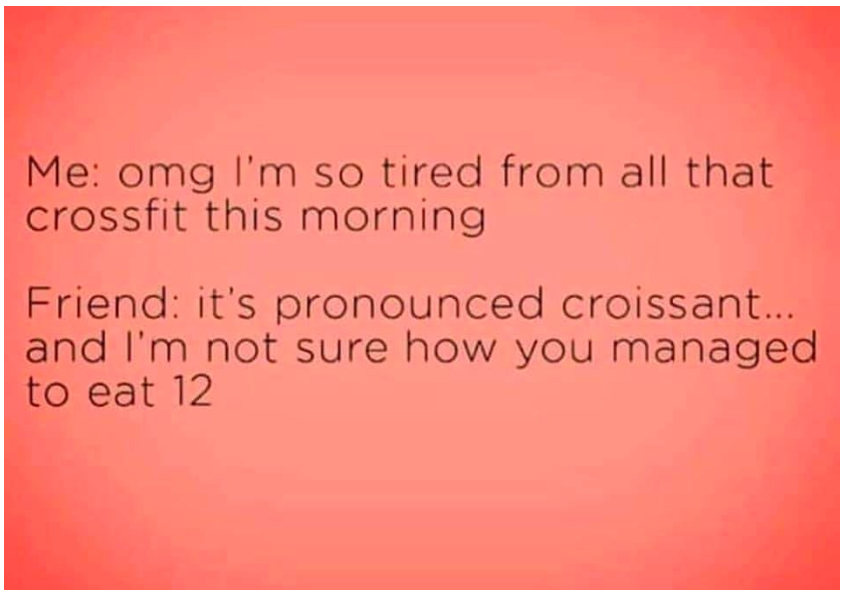
- Linked to improved executive functioning (Zuk, et al., 2015)
- "Expression of deep feelings of sorrow by singing can…lead to an emotional shift" (Smeijsters & van den Hurk, 1999, p. 249).
- Raises dopamine levels (Salimpoor, 2011)
- Playing with playlists, singing (Austin 2008; Iliya, 2015)

Sleep Hygiene

1. Adult: 7-9 hours. Children (6-12yo): 9-12. Adolescents (13-18): 8-10
2. Wake up same time every day (1/2 hr leeway)
3. Cool, dark, quiet room
4. No electronics 30-60 minutes prior (blue light interferes with melatonin production)
5. Cannot get back to sleep for 20 minutes? Get up, do something relaxing in low light, then try again
6. Cut down afternoon and evening caffeine
7. Exercise
8. Get sunlight exposure
9. Reduce stress
10. Do not eat late

(Suni, 2020)

- **Physical health often declines after loss. However, there are barriers that include guilt, lack of time, fatigue, and no motivation**
- **Research supports higher likelihood of hospital visits, longer hospital stays, cardiovascular problems, increase cortisol levels, reduces productivity and functioning at work**
- **Based on meta-analysis by Williams, et al., (2021), exercise benefits health outcomes and positively impacts the bereavement process:**
    1. **Alleviates depression**
    2. **Reduces anxiety**
    3. **Reduces PTSD symptoms**
    4. **Creates a sense of freedom**
    5. **Enables emotional expression**
    6. **Provides distractions**
    7. **Escape from grief**
    8. **Increases social engagement, cohesion, and reduced loneliness**
    9. **Improves quality of life and life satisfaction**
    10. **"Let's off stream"**
    11. **Decreases stress**
    12. **Decrease fatigue (emotional and physical)**
    13. **Increases motivation**
    14. **Improved adaptation to adverse life events**
    15. **Improves sleep quality and decreases insomnia**
    16. **Reduces aggression**
    17. **Increases self-efficacy**

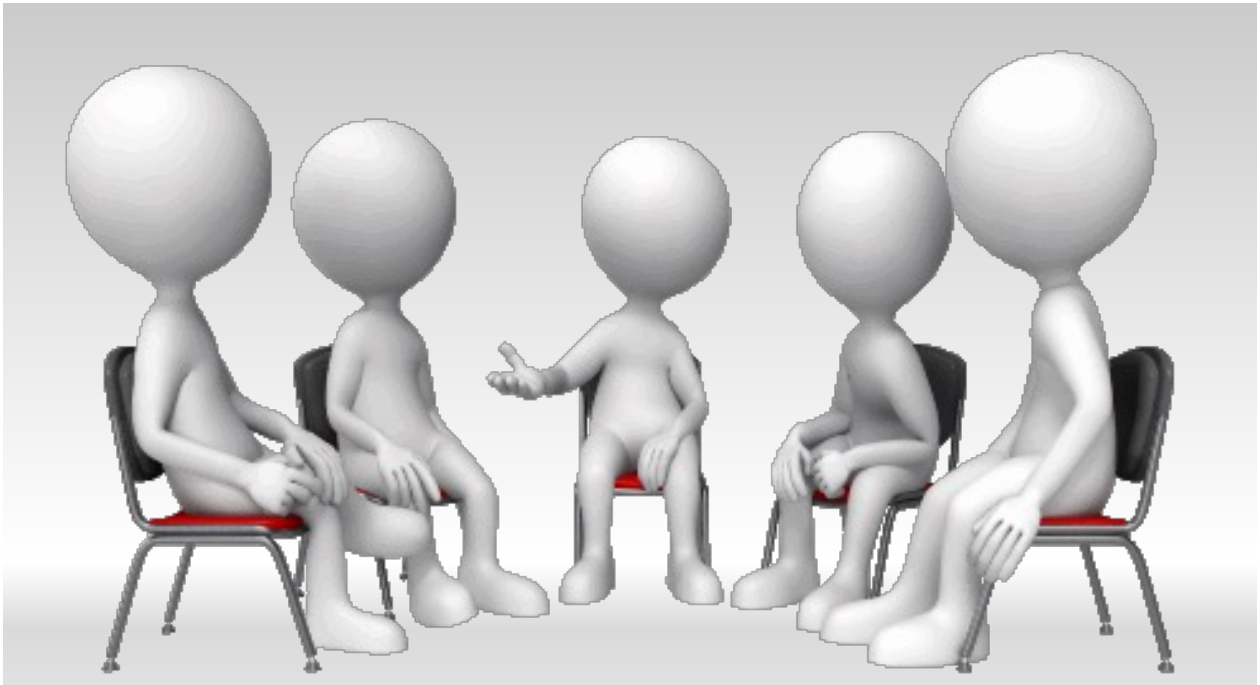


Food is Medicine

- Anticipate and prepare ahead of time
- Intentional ritual
- Acknowledgement and connection
- Meaningful event
- Social support
- Something pleasurable
- Honor continued bonds
- Care for self and let others care for you as well

(Shear, 2015)

Holidays/Anniversaries



Group Therapy

Closed vs. Open Groups

Closed Group

- All members start and end together
- No drop-ins
- Tend to be time-limited
- Smaller group size
- Therapeutic
- Run by trained professionals
- Leads towards homogeneity
- Usually vetted
- Usually has a "syllabus"

(DeLeo & Cimitan, 2014)

Open Group

- Participants can drop in and out, unpredictable attendance
- Not time limited
- Can be small or large
- Supportive
- Run by trained professionals or volunteers
- Can be homogenous or heterogeneous
- Not usually vetted
- Not usually planned out

Ideal Grief Group Recommendations

I. Informational issues

a. Inform how to find groups and their affiliation

b. Communicate aim and structure

II. Organizational Issues

a. Be explicit about possibilities and limits

b. Competent leadership

c. Homogenous group

d. Flexible or restricted groups pragmatically practiced

e. Time for attendance may vary

(Dyregrov, et al., 2013)

Ideal Grief Group Recommendations

III. Issues Concerning Content

a. Semi-standardized content

b. Content to promote hope and reduce rumination

(Dyregrov, et al., 2013-2014)

Example 8-Week Group

(Walijarvi, et al., 2012)

Week #:

1. Telling the story
2. Worries and fears
3. Anger and hurt
4. Releasing the trauma
5. Memories and bonds
6. Rebuilding
7. Creating a memorial
8. Good-byes and transitions

Couple of helpful resources:

Models of Adult Bereavement Support Groups (Sherman, N.)

Bereavement Groups and the Role of Social Support: Integrating Theory, Research, and Practice (Hoy, W.)

Behavior and Natural Environments

1. **Challenges accustomed patterns of functioning, feeling, and problem-solving.**
2. **Impartial, holding no criticalness or negative feelings and, therefore, it is a safe place to be authentic and non-defensive.**
3. **Relative predictability leads to a sense of control, therefore relaxed and open to learning.**
4. **Openness leads to genuine self-expression.**
5. **Not interacting with another person and the variables associated with the relationship, one has a greater sense of personal control and clarity of feelings.**

(Davis, 1998; Kaplan & Kaplan, 1998; Knopf, 1987)

Therapeutic Bereavement Rituals

1. Emotional reactions identified with feelings of person represented by symbol.
2. Symbolic actions comparable to changes in bereaved's life
3. Actions with symbols evoke and shape new experiences
4. Body/mind congruency

(Cas & Coman, 2106; van Unden & Zondag, 2016)

Therapeutic Bereavement Rituals

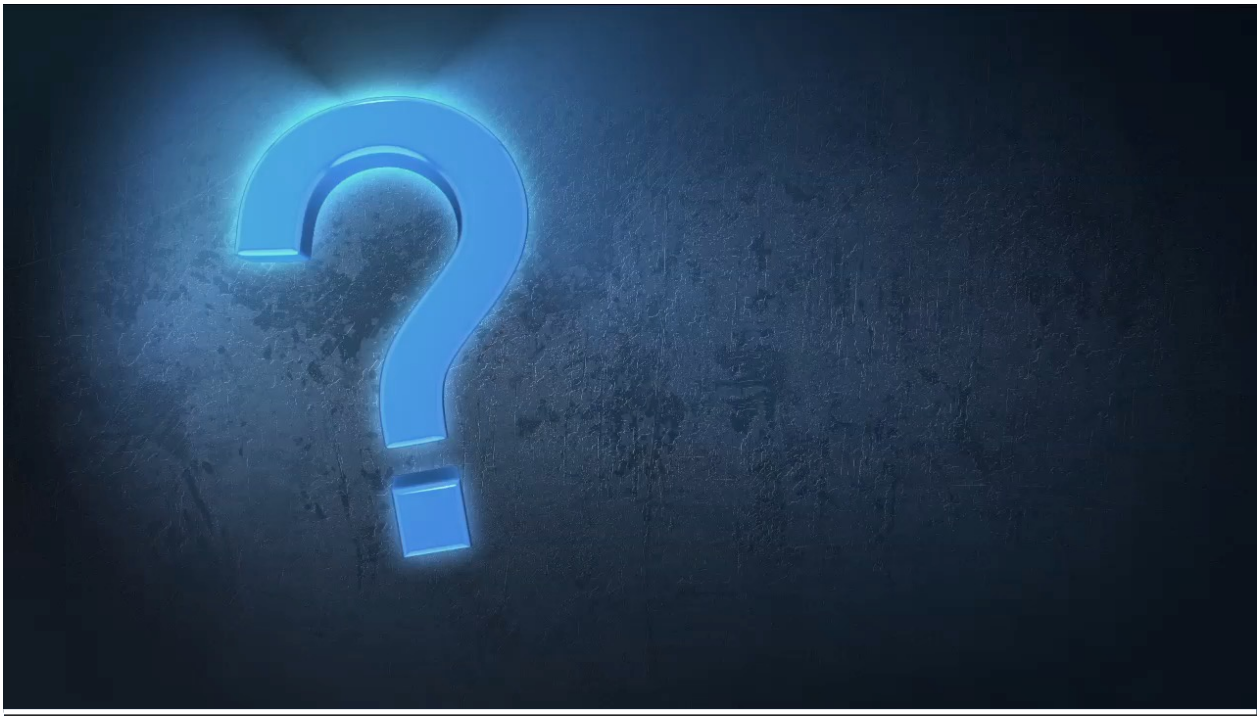
6. Increases sense of control of uncontrollable event
7. Experiences emotional shift
8. Movement towards integration
9. Enables closure
10. Cuts through intellectualization
11. Enables separation from loss

(Gillian, 1991; Rando, 1993; Sas & Camon, 2016; Wyrostok, 1995; van Der Har 1983)

Develop Your Own Nature-Based Bereavement Ritual

In your handouts, find the "Developing Your Own Nature-Based Ritual" worksheet.

After we discuss the steps, take 10 minutes to create a ritual for yourself.



Questions?? Comments?


My emotional support dog
after I tell him all my problems


Live like someone left the
gate open!

Center for Grief and Trauma Therapy

Dr. Christina Zampitella, Psy.D., FT
Licensed Clinical Psychologist
Fellow of Thanatology
Founder/Owner
5500 Skyline Dr.
Suite 4
Wilmington, DE 19808

(302) 635-0505

drz@centerforgrieftherapy.com
www.centerforgrieftherapy.com
Podcast: Phoenix Rising with Dr. Z

Center for Grief and Trauma Therapy

Seven Domains of Grief Reactions

It is important to consider all reactions to grief with caution. These reactions are commonly found in the grieving process, but if they remain intense over a prolonged period of time, it may be an indicator that the person is not adapting to his or her loss. A mental health professional who specializes in grief (Thanatologist) should be consulted if the symptoms do not relent. Additionally, it is important to collaborate with other health care professionals to ensure there is not another reason for the symptom(s) (i.e., ulcer, ADHD, neurological problem, etc.). The following symptoms may not be the only ones present.

I. Physical Reactions

- Headaches
- Nausea/fluttering in stomach
- Appetite disturbance
- Shortness of breath
- Heart palpitations/chest pain
- Vision problems
- Loss of motor skills
- Sweating
- Chills
- Bedwetting
- Dizziness
- Sleep difficulties
- Fatigue
- Choking sensation
- Muscle weakness
- Dry mouth
- Bodily pains
- Tremors
- Hyperactivity
- Increased risk of disease

II. Emotional Reactions

- Sadness/Sorrow/Depression
- Fear
- Anxiety
- Guilt
- Anger/Fury/Rage
- Relief
- Uncertainty
- Grief
- Hopelessness
- Feeling lost
- Shame/Embarrassment
- Numbness
- Release
- Helplessness
- Listlessness
- Loneliness
- Longing
- Overwhelmed
- Feeling abandoned
- Worry
- Wanting to die
- Indifference

III. Psychological Reactions

- Denial
- Repression
- Intellectualization
- Rationalization
- Projective identification
- Dissociation

IV. Cognitive Reactions

- Memory problems
- Poor concentration
- Poor decision-making
- Confusion
- Auditory or visual hallucinations

- Poor attention
- Calculation difficulties
- Sensing the deceased
- Intrusive or obsessive thoughts
- Disbelief
- Poor sequential processing
- Disruption of logical thinking
- Seeing an event repeatedly

V. Behavioral Reactions

- Regression
- Suspiciousness
- Crying
- Poor grades
- Carrying pictures/items
- Absentmindedness
- Loss of interest
- Retelling of events of loss
- Avoiding painful reminders
- Frequent sighing
- Intolerance of noise
- Appetite changes
- Hypervigilance/clinging
- Excessive humor
- Excessive silence
- Dreams/nightmares
- Reluctance to explore
- Excessive hugging/touching

VI. Interpersonal Reactions

- Distancing from others
- Changes in communication
- Argumentative and rejecting
- Separation anxiety
- Blaming others
- Identification with the deceased
- Rejects old friends and seeks new ones
- Turning to social supports

VII. Spiritual Reactions

- Inability to pray, meditate, etc. or change in the way prayer is used

- Belief system is no longer valid or sufficient
- Strengthening of spirituality
- Preoccupied with own death
- Rejection of higher power
- Loss of meaning
- Increase in meaning
- Loss of faith
- Anger towards higher power; feeling betrayed
- Not feeling “centered” or “balanced”
- Disappointment in belief system, clergy, or religious institution

Results from loss in infancy

- Wants to connect with others, but is unsure how
- Decreased frustration tolerance, impulse control, and attention span
- Cannot tolerate long periods of intense emotional pain – behavioral dysregulation
- Shifts between experiencing loss and engaging in activity
- Poor self-regulation
- May not seek stimulation
- Rapid emotion shifts
- Inability to self-soothe
- Uninhibited behavior
- Toilet training problems
- Reduced ability to become self-aware
- Attachment problems
- Delayed language development
- All or nothing thinking
- Inability to identify and empathize with others
- Oppositional behavior

Center for Grief and Trauma Therapy

Developing Your Own Nature-Based Rituals

Please answer the following questions you might use in creating the ritual:

1. What am I ritualizing (what ending, beginning, transformation, accomplishment, connection)? Is this ritual one of separation and saying "goodbye", trying to get "unstuck" in your grief in order to move forward, or focusing on putting the pieces of your life back together? Without a focused, meaningful intention, your ritual will not be impactful. Therefore, be sure to take time to identify what is important to you at this time in your life.

2. Why do you want to do this ritual?

3. What symbols will be best to bring? In other words, what meaningful items could I bring, create, or look for that would help me connect with my intention of the ritual I identified in item #1?

4. What symbolic actions would express the intention of the ritual? For example, if you were intending of letting go of fear, maybe you would do something that would make you have to face that fear, or perhaps you "bury" something. Or maybe you wish to start a new beginning, and so jumping in a body of water may represent a "clean" start. You should make sure to incorporate your items from #3.

5. Are there words that need to be spoken? What role will silence play? Where in the ritual will you speak and/or be in silence?

6. What are the steps of the ritual? What items need to be included or what actions will you do to express the intention of the ritual. Make sure to start with creating your plan and provide all the details from start to finish, so that if you read this to another person, he or she could almost do the ritual the way you will do it.

7. Nature has healing qualities that help deepen the ritual experience. Nature is non-judgmental, is not distracting, provides a soothing feeling, and helps with feeling mindful. It also is an example of natural cycles of life and death, beginnings and endings. When is the right time and where is the right place for this ritual? Since this ritual is meant to be completed outdoors, where could you find a location that feels soothing, beautiful, and private, away from many manmade distractions. Why did you choose this place? Does it have meaning for you?

8. Any other thoughts, feelings, items, intentions, etc. that you would like to add?

Differential Diagnosis of prolonged grief disorder, major depressive disorder, and post-traumatic stress disorder			
Characteristic	**Prolonged Grief Disorder**	**Major Depressive Disorder**	**Post-Traumatic Stress Disorder**
Affective Symptoms			
Depressed mood	Prominent; focused on loss; diagnostic criterion	Prominent; diagnostic criterion	May be present
Disbelief about death	Prominent; focused on loss; diagnostic criterion	Not usually present	May be present
Anhedonia	Not usually present	Prominent and pervasive; diagnostic criterion	Prominent and pervasive; diagnostic criterion
Anxiety	May be present; focused on separation anxiety	May be present	Prominent and pervasive; diagnostic criterion; focused on fear of recurrent danger
Yearning and Longing	Prominent and pervasive; diagnostic criterion	Not usually present	Not usually present
Guilt	Common; diagnostic criterion; related to regrets with deceased	Usually present; related to feelings of being undeserving and worthless	Prominent and pervasive; diagnostic criterion; usually focused on event or aftermath
Cognitive and Behavioral Symptoms			
Difficulty concentrating	Not usually present	Common; diagnostic criterion	Common; diagnostic criterion
Preoccupying thoughts	Common; Focused on thoughts and memories of the deceased; diagnostic criterion	May be present, focused on negative thoughts about self, other, the world	Negative, exaggerated, distorted thoughts related to the event; diagnostic criterion
Recurrent preoccupying images or thoughts	Common; focused on thoughts/memories of deceased; diagnostic criterion	May be present	Common; focused on event; associated with fear; diagnostic criterion
Avoidance of reminders of loss	Common; focused on reminders of the finality if the death; diagnostic criterion	May be present, but usually focused on social withdrawal	Common; focused on loss of safety or reminders of the event; diagnostic criterion
Loss of meaningful life	May feel meaningless without deceased; diagnostic criterion	May be present	May be present
Seeking proximity to the deceased	Common; diagnostic criterion	Not usually present	Not usually present

Identity disruption	Common; Sense of something inside has died; diagnostic criterion	May be present	May be present
Suicidal thinking/behavior	May or may not be present; usually to reunite with deceased	SI is present; increased risk of suicide; diagnostic criterion	SI is present; increased risk of suicide; diagnostic criterion
Abnormal eating patterns	May avoid certain foods or mealtimes; eat certain food to feel close	Change in eating patterns (weight gain/loss); diagnostic criterion	Not usually present
Disturbed sleep	May avoid bed due to reminders of loss; rumination	Common; diagnostic criterion	Sleep disturbance due to anxiety; diagnostic criterion
Nightmares	Not usually present	May be present	Related to traumatic event; diagnostic criterion

Rando, T. A. (1993). *Treatment of complicated mourning* (pp. 665-682). Champaign, IL: Research Press. (Website: www.thereserando.com)

APPENDIX

Grief and Mourning Status Interview and Inventory (GAMSII)

PART I: DEMOGRAPHIC INFORMATION

Name _____ Sex _____

Date of birth _____ Age _____

Address _____

_____

Where mourner calls home _____

Residence history _____

_____

_____

Note. The GAMSII is a clinical instrument based on Dr. Therese A. Rando's professional experience. Permission is granted for caregivers to reproduce the GAMSII for clinical use only, with the following acknowledgment: From *Treatment of Complicated Mourning* by T. A. Rando, 1993, Champaign, IL: Research Press. Copyright 1993 by T. A. Rando. Reprinted by permission.

Readers are urged to see chapter 6 in this volume for important background on use of the GAMSII and for a listing of other critical areas to explore in assessment.

Social/cultural/ethnic/religious background _____

_____

_____

Marital status _____ Year of current marriage _____

Dates, durations, and outcomes of previous marriages _____

_____

_____

Highest level of formal education _____

Military history _____

_____

Occupation _____

Occupational/work history _____

_____

_____

Income level and degree of financial security _____

_____

Religion and extent of practice _____

Number of pregnancies _____

Number of live births _____

Number of live-birth children who died _____

Names, sexes, and circumstances _____

_____

_____

Number and dates of abortions _____

_____

Number and dates of miscarriages _____

_____

Number, dates, sexes, gestational ages, and postdeath rituals for stillbirths

_____

_____

Surviving children (names, sexes, ages, occupations, family status, health, locations)

_____

_____

_____

_____

_____

_____

Family-of-origin members (names, sexes, ages, occupations, family status, health, locations)

_____

_____

_____

_____

_____

_____

_____

Close relatives, friends, and other supports (names, sexes, ages, occupations, family status, health, locations)

Prior losses (physical and psychosocial)

Date of identified current loss(es) _____

PART II: COMPREHENSIVE EVALUATION OF HISTORY, MENTAL STATUS, AND SELECTED PREMORBID PERSONALITY CHARACTERISTICS

The caregiver must obtain the following information according to the standard practices of the discipline to which he or she belongs.

Comprehensive Psychosocial/Medical History

- Presenting problem
- History of presenting problem
- Past personal history and current psychological functioning
  - Psychosocial history and current functioning
  - Occupational history and current functioning
  - Past psychiatric history and current status
  - Substance use history and current status
  - Medical history and current status
  - Financial history and current status
- Family history (psychosocial, psychiatric, medical, financial) and current status
- Concurrent stresses or crises

Mental Status Examination

In the modified mental status examination suggested here, the following areas must be evaluated.

- Appearance
- Behavior and psychomotor activity
- Speech and language
- Mood and affect
- Thought process and content
- Perceptual disturbances
- Sensorium functions
- Insight and judgment
- Symptoms of depression

- Symptoms of anxiety and post-traumatic stress disorder (PTSD)
- Suicide and homicide risk

Selected Premorbid Personality Characteristics

- Ego functioning and strength
- Coping and defense mechanisms, styles, and abilities (specifically when dealing with stress, anxiety, threat, and feelings)
- Frustration tolerance
- Personality dynamics and conflicts
- Characterological scripts
- Sense of self, self-concept, and self-esteem
- Internal versus external locus of control and processing
- Cognitive style and biases
- Problem-solving skills
- Maturity
- Assumptive world components
- Sense of personal meaning and fulfillment in life
- Philosophy of life and values
- Spirituality
- Communication style
- Relationship patterns
- Characteristic ways of managing psychosocial transitions
- Specific strengths, skills, and assets
- Specific vulnerabilities and liabilities

DIAGNOSTIC/CLINICAL IMPRESSIONS BASED ON DATA FROM PARTS I AND II

PART III: STRUCTURED INTERVIEW SCHEDULE

Topic Area A: Circumstances of the death; events that led up to and followed it

A–1. Tell me about the death and what led up to it.

a. If _____'s death followed an illness, please answer the following:

(1) What was _____'s experience during his/her illness?

(2) What was your experience during _____'s illness?

(3) What was the length and course of the illness?

(4) What, if any, was the nature of your participation in _____'s care during the illness?

(5) Did you ever discuss _____'s dying with him/her? If so, what was this like?

(6) What, if anything, was the nature of your anticipatory grief during _____'s illness?

(7) What were the hardest parts for you in _____'s illness?

(8) Do you have any unfinished business or unresolved conflicts about anything that happened or didn't happen during _____'s illness? If so, please explain.

(9) What would you change, if anything, if you could about the illness experience for you? For _____?

(10) Were you prepared when _____ died?

(11) How could things have been better for you during _____'s illness? At his/her death?

(12) What, if anything, do you feel good about regarding your interaction with _____ during his/her illness? Guilty about? Regretful about?

A–2. What happened immediately after the death and in the few days thereafter?

a. What kind of funeral activities or rituals took place?

(1) How were they for you?

(2) What kind of impact have they had on you?

Topic Area B: Nature and meaning of what has been lost

B–1. Tell me about _____.

a. Help me to know him/her as a person.

b. What was he/she like?

B–2. What type of relationship did the two of you have?

a. How did you get along?

b. How did your relationship start and what course did it take?

B–3. You've told me a great deal about what was positive in the relationship. Could you tell me a little about the aspects that were not so positive?

B–4. Exactly what did _____ and the relationship with him/her mean to you and give to you in your life?

a. In what ways (positive and negative) did _____ help you or cause you to be the person that you are/were?

B–5. Specifically, what have you lost in your life physically or symbolically with _____'s death?

a. What has/have been the impact(s) on you of this/these secondary loss(es)?

B–6. Do you have any unfinished business with _____? Anything you would have wanted to say or do that would have made you more comfortable with ending the relationship but that you never said or did and therefore lack closure on?

a. What do you think you need to do to finish this business?

Topic Area C: Mourner's reactions to the death and coping attempts

C–1. Please describe for me the type, quality, extent, and intensity of all the various reactions you have had since _____'s death.

a. What specific kinds of responses did you find yourself having and what particular kinds of behaviors did you witness in yourself?

b. Did you have any reactions and/or behaviors that were unexpected or that frightened you? If so, what were they?

c. Have you experienced any changes in your self-esteem, self-image, or sense of self? If so, what?

C–2. Tell me what you have done to cope with _____'s death.

a. How do you cope on an everyday basis?

b. Over the long haul?

c. Do you have what you personally require to cope with this loss? If not, why do you think that you do not?

d. If and when you feel pain over this loss, how do you deal with/defend against/protect yourself from it?

C–3. Please complete this sentence: "I feel that I am coping/have coped with this death . . ."

a. Rate your coping on a scale of 1 (worst possible coping) to 10 (best possible coping).

C–4. How would you complete these sentences?

a. "The things that I do/did that help/helped me the most are/were . . ."

b. "If I have/had problems related to this loss, they seem/seemed to be in the areas of . . ."

c. "The most difficult parts of this for me are/have been . . ."

d. "My most major concerns in all of this are . . ."

e. "What I have specifically done to try and help myself is . . ."

Topic Area D: Reactions of others in the mourner's world and perceived degree of support

D–1. How have others reacted to _____'s death?

D–2. How have they reacted to your reactions?

a. How have their reactions affected you?

D–3. Have your relationships with others changed since _____'s death?

a. If so, with whom, how, and why?

b. How do you feel about these changes?

c. Have these changes caused you any specific problems?

D–4. What types of support have you received from others to help you cope with _____'s death?

a. Who gave it and what did they do?

b. What was helpful? Not helpful?

c. Do you have some person(s) you can confide in? If so, who?

D–5. Were there any types of support or recognition you required but did not receive or any specific persons from whom you needed support or recognition but did not receive it?

a. Why do you think this happened?

D–6. How did the support or recognition you did and did not receive affect you and your grief and mourning?

D–7. What needs for support or recognition remain unmet?

a. From whom in particular?

Topic Area E: Changes in the mourner and the mourner's life since the death

E–1. Please describe what has happened to you in the time since _____ died. For example, what changes (either gains or losses; internal or external; physical or psychosocial; psychological, behavioral, social, physical, spiritual, occupational, or financial), if any, have occurred to you, in you, and in your life since _____'s death?

E–2. Do you feel changed by this death?

a. If so, in what ways are you different (positively and negatively)?

b. In what ways are you the same as before?

c. What percentage of your old self are you back to?

d. Do you feel, think, or act any differently than before? If so, how?

e. What is the current impact, if any, of grief and mourning on your ability to function normally (psychologically, behaviorally, socially, physically, spiritually, occupationally, financially)?

f. Have you blocked off any corners of the world since the death?

g. Have you experienced any changes in habits, activities, pleasures?

h. Have any new problems developed since _____'s death?

E-3. If this death has affected the way you look at and live life, how has it done so?

a. How has the death affected your assumptive world (i.e., your assumptions, expectations, and beliefs about and view of the world), religion, or philosophy of life?

E-4. What, if anything, have you learned (positively or negatively) from this loss?

Topic Area F: Mourner's relationship to the deceased and stimuli associated with the deceased

F-1. How would you describe _____'s role, if any, in your life at this time? In other words, do you have an ongoing sense of connection to _____ or does _____ play an active part in your ongoing life?

a. Do you think about _____?

b. Talk to _____?

c. Have you found yourself acting, thinking, or feeling in any ways _____ used to act, think, or feel? If so, how?

d. How do you relate to _____ at this time, if you do?

e. What types of things do you do to keep _____ "alive" to yourself and others or to maintain a sense of connection with _____?

f. What, if anything, do you do to memorialize _____?

g. What is it like for you to have this type of relationship or sense of connection with _____?

h. How do you feel about the ways in which you relate to, maintain a sense of connection to, or keep _____ "alive"?

i. What is the meaning in your life today of your current relationship with _____?

j. What about you today is influenced (positively or negatively) by your current relationship with _____?

k. What is your current image of yourself with regard to _____ (e.g., dependent child, adult)?

1. Was there anything in _____ that you would choose to develop in yourself? If so, what?

F–2. Many times after a person loses a loved one, he or she has some experiences in which there is a sense of the presence of the loved one. Sometimes the mourner takes these experiences as a "sign" or as some form of communication from the loved one. Sometimes there are vivid dreams, or the mourner has an experience of seeing the image of the deceased or hearing that person's voice. Sometimes mourners are reluctant to talk about this because they think it makes them sound crazy, even though they are not. I know that this happens with many mourners, and I am wondering if anything like this has ever happened to you. Have you ever had any of these types of experiences or anything like them?

   a. What was it like for you to have this happen?

   b. How did you respond?

   c. What was the nature of the experience for you? Did you view it as positive (as comforting or something that made you feel good) or was it more negative (something frightening that you would not want to have happen again)?

F–3. How are you choosing to deal with _____'s room? Clothing? Other possessions?

   a. What is this like for you?

   b. Have you saved any special items?

      (1) What do you do with it/them?

      (2) Where do you keep it/them?

      (3) What made you choose it/them?

      (4) What does/do it/they represent to you?

      (5) How does/do it/they make you feel when you encounter it/them?

F–4. At this point, how is it for you when you come across things that remind you of _____ or bring back memories of him/her? For example, how may you react when you see pictures of him/her, suddenly remember a special time you shared, or go to an event and wish he/she would be there with you, such as a wedding or holiday gathering?

a. How do you tend to handle these things?

b. Are there some things that are more difficult than others?

c. What kind of reactions, if any, do you have?

d. What types of memories tend to come back to you?

e. What characteristics do your memories have and what types of reactions do they precipitate in you?

f. Do you talk about your memories to anyone? If so, who?

g. Is it comfortable or uncomfortable to remember _____? Under what conditions?

F–5. Have you noticed any responses on your part around the anniversary of the death, during other occasions, or under other circumstances (i.e., STUG reactions)?

a. If so, what are they like?

b. How intense are they?

c. How do you cope with them?

F–6. How do you think _____ would want you to respond in your grief and mourning over him/her?

a. What would he/she want of you as you live without him/her?

b. Did you and _____ ever discuss how he/she wanted you to go on? If so, what was said?

c. Even if you two never discussed this topic, what do you think _____ would expect you to do?

d. Is there anything from your relationship with _____ that guides you in your going on without him/her? If so, what?

Topic Area G: History, status, and influence of prior loss experiences, including mourner's methods of coping

G–1. What other difficult physical or psychosocial losses have you experienced in your life?

G–2. What types of things did you do to cope with each loss?

a. How effective were you in coping?

b. In what ways did the loss affect you then?

c. How does the loss affect you now, if it still does?

d. Did you learn anything in particular from the loss?

e. Was that loss different for you from this one? If so, in what ways?

Topic Area H: Mourner's self-assessment of healthy accommodation of the loss now and in the future

H–1. Compared to how you coped with and functioned in life in general prior to the death, how do you think you are doing now?

a. Rate your previous and present general coping on a scale of 1 (worst possible coping) to 10 (best possible coping).

H–2. How do you think you are coping/have coped with this specific loss?

a. Rate your coping on a scale of 1 (worst possible coping) to 10 (best possible coping).

H–3. To what extent, if any, has the loss been integrated into your life?

H–4. How do you view the future?

H–5. How do you think you will ultimately do in your grief and mourning, and in learning to live without _____?

a. Rate how you think you will ultimately do on a scale of 1 (worst possible outcome) to 10 (best possible outcome).

H–6. What remains for you to do or change in your grief and mourning and in your life to reach the point where you will be doing the best you can in coping with this loss and living without _____?

H–7. Have you made a decision to "make it"?

H–8. In what areas is/will it be the hardest to rebuild your life and/or to reinvest in it?

a. The easiest?

H–9. How do you, if you do, make sense out of this loss and its having occurred in your life?

H–10. In retrospect thus far, is there anything you would do differently in your grief and mourning?

Topic Area I: Mourner's degree of realistic comprehension of and expectations for grief and mourning

I–1. What do you think is necessary to cope with or survive a loss like this?

I–2. In your estimation, what is normal to experience after this kind of death?

I–3. In what ways do you think you have been a healthy and successful mourner?

a. In what ways do you think you have been unhealthy or unsuccessful?

I–4. How do you anticipate the rest of your mourning will go?

I–5. What will indicate to you when you have achieved the best possible accommodation of this loss or are coping the very best you ever will be able to with _____'s death?

Topic Area J: Open topic

J–1. Are there any areas pertinent to your grief and mourning that we have not examined?

J–2. Are there any topics we have discussed that you feel we should consider further?

J–3. What do you feel is the most important piece of information about your grief and mourning?

DIAGNOSTIC/CLINICAL IMPRESSIONS BASED ON DATA FROM PART III

SUMMARY: DIAGNOSTIC/CLINICAL IMPRESSIONS BASED ON SYNTHESIS OF PARTS I, II, and III

Center for Grief and Trauma Therapy

5500 Skyline Dr.
Suite 4
Wilmington, DE
19808
Phone: (302) 635-0505
Fax: (302) 861-3838
www.centerforgrieftherapy.com
contact@centerforgrieftherapy.com

We often try to say things to support and help people we care about after they have experienced a loss. However, some things that are often said can lead the person feeling alone, shut down, or feel like he or she is grieving "wrong." Below are examples of some things that are helpful and not helpful when reaching out to help a friend or loved one.

Helpful Things to Say to Someone Who is Grieving

1. I am so sorry for your loss.
2. I wish I had the right words, just know I care.
3. I don't know how you feel, but I am here to help in any way I can.
4. You and your loved one will be in my thoughts and prayers.
5. My favorite memory of your loved one is…
6. I am always just a phone call away
7. Give a hug instead of saying something
8. We all need help at times like this, I am here for you
9. I am usually up early or late if you need anything
10. Saying nothing, just be with the person
11. I know it's hard to be strong right now
12. There was no good reason for this to happen
13. It's OK to feel this way

Unhelpful Things to Say to Someone Who is Grieving

1. At least she lived a long life, many people die young
2. He is in a better place
3. She brought this on herself
4. There is a reason for everything
5. Aren't you over him yet, he has been dead for a while now
6. You can have another child still
7. She was such a good person God wanted her to be with him
8. I know how you feel
9. She did what she came here to do, and it was her time to go
10. Be strong
11. It's good she is no longer suffering. Now she is at peace
12. Maybe if you started dating again?
13. I know it's tough, but he wouldn't want you to suffer like this
14. You have to remember the good times. Those are what matters

Death Studies

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/udst20

Inventory of Complicated Spiritual Grief 2.0 (ICSG 2.0): Validation of a revised measure of spiritual distress in bereavement

Laurie A. Burke, A. Elizabeth Crunk, Robert A. Neimeyer & Haiyan Bai

To cite this article: Laurie A. Burke, A. Elizabeth Crunk, Robert A. Neimeyer & Haiyan Bai (2021) Inventory of Complicated Spiritual Grief 2.0 (ICSG 2.0): Validation of a revised measure of spiritual distress in bereavement, Death Studies, 45:4, 249-265, DOI: 10.1080/07481187.2019.1627031

To link to this article: https://doi.org/10.1080/07481187.2019.1627031

DEATH STUDIES
2021, VOL. 45, NO. 4, 249–265
https://doi.org/10.1080/07481187.2019.1627031

Routledge
Taylor & Francis Group

Inventory of Complicated Spiritual Grief 2.0 (ICSG 2.0): Validation of a revised measure of spiritual distress in bereavement

Laurie A. Burke[a], A. Elizabeth Crunk[b], Robert A. Neimeyer[a], and Haiyan Bai[c]

[a]Department of Psychology, University of Memphis, Memphis, Tennessee, USA; [b]Department of Counseling and Human Development, George Washington University, Washington, District of Columbia, USA; [c]Department of Learning Sciences & Educational Research, University of Central Florida, Orlando, Florida, USA

ABSTRACT

Spirituality has long served as a source of solace for many grievers following a loss. For other mourners, whose bereavement experience has been significantly challenged by struggles in their relationship with God and/or their faith community, the opposite is true. Complicated spiritual grief (CSG) is a spiritual crisis following the loss of a loved one. To assess CSG in samples of bereaved adults, a simple-to-use, multidimensional measure of spiritual crisis following loss called the Inventory of Complicated Spiritual Grief (ICSG) was previously developed and validated. However, subsequent research providing greater clarity about the construct of CSG supported the need to revise and update the ICSG. The goal of the present study was to establish the psychometric validity of a revised measure of CSG, called the Inventory of Complicated Spiritual Grief 2.0 (ICSG 2.0), with a large, diverse cohort of bereaved Christian adults ($N = 440$). Analyses of the bifurcated sample supported a three-factor model measuring insecurity with God, estrangement from the spiritual community, and disruption in religious practices. Further analyses supported the convergent and incremental validity of a 28-item scale relative to other theoretically similar instruments and measures of poor bereavement outcome, indicating the instrument's research and clinical usefulness.

Introduction

Of all distressing human experiences, grief is one of the most ubiquitous. Individuals express a variety of reactions to loss ranging from resilient to complicated (Galatzer-Levy & Bonanno, 2012). and cope in myriad ways (Meichenbaum & Myers, 2016). Religion and spirituality are among the most important means by which bereaved individuals cope with crises (Hill & Pargament, 2008), and particularly the death of a loved one (Wortmann & Park, 2008). Many people experience spirituality in bereavement as a comfort; however, increasingly, research shows that a significant subset of grievers finds the opposite to be true (e.g. Burke, Neimeyer, McDevitt-Murphy, Ippolito, & Roberts, 2011). Anger, distrust, and other negative sentiments toward God – who once was viewed as "good," – are relatively common among spiritually inclined grievers, especially when the unbearably painful reality of the death is inconsistent with their prior spiritual beliefs, practices, or experiences (Burke et al., 2011). Specifically, a crisis of faith occurs when grievers, who once perceived God as providing care and comfort, now perceive that they are being punished or abandoned by a distant, controlling, or authoritative deity (e.g. Burke & Neimeyer, 2014).

Within the context of bereavement, this phenomenon is known as complicated spiritual grief (CSG; Burke & Neimeyer, 2014) – the collapse or erosion of the bereaved individual's sense of relationship to God, which is often accompanied by discord with and/or a distancing from his or her faith community. CSG has been associated contemporaneously and prospectively with other forms of bereavement distress, including anticipatory grief, complicated grief (CG), depression, and post-traumatic stress disorder (PTSD; Burke et al., 2015; Burke & Neimeyer, 2014; Burke et al., 2011). Longitudinal studies indicate that spiritually inclined grievers who struggle in terms of their lost relationship with the deceased also tend to struggle spiritually over time in relation to God and/or their spiritual community (Burke et al., 2011). Studies also show that survivors of violent death loss (e.g. suicide,

CONTACT Laurie A. Burke laburke@burkepsychological.com University of Memphis, 202 Psychology Building, 400 Innovation Dr., Memphis 38152, Tennessee, USA.

homicide, fatal accident) have higher levels of CSG than do survivors of natural death loss (e.g. old age; Burke & Neimeyer, 2014).

Until recently, measurement of CSG was conducted using instruments that were not specifically designed for use with bereaved samples. To address this critical gap, Burke, Neimeyer, Holland, et al. (2014) validated a measure of CSG, called the Inventory of Complicated Spiritual Grief (ICSG). However, subsequent qualitative research (Burke, Neimeyer, Young, Piazza Bonin, & Davis, 2014) not only provided greater clarity about the construct of CSG but also highlighted numerous themes that suggested the need to revise the original measure. Thus, the current study sought to modify, expand, and improve the ICSG to accommodate these new data.

Complicated spiritual grief

Complicated spiritual grief (CSG) is a spiritual crisis during bereavement that compromises the griever's sense of relationship to God and/or the faith community, such that he or she struggles to reestablish spiritual equilibrium following the loss (Burke & Neimeyer, 2014). Findings from a diverse sample of bereaved Christian adults showed that 43% of participants endorsed CSG (Burke, Neimeyer, Young, et al., 2014). This is consistent with other samples, including homicide survivors who reported feeling distant from and angry toward God and fellow church members (Burke et al., 2011) or who pled unsuccessfully to God for a miracle (Thompson & Vardaman, 1997), and spiritually inclined bereaved parents who questioned God's role in the death of their child (Lichtenthal, Currier, Neimeyer, & Keesee, 2010). Intense fury toward God (Burke, Neimeyer, Young, et al., 2014), an inability to trust God's goodness in the face of indescribable anguish (Burke & Neimeyer, 2014), and an existential crisis that makes or breaks ones' faith (Hill & Pargament, 2008) all describe how some mourners experience CSG. Notably, CSG increasingly has been associated with other deleterious forms of bereavement distress and is prevalent at high levels in violently bereaved adults (e.g. Burke & Neimeyer, 2014).

The Inventory of Complicated Spiritual Grief (ICSG)

To assess CSG, Burke et al. (2014) validated a novel, easy-to-use measure called the Inventory of Complicated Spiritual Grief (ICSG). The ICSG systematically evaluates CSG using 18 items and two subscales (Insecurity with God and Disruption in Religious Practice) to capture spiritual reactions to loss beyond that of generic, non-grief-specific measures of spiritual struggle (e.g. the Spiritual Assessment Inventory (Hall & Edwards, 2002); the Brief RCOPE (Pargament, Smith, Koenig, & Perez, 1998); the Attitudes Toward God Scale-9 (Wood, et al., 2010)) designed for use with samples of adults experiencing a range of life stressors. However, Burke, Neimeyer, Young, et al.'s (2014) study revealed additional information about the construct of CSG not found on the original scale.

Need for a revised measure of spiritual crisis in bereavement

Research consistently suggests that CSG represents a compromised spiritual system wherein the bereaved struggle both vertically in terms of their relationship with God and also horizontally in their relationship with their spiritual community. However, Burke et al. (2014) gleaned narrative data from 84 grievers, which, when coupled with focus group data, revealed 17 CSG themes that were not found on the original ICSG. Specifically, focus group members' overarching narrative was one of resentment and doubt toward God, dissatisfaction with the spiritual support received, and substantial changes in their spiritual beliefs and behaviors following the loss. Together, this new information (Burke et al., 2014), CSG's relation to CG, PTSD, and depression (e.g. Burke & Neimeyer, 2014), and the role of traumatic death loss in the development of CSG (e.g. Burke et al., 2011) indicated that developing a modified, expanded instrument to measure CSG was clinically and scientifically warranted. The current study thus sought to revise and expand the ICSG to accommodate new data, to test the scale's psychometric properties using exploratory factor analysis (EFA) and confirmatory factor analysis (CFA), and to evaluate its internal consistency and test–retest reliability, and convergent and discriminant validity with a large, diverse sample of bereaved Christian adults.

Method

Participants

Two groups of participants were recruited for the qualitative and quantitative phases of the study, respectively. In the first case, the lead investigator (LAB) invited 10 Christian grievers who had received grief psychotherapy through her private practice in

Portland, OR to assist in the pilot testing of the ICSG 2.0. Eight clients agreed to participate in a focus group, including five women and three men, all of whom were Caucasian, and had lost a loved one to either natural- (e.g. cancer) or violent causes (e.g. fatal accident). In the second instance, study participants were recruited from Amazon's Mechanical Turk (MTurk), a web-based recruitment and data collection site with an international reach, to ensure a diverse sample of bereaved participants (e.g. varying in ethnicity, age, gender, type of loss).

In both instances, participants (1) were 18 years old or older, (2) endorsed the Christian faith tradition, (3) had been bereaved at least 6 months but no more than 5 years, (4) did not belong to a vulnerable population (e.g. pregnant women), (5) could read English fluently, (6) could operate a computer, and (7) had access to the internet while completing the questionnaires. Of the 1472 individuals who registered for the validation study, we removed those participants with extensive missing data (i.e. missing more than 50% of the total assessment battery; $n = 291$), who did not complete the measures of convergent and discriminant validity ($n = 13$), who did not meet inclusion criteria ($n = 652$), or who had random responding to two out of three validation items ($n = 36$). Finally, we generated boxplots for each item and removed univariate outliers ($n = 40$). Cleaning and vetting of the data yielded a final sample of $N = 440$ usable cases, which was bifurcated into subsamples prior to conducting further analyses.

In terms of demographics, our subsamples were quite similar. Participants were mostly Caucasian (74%), women (64%), between 25–44 years old (64%), who were employed full-time (66%), living in North America (93%), had completed university or trade school (41%), made at least $50,000/year (54%), and had lost a parent or grandparent (48%) to a natural anticipated (e.g. cancer) or natural sudden (e.g. heart attack) death (74%) approximately 2.6 years prior (see Table 1).

Procedure

The development and testing of the proposed new scale included pilot testing through the use of the focus group and validation testing through the use of the large, diverse, online sample.

Scale development

Using all 18 items from the ICSG as its basis, the ICSG 2.0 was developed by using previous focus group members' narratives and other qualitative data (Burke, Neimeyer, Young, et al., 2014) to formulate candidate items for the revised scale. This beta version was critically examined by grief experts with knowledge and experience in assessing and treating CSG, who added additional items based on their clinical experience. Prior to validation, a focus group was conducted to pilot test the new measure to establish its face validity with a sample of spiritually inclined bereaved adults.

Focus group recruitment and data collection

Our goal in conducting a focus group was to gain insight regarding grievers' understanding, attitudes, perceptions, and ideas about CSG (Plummer-D'Amato, 2008). Eight grievers participated in a one-time focus group session that lasted 60 min, and each received a $10 gift card for their time and contribution to this study.

First, focus group participants completed pencil/paper versions of the Background Information and ICSG 2.0. Next, they met together with the focus group leader (a clinical psychologist who did not know them), who answered their study questions prior to their signing the informed consent form. During the audiotaped session, the facilitator asked participants semi-structured questions, allowing time for spontaneous responses and/or prompting them to respond if they wished.

Focus group members addressed issues related to: instruction clarity, response option formatting, item understandability (e.g. confusing wording), particularly relevant/irrelevant items (to self and others), whether they could easily keep in mind that the scale assessed CSG since the loss, other examples of CSG experienced by self or others, and what we might have missed. Finally, we asked "If you could tell us only one thing about your experience of spiritual struggle following loss, what would that be?" Next, the initial pool of ICSG 2.0 candidate items was again reviewed by the team of CSG experts, who used the focus group's feedback and suggested items as a basis for further modification and expansion prior to validity testing of an enlarged 55-item beta version of the scale.

Validation study recruitment and data collection

Participant recruitment and data collection were conducted through MTurk, an online survey system. MTurk has been validated as an efficient and inexpensive means of gathering good quality data for psychological studies (e.g. Berinsky, Huber, & Lenz, 2012),

Table 1. Participant demographic and loss-related information for EFA and CFA samples.

EFA Sample ($n = 220$)			CFA Sample ($n = 220$)		
	Total (n)	%		Total (n)	%
Age (Range: 19–78 years; $M = 38.3$ years; $SD = 12.1$)			Age (Range: 20–76 years; $M = 37.3$ years; $SD = 12.5$)		
18–24	18	8.2	18–24	29	13.2
25–34	92	41.8	25–34	88	40.0
35–44	49	22.3	35–44	45	20.5
45–54	24	10.9	45–54	31	14.1
55–64	27	12.3	55–64	18	8.2
65+	10	4.5	65+	9	4.1
Gender			Gender		
Female	149	67.7	Female	131	59.5
Male	70	31.8	Male	88	40.0
Other	1	<1	Other	1	<1
Race/Ethnicity (if American)			Race/Ethnicity (if American)		
African American	14	6.4	African American	15	6.8
Asian American	25	11.4	Asian American	15	6.8
Hispanic/Latino/Latina	12	5.5	Hispanic/Latino/Latina	17	7.7
Native American	7	3.2	Native American	7	3.2
White	158	71.8	White	168	76.4
Other	1	<1	Other	1	<1
Not American	12	5.5	Not American	6	2.7
Continent of Residence			Continent of Residence		
Asia	13	5.9	Asia	5	2.3
Australia/Oceania	1	<1	Australia/Oceania	0	0
Europe	2	<1	Europe	5	2.3
North America	201	91.4	North America	209	95.0
South America	3	1.4	South America	1	<1
Employment Status			Employment Status		
Employed full-time	139	63.2	Employed full-time	150	68.2
Employed part-time	36	16.4	Employed part-time	31	14.1
Not currently employed, looking	12	5.5	Not currently employed, looking	16	7.3
Not currently employed, not looking	18	8.2	Not currently employed, not looking	16	7.3
Full-time student	5	2.3	Full-time student	4	1.8
Other (e.g. retired)	10	<1	Other (e.g. retired)	9	4.1
Educational Level (Years of education)			Educational Level (Years of education)		
Middle school (8)	0	<1	Middle school (8)	1	<1
Some high school (<12)	3	1.4	Some high school (<12)	0	<1
High school graduate or GED (12)	17	7.7	High school graduate or GED (12)	24	10.9
Some university or trade school	45	20.5	Some university or trade school	52	23.6

Completion of university or trade school	97	44.1
Some post-graduate or professional school	17	7.7
Completed post-graduate or professional degree	41	18.6
Household Income		
Less than $10,000	10	4.5
$10,000 to less than $20,000	23	10.5
$20,000 to less than $30,000	21	9.5
$30,000 to less than $40,000	26	11.8
$40,000 to less than $50,000	20	9.1
$50,000 to less than $75,000	58	26.4
$75,000 to less than $100,000	35	15.9
$100,000 to less than $150,000	21	9.5
$150,000 or more	6	2.7
Participant Relationship to the Deceased		
Aunt or uncle	2	<1.0
Cousin	7	3.2
Daughter or son	51	23.2
Friend	14	6.4
Granddaughter or grandson	57	25.9
Grandparent	3	1.4
Niece or nephew	13	5.9
Parent	9	4.1
Intimate partner/fiancé(e)	25	11.4
Sibling	16	7.3
Spouse	7	3.2
Other (e.g. co-worker)	16	7.3
Cause of Death		
Natural anticipated	95	43.2
Natural sudden	69	31.4
Accident	26	11.8
Violent or traumatic (e.g. homicide, suicide, terrorism, natural disaster)	11	5.0
Other (e.g. medical malpractice)	19	8.6
Years Since Loss ($M = 2.4$ years; $SD = 1.4$)		

Completion of university or trade school	84	38.2
Some post-graduate or professional school	20	9.1
Completed post-graduate or professional degree	39	17.7
Household Income		
Less than $10,000	8	3.6
$10,000 to less than $20,000	18	8.2
$20,000 to less than $30,000	25	11.4
$30,000 to less than $40,000	27	12.3
$40,000 to less than $50,000	23	10.5
$50,000 to less than $75,000	57	25.9
$75,000 to less than $100,000	27	12.3
$100,000 to less than $150,000	26	11.8
$150,000 or more	9	4.1
Participant Relationship to the Deceased		
Aunt or uncle	5	2.3
Cousin	6	2.7
Daughter or son	50	22.7
Friend	13	5.9
Granddaughter or grandson	55	25.0
Grandparent	2	<1.0
Niece or nephew	14	6.4
Parent	14	6.4
Intimate partner/fiancé(e)	29	13.2
Sibling	16	7.3
Spouse	6	2.7
Other (e.g. co-worker)	9	4.1
Cause of Death		
Natural anticipated	111	50.5
Natural sudden	49	22.3
Accident	31	14.1
Violent or traumatic (e.g. homicide, suicide, terrorism, natural disaster)	13	5.9
Other (e.g. medical malpractice)	11	5.0
Years Since Loss ($M = 2.8$ years; $SD = 5.6$)		

and used successfully by this research team across several studies. Specifically, we recruited participants to "answer a survey about how your spirituality relates to your grief following the death of a loved one," and used the keywords: survey, questionnaires, grief, bereavement, death, loss, faith, religion, and spirituality. MTurk workers received our study's task description, eligibility criteria, anticipated completion time, task instructions, and compensation rate.

Measures

In addition to the Inventory of Complicated Spiritual Grief 2.0 (see Appendix A), to assess background information, convergent and discriminant validity, and to conduct factor analyses, we also administered a total of seven measures, including:

Demographic information

We garnered information about both the deceased and the bereaved participant, such as age, religious affiliation, type of death, and time since loss.

Complicated grief

Two instruments were used to measure complicated grief:

The Persistent Complex Bereavement Inventory (PCBI). The PCBI (Lee, 2015) is a 16-item instrument that measures persistent complex bereavement disorder (PCBD), using three factors that correspond with DSM-5 criteria for PCBD, by assessing symptom frequency using a Likert scale ranging between not at all (no symptomatology) to nearly every day (severe symptomatology). An example item includes: Found it extremely difficult to accept the death. The PCBI yielded strong internal consistency in two samples of bereaved college students (α = .95; Lee, 2015). In the present study, the PCBI demonstrated high internal consistency (α = .95 for both EFA and CFA subsamples).

The Inventory of Complicated Grief-Revised (ICG-R). The ICG-R (Prigerson & Jacobs, 2001) is a 30-item scale that uses 5-point Likert-style ratings (almost never to always) to measure the frequency of grief symptoms indicative of long-term dysfunction. A representative item is: Memories of _____ upset me. The scale achieved high internal consistency in a sample of homicidally bereft African Americans (α = .95; Burke, Neimeyer, & McDevitt-Murphy, 2010). In the present sample, the ICG-R had very high internal consistency (α = .97 in both subsamples).

Convergent validity

Two instruments were used to measure convergent validity:

The Religious and Spiritual Struggles Scale (RSS). The RSS (Exline, Pargament, Grubbs, & Yali, 2014) has 26 items measuring general spiritual/religious struggle using six domains: Divine, moral, doubt, ultimate meaning, demonic, and interpersonal. A sample item includes: Felt hurt, mistreated, or offended by religious/spiritual people. The RSS and its subscales achieved high internal consistency in adult and undergraduate samples (α = .85 to .93; Exline et al., 2014). The RSS in the present samples showed very high internal consistency (α = .97, EFA; α = .96, CFA).

The Negative Religious Coping (NRC) subscale of the Brief RCOPE. The NRC (Pargament et al., 1998) subscale uses seven items to measure negative religious coping. An example item is: Wondered whether God had abandoned me. The NRC subscale has shown good reliability in a sample of family members bereaved of a terminally ill Veteran (α = .84; Burke, Neimeyer, Bottomley, & Smigelsky, 2017). Likewise, the NRC subscale achieved good reliability in this study (α = .90 and .89 for EFA and CFA subsamples, respectively).

Discriminant validity

Two instruments were used to measure discriminant validity:

The Positive Religious Coping (PRC) subscale of the Brief RCOPE. The PRC (Pargament et al., 1998) subscale uses seven items to measure positive religious coping. An example item includes: Tried to see how God might be trying to strengthen me in this situation. In a sample of violently bereaved African Americans, the PRC subscale showed good internal reliability (α = .88; Burke et al., 2011). In this sample, the PRC subscale achieved high internal consistency reliability (α = .93 and .94 for EFA and CFA, respectively).

The Inventory of Stressful Life Events Scale-Short Form (ISLES-SF). The ISLES-SF (Holland, Currier, & Neimeyer, 2014) assesses meaning made of stressful life experiences, using a six-item scale and Likert response options ranging from strongly agree to

strongly disagree. A representative item is: This event is incomprehensible to me. In the present sample, the ISLES-SF had high internal consistency reliability ($\alpha = .92$, EFA; $\alpha = .91$, CFA).

Data analysis plan

Data cleaning and exploratory factor analyses were conducted using SPSS (Mac and Windows Version 24.0). Kolmogorov–Smirnov value of $p < .001$ (Pallant, 2013) indicated that the data were not normally distributed. Bartlett's test of sphericity yielded a significant value of χ^2 (1485) = 10105.730 ($p < .001$) and the Kaiser-Meyer-Olkin (Kaiser, 1974) measure of sampling adequacy was .958 for the original 55-item scale, indicating that the data were appropriate for EFA (Pallant, 2013). We split the dataset in half for EFA ($n = 220$) and CFA ($n = 220$), rendering an adequate sample size for EFA (Hair, Black, Babin, & Anderson, 2010) and yielding a participant-to-item ratio (*N*:*p*; Hair, Black, Babin, Anderson, & Tatham, 2006) of 4:1 (i.e. 4 subjects for each of the 55 items).

We used the principal axis factoring method to analyze only the common variance and an oblique (i.e. direct oblimin) rotation method, which assumes that factors are correlated (Mvududu & Sink, 2013). Our criteria for item selection were: (a) items with communalities > .50 (Kline, 1994), (b) the Guttman-Kaiser criterion of eigenvalues > 1.00, (c) items with factor loadings of .30 or higher, and (d) factors with 3 or more items (Costello & Osborne, 2005). Items with cross-loadings >.30 were removed, and we examined the scree plot for factor selection.

We used EFA to obtain optimal item pool and factor structure, and CFA to cross-validate the construct validity of the instrument. CFA was performed using SPSS Amos (Windows Version 24.0). The CFA model was tested using chi-square goodness-of-fit, Root Mean Square Residual, Normed Fit, Comparative Fit, and Root Mean Square Error of Approximation (Mvududu & Sink, 2013).

With the EFA and CFA subsamples, we examined bivariate correlations between the ICSG 2.0 and the NRC subscale and the RSS, and the PRC subscale and the ISLES-SF to test convergent and discriminant validity, respectively. We examined differences between demographic factors and ICSG 2.0 total and subscale scores using nonparametric equivalent tests when necessary to correct for heterogeneous variances (Pallant, 2013). Incremental validity was assessed using multiple regression analyses in both subsamples to test the association between ICSG 2.0 and ICG-R scores after variance associated with the NRC measure was accounted for. We also examined the internal consistency reliability of the total scale, as well as for the three factors extricated through factor analysis. Finally, Pearson correlations assessed test-retest reliability at 10–14 weeks with a subset of participants.

Results

Exploratory factor analysis

The EFA subsample ($n = 220$) yielded a parsimonious three-factor, 28-item factor structure representing the best performing items based on our preestablished item retention criteria. Bartlett's test of sphericity remained favorable, with a significant value of χ^2 (378) = 4815.251 ($p < .001$) and a KMO value of .954. Each of the three factors had eigenvalues greater than 1.00 and all items possessed communalities greater than .50, with the exception of two items with communalities of .43 and .47. EFA resulted in three factors that we named based on content of item clusters: (a) Estrangement from Spiritual Community, (b) Insecurity with God, (c) Disruption in Religious Practices (see Tables 2 and 3). Moderate correlations (i.e. .55–.67) indicated that relations between factors were high enough to support CSG as the structure's overarching construct, but low enough to indicate distinctness between factors.

Confirmatory factor analysis

With the CFA subsample ($n = 220$), we tested the three-factor exploratory structure for item selection. The CFA model demonstrated adequate model fit after model specification, χ^2 (341) = 817.404, $p < .001$; RMR = .069; NFI = .822; CFI = .887; RMSEA = .080, 90% confidence interval (CI) = .073–.087). Although chi-square fit indices should be nonsignificant ($p > .05$), significant chi-square is common with large samples and data from Likert scales. CFA supported a three-factor, 28-item scale, with each item loading above .60 (see Figure 1).

Internal consistency reliability

The total 28-item ICSG 2.0 demonstrated high internal consistency reliability ($\alpha = .96$ for both subsamples). Good internal consistency also was found for the 11-item Estrangement from Spiritual Community subscale ($\alpha = .94$ and .93 for EFA and CFA, respectively), the 11-item Insecurity with God subscale ($\alpha = .94$ and .93 for EFA and CFA,

Table 2. Factor loadings for exploratory factor analysis of the ICSG 2.0.

		Factor		
Item		1	2	3
43.	People in my spiritual community don't want me to express my grief much or at all.	.914		
38.	My spiritual community thinks I've been grieving for too long.	.821		
14.	My spiritual community appears to care more about their own comfort than my pain.	.793		
52.	Sharing my spiritual struggle with my spiritual community seems to complicate our relationship.	.775		
19.	My spiritual community places unrealistic expectations on my grieving process (e.g. suggesting I should "get over it").	.743		
34.	People in my spiritual community act as if my loved one's death didn't happen.	.689		
46.	My grief responses often contradict my spiritual community's spiritual beliefs.	.607		
47.	Since my loss, my spiritual beliefs are overshadowed by the beliefs of my spiritual community.	.567		
48.	My spiritual community might reject me because of the way that my loss has re-shaped my spiritual beliefs.	.543		
29.	My spiritual community criticizes my anger toward God.	.525		
44.	It is challenging to find a spiritual leader to discuss difficult spiritual issues with.	.436		
7.	I feel it is unfair that God took my loved one.		.868	
26.	I'm confused as to why God would let this happen.		.855	
11.	I struggle with accepting how a good God allowed bad things to happen.		.745	
36.	I am a faithful believer, so I don't understand why God didn't protect me.		.734	
2.	I feel angry at God.		.729	
17.	I sometimes feel like God is punishing me.		.708	
32.	I sometimes feel disappointed with God.		.671	
27.	I sometimes feel abandoned by God.		.642	
35.	My doubts about my spiritual beliefs trouble me.		.566	
41.	I feel like I have been robbed of the future God had planned for me.		.533	
6.	I no longer feel safe and protected by God, knowing that anything can happen to anyone.		.514	
13.	I find that spiritual/religious activities (e.g. prayer, worship, Bible reading) are no longer fulfilling.			.907
28.	I have lost the desire to worship.			.849
8.	I go out of my way to avoid spiritual/religious activities (e.g. prayer, worship, Bible reading).			.667
18.	I find it difficult to pray.			.658
37.	I have walked away from my faith.			.591
3.	I have withdrawn from my spiritual community.			.471

Note: Factor 1: Estrangement from Spiritual Community; Factor 2: Insecurity with God; Factor 3: Disruption in Religious Practice.

Table 3. ICSG 2.0 descriptive statistics of the EFA subsample.

Item		Factor	Scores	
			M	*SD*
43.	People in my spiritual community don't want me to express my grief much or at all.	1	1.64	1.10
38.	My spiritual community thinks I've been grieving for too long.	1	1.62	1.05
14.	My spiritual community appears to care more about their own comfort than my pain.	1	1.88	1.16
52.	Sharing my spiritual struggle with my spiritual community seems to complicate our relationship.	1	1.83	1.21
19.	My spiritual community places unrealistic expectations on my grieving process (e.g. suggesting I should "get over it").	1	1.77	1.12
34.	People in my spiritual community act as if my loved one's death didn't happen.	1	1.65	1.10
46.	My grief responses often contradict my spiritual community's spiritual beliefs.	1	1.79	1.10
47.	Since my loss, my spiritual beliefs are overshadowed by the beliefs of my spiritual community.	1	1.65	1.03
48.	My spiritual community might reject me because of the way that my loss has re-shaped my spiritual beliefs.	1	1.72	1.14
29.	My spiritual community criticizes my anger toward God.	1	1.54	1.02
44.	It is challenging to find a spiritual leader to discuss difficult spiritual issues with.	1	2.06	1.26
7.	I feel it is unfair that God took my loved one.	2	2.42	1.36
26.	I'm confused as to why God would let this happen.	2	2.14	1.28
11.	I struggle with accepting how a good God allowed bad things to happen.	2	2.25	1.27
36.	I am a faithful believer, so I don't understand why God didn't protect me.	2	1.80	1.74
2.	I feel angry at God.	2	1.85	1.15
17.	I sometimes feel like God is punishing me.	2	1.95	1.23
32.	I sometimes feel disappointed with God.	2	1.89	1.10
27.	I sometimes feel abandoned by God.	2	1.90	1.16
35.	My doubts about my spiritual beliefs trouble me.	2	1.91	1.10
41.	I feel like I have been robbed of the future God had planned for me.	2	1.66	1.10
6.	I no longer feel safe and protected by God, knowing that anything can happen to anyone.	2	1.74	1.12
13.	I find that spiritual/religious activities (e.g. prayer, worship, Bible reading) are no longer fulfilling.	3	1.65	1.04
28.	I have lost the desire to worship.	3	1.88	1.26
8.	I go out of my way to avoid spiritual/religious activities (e.g. prayer, worship, Bible reading).	3	1.64	1.10
18.	I find it difficult to pray.	3	1.94	1.17
37.	I have walked away from my faith.	3	1.63	1.08
3.	I have withdrawn from my spiritual community.	3	1.57	0.98

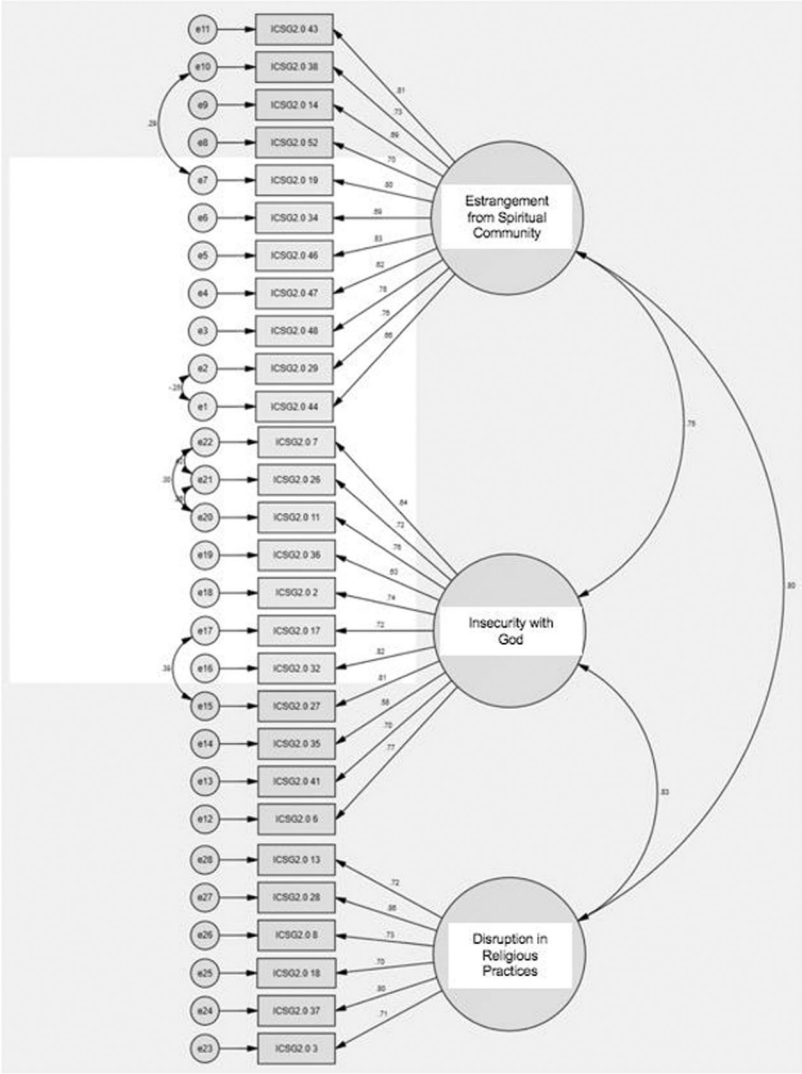


Figure 1. Three-factor confirmatory factor analysis for the 28-item ICSG 2.0.

respectively), and the 6-item Disruption in Religious Practices subscale ($\alpha = .90$ and .89 for EFA and CFA, respectively).

Overall, adequate test-retest correlations over a period of 10-14 weeks were obtained with a subset of 28 participants for the total ICSG 2.0 ($r = .82$, $p < .001$), for the Estrangement from Spiritual Community subscale ($r = .84$, $p < .001$), and the Insecurity with God subscale ($r = .72$, $p < .001$); however, the Disruption in Religious Practices subscale showed a weaker association ($r = .63$, $p < .001$).

Validity

Convergent validity

ICSG 2.0 total- and subscale scores were significantly associated with each measure in the anticipated directions. Specifically, high ICSG 2.0 scores correlated with high negative religious coping and spiritual struggle scores (see Table 4).

Discriminant validity

High ICSG 2.0 total- and subscale scores correlated with lower PRC scores and meaning making scores. Small effect sizes (i.e. $r < .30$) provided evidence of discriminant validity between the ICSG 2.0 and the PRC subscale of the Brief RCOPE, but not for the ICSG 2.0 and the ISLES, which yielded higher effect sizes. The correlation of the PRC subscale and the *Insecurity with God* subscale of the ICSG 2.0, which was nonsignificant in the EFA subsample (see Table 4), provided further support for discriminant validity, and consistent with research showing no relation between PRC and spiritual- or grief distress (e.g. Burke & Neimeyer, 2014).

Table 4. Correlations between the ICSG 2.0 and measures of related constructs in the EFA and CFA subsamples.

	EFA Subsample				CFA Subsample			
Measure	Total	Factor 1	Factor 2	Factor 3	Total	Factor 1	Factor 2	Factor 3
Inventory of Complicated Grief – Revised	.642**	.550**	.669**	.442**	.621**	.547**	.645**	.418**
Persistent Complex Bereavement Inventory	.619**	.516**	.650**	.441**	.627**	.570**	.626**	.437**
Brief RCOPE: Negative	.720**	.621**	.713**	.555**	.762**	.677**	.734**	.608**
Brief RCOPE: Positive	−.184**	−.13**	−.129**	−.288**	−.270**	−.176**	−.240**	−.362**
RSS Total	.807**	.677**	.797**	.662**	.841**	.720**	.790**	.664**
RSS F1: Divine Struggles	.778**	.595**	.848**	.591**	.791**	.614**	.854**	.605**
RSS F2: Demonic Struggles	.645**	.574**	.598**	.546**	.620**	.587**	.557**	.500**
RSS F3: Interpersonal Struggles	.796**	.736**	.703**	.689**	.801**	.771**	.689**	.679**
RSS F4: Moral Struggles	.647**	.536**	.644**	.532**	.625**	.564**	.589**	.499**
RSS F5: Doubt Struggles	.679**	.546**	.701**	.540**	.698**	.858**	.692**	.572**
RSS F6: Ultimate Meaning Struggles	.782**	.638**	.773**	.669**	.786**	.673**	.769**	.640**
Integration of Stressful Life Experiences Scale – Short Form (ISLES-SF)	−.538**	−.408**	−.621**	−.349**	−.526**	−.424**	−.591**	−.332**
ISLES-SF F1 Comprehensibility	−.454**	−.311**	−.571**	−.265**	−.431**	−.317**	−.535**	−.232**
ISLES-SF F2 Footing in the World	−.539**	−.442**	−.576**	−.378**	−.540**	−.465**	−.558**	−.380**

*Correlation is significant at the 0.05 level (2-tailed)
**Correlation is significant at the 0.01 level (2-tailed)
Note: Factor 1: Estrangement from Spiritual Community; Factor 2: Insecurity with God; Factor 3: Disruption in Religious Practices.

Demographic and loss-related analyses

Table 5 shows demographic and loss-related comparisons. Age was negatively associated with CSG in both the EFA and CFA subsamples, with younger adults endorsing higher levels of CSG on total ICSG 2.0 ($r = -.35$, $p < .001$), Estrangement from Spiritual Community ($r = -.28$, $p < .001$), Insecurity with God ($r = -.33$, $p < .001$), and Disruption in Religious Practices ($r = -.32$, $p < .001$) in the EFA subsample, as well as in the CFA subsample on the total ICSG 2.0 ($r = -.17$, $p = .01$) and on the Insecurity with God subscale ($r = -.175$, $p = .009$). However, age was not significantly associated with CSG on the Estrangement from Spiritual Community and Disruption in Religious Practices subscales in the CFA subsample.

No significant differences between ICSG 2.0 total- or subscale scores for income level were found in either subsample. In terms of gender comparisons, men generally had significantly higher CSG than women in both subsamples (total scores, EFA, $U = 4394.5$, $z = -2.03$, $p = .04$; CFA, $U = 4793.5$, $z = -2.24$, $p = .03$; Estrangement from Spiritual Community, EFA, $U = 4303.5$, $z = -2.261$, $p = .02$; CFA, $U = 4470.5$, $z = -2.95$, $p < .01$; Disruption in Religious Practices, EFA, ns; CFA, $U = 4748.0$, $z = -2.38$, $p = .02$). As the single exception, significant gender differences were not found for the Insecurity with God subscale in either subsample.

Except for Insecurity with God, racial/ethnic minorities had significantly higher CSG than Whites within the American sample (total scores; EFA, ns; CFA, $U = 3698.0$, $z = -2.41$, $p = .02$; Estrangement from Spiritual Community, EFA, $U = 4035.0$, $z = -2.50$, $p = .01$; CFA, $U = 3343.0$, $z = -3.30$, $p = .001$; Disruption in Religious Practices, EFA, ns; CFA, $U = 3803.5$, $z = -2.19$, $p = .03$).

Fine-grained examination of loss-related factors also revealed some intriguing patterns. For example, significant differences between kinship and CSG emerged (total score, EFA, $F(4, 215) = 3.68$, $p = .006$; CFA, ns; Estrangement from Spiritual Community, EFA, $F(4, 215) = 2.53$, $p = .04$; CFA, ns; Insecurity with God, EFA, $F(4, 215) = 4.32$, $p = .002$; Disruption in Religious Practices, EFA, ns; CFA, ns). Interestingly, Tukey's post hoc tests with the EFA subsample revealed that grievers who lost an intimate partner had significantly higher CSG than those bereaved of all other relationships (e.g. child, co-worker). Mean scores of EFA and CFA groups were similar, with participants bereaved of an intimate partner endorsing higher levels CSG.

Table 5. Descriptive statistics of demographic and loss-related factors.

	EFA subsample				CFA Subsample				
Variable	*n*	Total *M* (*SD*)	Factor 1 *M* (*SD*)	Factor 2 *M* (*SD*)	Factor 3 *M* (*SD*)	*n*	Total *M* (*SD*)	Factor 1 *M* (*SD*)	Factor 2 *M* (*SD*)	Factor 3 *M* (*SD*)
Income										
< $10,000–19,999	33	56.55 (22.19)	22.55 (10.38)	22.88 (9.86)	11.12 (4.99)	26	59.58 (23.18)	22.00 (8.81)	24.00 (10.61)	13.58 (5.74)
$20,000–29,000	21	52.14 (28.74)	20.05 (12.30)	21.86 (11.96)	10.24 (5.78)	25	55.68 (24.29)	21.76 (9.86)	22.12 (12.15)	11.80 (6.13)
$30,000–39,000	26	53.35 (25.78)	20.35 (10.33)	22.96 (12.00)	10.04 (5.81)	27	51.15 (20.43)	19.96 (9.54)	20.59 (8.42)	10.59 (5.35)
$40,000–49,000	20	50.35 (25.08)	19.15 (10.32)	20.85 (10.38)	10.35 (5.65)	23	53.61 (20.94)	22.39 (8.70)	20.48 (8.62)	10.74 (4.82)
$50,000–74,000	58	50.16 (21.09)	17.67 (8.04)	21.88 (10.50)	10.60 (5.90)	57	49.49 (19.02)	18.40 (8.37)	21.63 (8.65)	9.46 (4.25)
$75,000–99,000	35	45.71 (19.79)	16.86 (8.34)	19.94 (9.34)	8.91 (4.66)	27	51.41 (23.62)	19.15 (8.69)	21.70 (10.41)	10.56 (5.67)
$100,000 to >150,000	27	50.00 (21.26)	19.41 (10.01)	19.89 (8.81)	10.70 (5.55)	35	45.34 (19.75)	16.20 (8.92)	19.31 (9.35)	9.83 (5.10)
Gender										
Female	149	48.36 (20.61)	18.19 (9.20)	20.36 (9.21)	9.80 (4.98)	131	48.31 (18.66)	17.92 (7.72)	20.54 (9.03)	9.85 (4.54)
Male	71	56.46 (26.04)	21.20 (10.43)	23.92 (11.96)	11.35 (6.27)	89	56.44 (24.11)	21.98 (10.00)	22.56 (10.32)	11.90 (6.00)
Race/Ethnicity (if American)										
White	153	48.95 (21.57)	18.05 (8.95)	20.73 (10.02)	10.18 (5.43)	162	49.22 (19.92)	18.31 (8.23)	20.82 (9.46)	10.09 (4.83)
Racial/ethnic minority	67	55.58 (24.85)	21.72 (10.84)	23.30 (10.73)	10.57 (5.57)	58	58.22 (23.91)	23.03 (9.86)	22.86 (9.92)	12.33 (6.10)
Participant relationship to deceased										
Immediate family	133	47.68 (22.22)	18.08 (9.62)	19.83 (9.82)	9.77 (5.26)	138	49.69 (19.92)	19.17 (8.68)	20.14 (8.85)	10.37 (5.08)
Extended family	30	53.70 (19.42)	19.40 (9.11)	23.47 (9.58)	10.83 (5.19)	33	52.45 (24.10)	18.27 (9.47)	23.85 (11.85)	10.33 (5.55)
Friend	14	56.07 (24.68)	22.29 (11.68)	23.21 (9.91)	10.57 (4.89)	13	50.92 (20.88)	20.54 (9.02)	20.38 (8.05)	10.00 (4.51)
Romantic partner or fiancé(e)	31	63.10 (24.51)	23.29 (9.60)	27.35 (11.27)	12.45 (6.68)	29	59.52 (24.08)	22.69 (9.47)	24.21 (9.73)	12.62 (6.10)
Other	12	43.42 (19.57)	16.25 (6.62)	18.17 (9.43)	9.00 (4.75)	7	53.57 (22.72)	18.43 (7.68)	23.57 (11.87)	11.57 (4.76)
Cause of death										
Nonviolent	164	48.59 (22.35)	18.47 (9.33)	20.07 (9.99)	10.05 (5.48)	160	50.06 (20.93)	18.86 (8.48)	20.61 (9.58)	10.59 (5.25)
Violent	37	61.03 (22.95)	22.65 (10.67)	27.24 (10.32)	11.14 (5.37)	44	58.27 (23.16)	22.50 (9.79)	24.43 (9.48)	11.34 (5.75)
Other	19	52.00 (21.67)	18.37 (9.81)	22.79 (9.05)	10.84 (5.59)	16	48.63 (17.78)	18.50 (9.57)	20.38 (8.99)	9.75 (3.94)

Note: Factor 1: Estrangement from Spiritual Community; Factor 2: Insecurity with God; Factor 3: Disruption in Religious Practices.

Violent death loss (e.g. suicide, homicide, or accident) was associated with significantly higher CSG on two dimensions of the construct than nonviolent death loss (e.g. cancer; total scores, EFA, $F(2, 217) = 4.70$, $p = .01$; CFA, ns; Estrangement from Spiritual Community, EFA, $F(2, 217) = 2.92$, $p = .056$; CFA, $F(2, 217) = 3.06$, $p = .05$; Insecurity with God, EFA, $F(2, 217) = 8.00$, $p < .001$; CFA, $F(2, 217) = 2.90$, $p = .059$). However, this difference was not evident on Disruption in Religious Practices (EFA, ns; CFA, ns).

Incremental validity

Finally, higher ICSG 2.0 scores were associated with higher CG scores, even after controlling for NRC scores in both subsamples (EFA, $\beta = .32$, $p < .001$; CFA, $\beta = .35$, $p < .001$), supporting the new measure's incremental validity over a validated general purpose measure of spiritual struggle.

Discussion

Conducting an earlier qualitative inquiry with a diverse sample of spiritually distressed survivors (Burke, Neimeyer, Young, et al., 2014) enabled us to garner data to bolster our existing measure, the ICSG (Burke, Neimeyer, Holland, et al., 2014). Fine-grained analyses of participant narratives suggested candidate items for a revised scale – the ICSG 2.0 – with apparent face validity and clinical utility. Thus, developing the ICSG 2.0 and testing its psychometric properties was the focus of our study.

This study provides initial evidence for a 3-factor, 28-item revised measure of spiritual distress in bereavement demonstrating good psychometric properties, including replication with CFA. Specifically, testing of the ICSG 2.0 with a diverse sample of Christian bereaved adults revealed that the instrument performed well in terms of high internal consistency reliability, adequate test-retest reliability, and evidence of convergent, discriminant, and incremental validity with other established instruments. However, Disruption in Religious Practices revealed more modest test-retest reliability across a period of several weeks. While this could reflect lower stability for this dimension of CSG, it is also possible that participants' behavioral engagement with their faith was actually more variable across time than the attitudinal dimensions of their spiritual struggle, as might be expected if they were to experience ongoing disenchantment with God or members of their spiritual communities, while continuing to join sporadically in worship services and rituals. A more substantial longitudinal study could shed light on temporal shifts in the expression of spiritual struggle in bereavement.

With regard to CG, our results are consistent with Burke, Neimeyer, Holland et al. (2014) study, such that grievers in our sample with high levels of CSG on generic instruments like the R-COPE or high levels of CG also had high ICSG 2.0 scores. Likewise, participants with high CSG reported lower levels of sense-making and higher ultimate meaning struggles. In fact, grievers with high ICSG 2.0 scores not only scored high on all aspects of CSG (e.g. NRC, interpersonal-, doubt-, and ultimate meaning struggles), but also on divine- and demonic struggles as measured by the RSS, suggesting that CSG is experienced by spiritually inclined grievers in multiple clinically significant domains (Burke et al., 2011).

Exploration of demographic factors revealed interesting variations in ICSG 2.0 scores. For example, in contrast to Burke et al. (2014) who found no differences on the original ICSG in terms of gender, age, and specific relationship category, we found that being younger, male, and losing an intimate partner exacerbated participants' spiritual reactions to the death as assessed by the ICSG 2.0, especially in terms of relating to one's spiritual community – a dimension of spiritual distress addressed more explicitly on the revised measure. Our finding that CSG is more pronounced in younger mourners might be explained by the evolving spiritual identity and religious practices of emerging adults/Millennials. Although men and women did not differ in terms of their level of discontent with God, males struggled more in terms of engagement with their religious relationships and practices, which might reflect men's generally lower interest and participation in religion (Pew Research Center, 2018, "The Gender Gap in Religion," para. 2), especially when faith is further compromised by loss. Our finding that loss of an intimate partner was uniquely associated with CSG relative to other relationship types is surprising, especially in light of studies showing that being either the parent or spouse/partner of the deceased is a risk factor for poor bereavement outcome (Burke & Neimeyer, 2013). Perhaps grievers made single by a loss have a more difficult time re-engaging in their spiritual community and/or feel more lost in terms of knowing God's plan for their life in their partner's absence. Follow-up studies are needed to determine if spiritual distress, *per se*, has an especially negative effect on specific types of relationship loss.

Likewise, in contrast to Burke et al. (2014) who found that Caucasians completing the original ISCG had higher spiritual distress, this same demographic group displayed less distress on the ICSG 2.0, particularly with regard to their spiritual community and religious practices. Such divergent findings suggest that further research with diverse samples is needed to understand the role of race/ethnicity in CSG. In contrast, violent death loss proved to be a robust risk factor for CSG in both previous research (Burke et al., 2011; Burke, Neimeyer, Holland, et al., 2014; Burke & Neimeyer, 2014) and in the present study. Unsurprisingly, our violently bereaved mourners experienced both more global spiritual distress and more discontent in their relationships with God and their spiritual community. Grievers' lived experiences (Burke et al., 2014) help explain the "why" of this, such that, on one hand, everything about the nature of violent death is incongruent with a loving God, and, on the other hand, stigmatization and ostracism by one's spiritual family can be unbearably painful and isolating.

Limitations and future directions

The present study provides substantial evidence for the validity, factorial structure, and reliability of the ICSG 2.0, suggesting that this improved measure should prove useful in both research and clinical settings ongoing. However, the ICSG 2.0 is not without limitations. For instance, expanding beyond MTurk as a sampling source would be valuable in future studies in order to more confidently generalize to other populations (e.g. clinical samples, grievers without Internet access).

Still, although a majority of our participants were 25–44 years old ($M = 37$ years), studies using non-web data collection means often attract mostly similarly aged adults (e.g. 20–33 years; Burke et al., 2014). Additionally, unlike grievers who were recruited using more traditional means (e.g. through churches), or who contribute without being compensated, MTurk workers participate primarily to be monetarily compensated, which may have affected participants' responses. Our cross-sectional, correlational study also meant that possible causal relations between variables could not be inferred.

Future studies should include mourners who endorse other monotheistic traditions such as Judaism or Islam, or other faith traditions such as Buddhism, which emphasizes impermanence and encourages meaning-making in the face of suffering. That said, the development of a one-size-fits-all scale is unlikely, especially given that CSG is experienced differently by grievers regardless of one's particular faith tradition (Burke, Neimeyer, Young, et al., 2014). Thus, although spiritual struggle might be expressed in terms of disruptions of spiritual communities and practices across different religions, "insecurity with God," understood in terms of compromised attachment to what was once a security enhancing being, may be irrelevant for traditions that do not conceive the divine in these terms. Thus, these differences warrant further exploration, as does the role of attachment style as a predisposing factor for spiritual struggle in general, and security with God in particular. In fact, even grievers who do not endorse a faith tradition *per se* – who rely instead on naturalistic, practical, or philosophic worldviews to make sense of the world – likely would benefit from research exploring ways to understand and capture the existential challenges inherent in life and loss.

In conclusion, the ICSG 2.0 shows potential as a valid and multidimensional tool for researchers, mental health professionals, and clergy alike to understand, assess, and document grief-related spiritual crisis to facilitate healing in bereavement for grievers and their spiritual communities.

References

Berinsky, A. J., Huber, G. A., & Lenz, G. S. (2012). Evaluating online labor markets for experimental research: Amazon.com's Mechanical Turk. *Political Analysis*, *20*(3), 351–368. doi:10.1093/pan/mpr057

Burke, L. A., Clark, K. A., Ali, K. S., Gibson, B. W., Smigelsky, M. A., & Neimeyer, R. A. (2015). Risk factors for anticipatory grief in family members of terminally ill veterans receiving palliative care services. *Journal of Social Work in End-of-Life & Palliative Care*, *11*(3–4), 244–266. doi:10.1080/15524256.2015.1110071

Burke, L. A., & Neimeyer, R. A. (2013). Prospective risk factors for complicated grief: A review of the empirical literature. In M. S. Stroebe, H. Schut, J. van der Bout & P. Boelen (Eds.), *Complicated grief: Scientific foundations for healthcare professionals* (pp. 145–161). New York, NY: Routledge.

Burke, L. A., & Neimeyer, R. A. (2014). Complicated spiritual grief I: Relation to complicated grief symptomatology following violent death bereavement. *Death Studies*, *38*(4), 259–267. doi:10.1080/07481187.2013.829372

Burke, L. A., Neimeyer, R. A., Bottomley, J. S., & Smigelsky, M. A. (2017). Prospective risk factors for intense grief in family members of Veterans who died of terminal illness. *Illness, Crisis, & Loss*, *27*, 147–171. doi:10.1177/1054137317699580

Burke, L. A., Neimeyer, R. A., Holland, J. M., Dennard, S., Oliver, L., & Shear, K. M. (2014). Inventory of Complicated Spiritual Grief Scale: Development and

initial validation of a new measure. *Death Studies*, *38*(4), 239–250. doi:10.1080/07481187.2013.810098

Burke, L. A., Neimeyer, R. A., & McDevitt-Murphy, M. E. (2010). African American homicide bereavement. *Omega*, *61*(1), 1–24. doi:10.2190/OM.61.1.a

Burke, L. A., Neimeyer, R. A., McDevitt-Murphy, M. E., Ippolito, M. R., & Roberts, J. M. (2011). In the wake of homicide: Spiritual crisis and bereavement distress in an African American sample. *International Journal for Psychology of Religion*, *21*, 1–19. doi:10.1080/10508619.2011.60741

Burke, L. A., Neimeyer, R. A., Young, M. J., Piazza Bonin, B., & Davis, N. L. (2014). Complicated spiritual grief II: A deductive inquiry following the loss of a loved one. *Death Studies*, *38*(4), 268–281. doi:10.1080/07481187.2013.829373

Costello, A. B., & Osborne, J. W. (2005). Best practices in exploratory factor analysis: Four recommendations for getting the most from your analysis. *Practical Assessment, Research & Evaluation*, *10*(7), 1–9.

Exline, J. J., Pargament, K. I., Grubbs, J. B., & Yali, A. M. (2014). The Religious and Spiritual Struggles Scale: Development and initial validation. *Psychology of Religion and Spirituality*, *6*(3), 208. doi:10.1037/a0036465

Galatzer-Levy, I. R., & Bonanno, G. A. (2012). Beyond normality in the study of bereavement: Heterogeneity in depression outcomes following loss in older adults. *Social Science & Medicine*, *74*(12), 1987–1994. doi:10.1016/j.socscimed.2012.02.022

Hair, J. F., Black, W. C., Babin, B. J., & Anderson, R. E. (2010). *Multivariate data analysis: A global perspective*. Hoboken, NJ: Pearson.

Hair, J. F., Black, W. C., Babin, B. J., Anderson, R. E., & Tatham, R. L. (2006). *Multivariate data analysis* (Vol. 6). Hoboken, NJ: Pearson.

Hall, T. W., & Edwards, K. J. (2002). The Spiritual Assessment Inventory. *Journal for the Scientific Study of Religion*, *41*(2), 341–357. doi:10.1111/1468-5906.00121

Hill, P. C., & Pargament, K. I. (2008). Advances in the conceptualization and measurement of religion and spirituality: Implications for physical and mental health research. *Psychology of Religion and Spirituality*, *S*(1), 3–17. doi:10.1037/1941-1022.S.1.3

Holland, J. M., Currier, J. M., & Neimeyer, R. A. (2014). Validation of the integration of stressful life experiences scale–short form in a bereaved sample. *Death Studies*, *38*(4), 234–238. doi:10.1080/07481187.2013.829369

Kaiser, H. F. (1974). An index of factorial simplicity. *Psychometrika*, *39*(1), 31–36. doi:10.1007/BF02291575

Kline, P. (1994). *An easy guide to factor analysis*. Abingdon-on-Thames: Routledge.

Lee, S. A. (2015). The Persistent Complex Bereavement Inventory: A measure based on the DSM-5. *Death Studies*, *39*(7), 399–410. doi:10.1080/07481187.2015.1029144

Lichtenthal, W. G., Currier, J. M., Neimeyer, R. A., & Keesee, N. J. (2010). Sense and significance: A mixed methods examination of meaning making after the loss of one's child. *Journal of Clinical Psychology*, *66*(7), 791–812.

Meichenbaum, D., & Myers, J. (2016). Strategies for coping with grief. In R. A. Neimeyer (Ed.), *Techniques of grief therapy: Assessment and intervention* (pp. 117–123). New York, NY: Routledge.

Mvududu, N. H., & Sink, C. A. (2013). Factor analysis in counseling research and practice. *Counseling Outcome Research and Evaluation*, *4*(2), 75–98. doi:10.1177/2150137813494766

Pallant, J. (2013). *SPSS survival manual: A step-by-step guide to data analysis using IBM SPSS*. Berkshire, England: Open University Press/McGraw-Hill.

Pargament, K., Smith, B., Koenig, H., & Perez, L. (1998). Patterns of positive and negative religious coping with major life stressors. *Journal for the Scientific Study of Religion*, *37*(4), 710–724. doi:10.2307/1388152

Pew Research Center. (2018). *The gender gap in religion around the world*. Retrieved from http://www.pewforum.org/2016/03/22/the-gender-gap-in-religion-around-the-world

Plummer-D'Amato, P. (2008). Focus group methodology part 1: Considerations for design. *International Journal of Therapy and Rehabilitation*, *15*, 69–73. doi:10.12968/ijtr.2008.15.2.28189

Prigerson, H. G., & Jacobs, S. C. (2001). Traumatic grief as a distinct disorder. In M. S. Stroebe, R. O. Hansson, W. Stroebe & H. Schut (Eds.), *Handbook of Bereavement Research* (pp. 613–645). Washington, DC: American Psychological Association.

Thompson, M. P., & Vardaman, P. J. (1997). The role of religion in coping with the loss of a family member to homicide. *Journal for the Scientific Study of Religion*, *36*(1), 44–51. doi:10.2307/1387881

Wood, B. T., Worthington, E., Exline, J., Yali, A., Aten, J. D., & McMinn, M. R. (2010). Development, refinement, and psychometric properties of the Attitudes Toward God Scale (ATGS-9). *Psychology of Religion and Spirituality*, *2*(3), 148–167. doi:10.1037/a0018753

Wortmann, J. H., & Park, C. L. (2008). Religion and spirituality in adjustment following bereavement: An integrative review. *Death Studies*, *32*(8), 703–736. doi:10.1080/07481180802289507

Appendix A

Inventory of Complicated Spiritual Grief—2.0 (ICSG 2.0)

Important points to read before completing this questionnaire:

- During bereavement, many people experience struggles, concerns, or doubts regarding spiritual or religious issues.
- The purpose of this scale is to understand how you have been coping spiritually since your loss.
- On the list of items below there are no right or wrong answers. The best answer is the one that most accurately reflects your experience. If a statement does not apply to you or your situation, simply mark N/A (not applicable).
- When items refer to your "spiritual community," please allow that to represent whatever *spiritual community* means to you. It's meant to include all spiritually inclined individuals in your social network, for instance, fellow believers, members of your church, spiritually like-minded friends or family, etc.
- Please read each statement with the loss you are currently grieving in mind.
- We want you to respond based on how you *actually* feel, not how you believe you *should* feel.
- Please think about your loss of _____, and then read each statement carefully.
- Choose the answer that best describes how you have been feeling *about your loss* during the **past month** including today.

Since the death of _____	Not at all true/ NA	A little true	Somewhat true	Mostly true	Very definitely true
1. People in my spiritual community don't want me to express my grief much or at all.	0	1	2	3	4
2. I feel it is unfair that God took [LOVED ONE].	0	1	2	3	4
3. My spiritual community appears to care more about their own comfort than my pain.	0	1	2	3	4
4. I struggle with accepting how a good God allows bad things to happen.	0	1	2	3	4
5. My spiritual community places unrealistic expectations on my grieving process (e.g. suggesting I should "get over it").	0	1	2	3	4
6. I feel angry at God.	0	1	2	3	4
7. My grief responses often contradict my spiritual community's spiritual beliefs.	0	1	2	3	4
8. I sometimes feel disappointed by God.	0	1	2	3	4
9. I find that spiritual/religious activities (e.g. prayer, worship, Bible reading) are no longer fulfilling.	0	1	2	3	4
10. People in my spiritual community act as if [LOVED ONE]'s death didn't happen.	0	1	2	3	4
11. It is challenging to find a spiritual leader to discuss difficult spiritual issues with.	0	1	2	3	4
12. I sometimes feel like God is punishing me.	0	1	2	3	4
13. I'm confused as to why God would let this happen.	0	1	2	3	4
14. My spiritual community criticizes my anger toward God.	0	1	2	3	4
15. I am a faithful believer, so I don't understand why God didn't protect me.	0	1	2	3	4
16. My spiritual community thinks I've been grieving for too long.	0	1	2	3	4
17. Since my loss, my spiritual beliefs are overshadowed by the beliefs of my spiritual community.	0	1	2	3	4
18. Sharing my spiritual struggle with my spiritual community seems to complicate our relationship.	0	1	2	3	4
19. I sometimes feel abandoned by God.	0	1	2	3	4
20. My doubts about my spiritual beliefs trouble me.	0	1	2	3	4
21. I have lost my desire to worship	0	1	2	3	4
22. I no longer feel safe and protected by God, knowing that anything can happen to anyone.	0	1	2	3	4
23. My spiritual community might reject me because of the way that my loss has re-shaped my spiritual beliefs.	0	1	2	3	4
24. I feel like I have been robbed of the future God had planned for me.	0	1	2	3	4
25. I go out of my way to avoid spiritual/religious activities (e.g. prayer, worship, Bible reading).	0	1	2	3	4
26. I have walked away from my faith.	0	1	2	3	4
27. I find it difficult to pray.	0	1	2	3	4
28. I have withdrawn from my spiritual community.	0	1	2	3	4
OPEN-ENDED ITEMS					
If your spiritual struggle has been experienced in ways not covered by the items above, please add your statements below:					

1._____	0	1	2	3	4
2._____	0	1	2	3	4
3._____	0	1	2	3	4
4._____	0	1	2	3	4
5._____	0	1	2	3	4

Note:.

Scoring Instructions:

A total ICSG 2.0 score can be calculated by summing all 28 items and dividing that sum by 28.

Subscales by item #

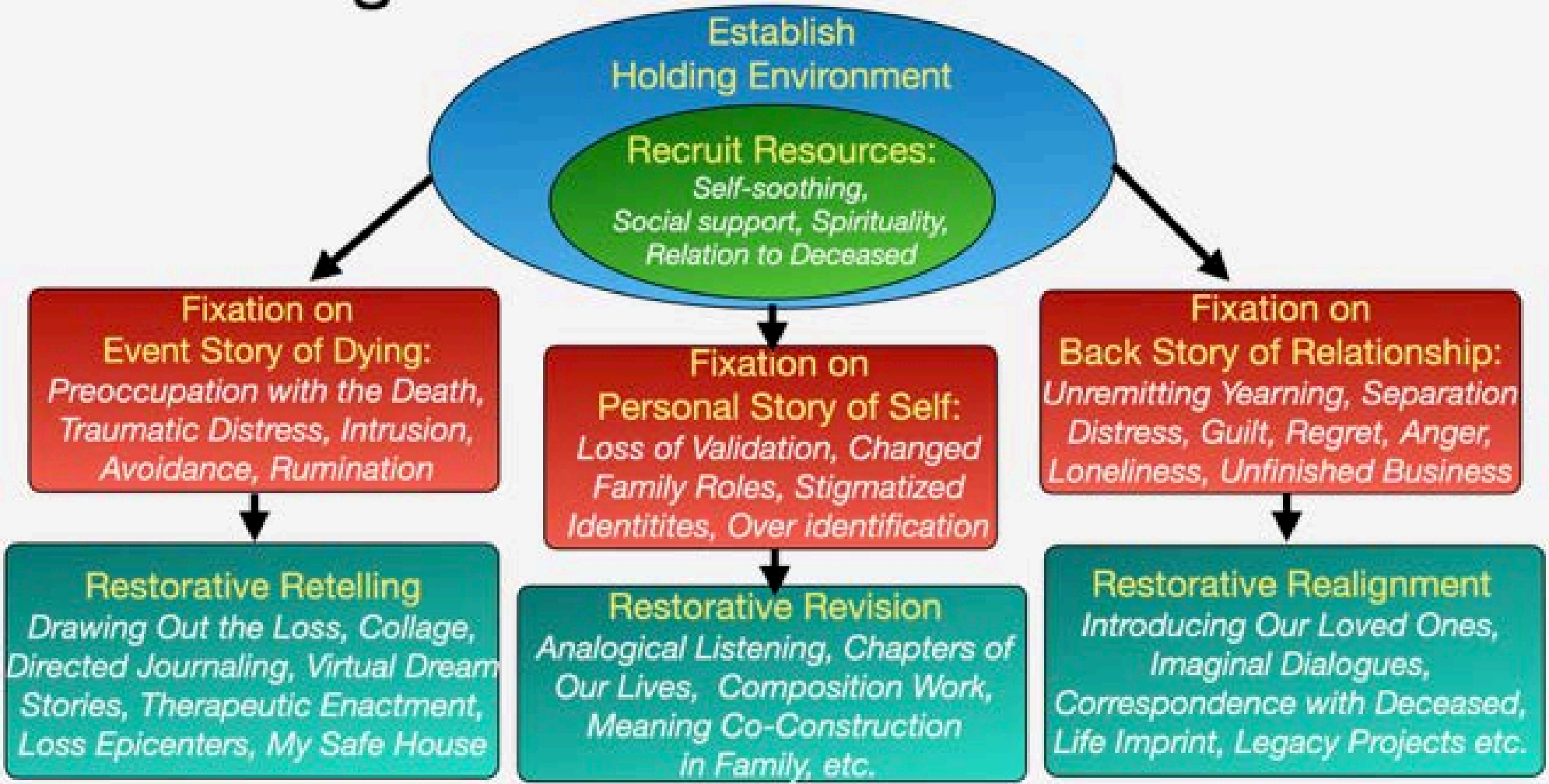
(calculated by summing the items and dividing by the number of items in parentheses):

Insecurity with God (13): 2, 4, 6, 8, 11, 12, 13, 14, 15, 19, 20, 22, 24

Estrangement from Spiritual Community (9): 1, 3, 5, 7, 10, 16, 17, 18, 23

Disruption in Religious Practices (6): 9, 21, 25, 26, 27, 28

Meaning Reconstruction in Suicide Loss



GROUP, *Vol. 35, No. 4, Winter* 2011

Adult Surviving Siblings: The Disenfranchised Grievers

Christina Zampitella[1]

Adult siblings have a relationship unique to all others. They share not only 50% of their biological composition but a familial story. They expect to outlive their parents, but this expected trajectory of life and loss is not followed when one sibling dies, leaving behind an adult surviving sibling. These survivors compose a group of disenfranchised grievers, complicating an already painful grieving process. For clinicians, it is essential not only that the bereavement process for these specific grievers be understood but also that they know the most effective interventions to ensure an uncomplicated grieving process. This article will explore adult sibling loss and the familial changes that occur as a result and will suggest specific considerations in group therapy.

KEYWORDS: Siblings; adult sibling; disenfranchised; grief; grief group; bereavement.

The sibling relationship is distinctive in comparison to all other human relationships. Siblings share personal and familial history, experiences, values, and traditions; are often each other's first playmates and confidants; and even share 50% of their genetic composition. They can spend 80%–100% of their lifetimes with each other, with the feeling of affection and closeness often increasing with age (Davies, 2003). It is the most equal of all familial relationships. Siblings expect to outlive their parents and grow old together in what may be one of the most intimate relationships of their lives. However, the death of a sibling signals the end to such promise and marks the beginning of a unique and intense loss experience. Unfortunately, a review of the literature in the field of psychology (and in other fields such as thanatology and medicine) reveals only a handful of studies that focus attention on this group of

1 Licensed clinical psychologist, Fellow of Thanatology, and adjunct faculty, Alliant International University and National University, San Diego. Correspondence should be addressed to Christina Zampitella, PsyD, FT, 8765 Aero Drive, Suite 221, San Diego, CA 92123. E-mail: czampitella@alliant.edu.

ISSN 0362-4021

unique grievers. In fact, one need only review the books and journals that address death, dying, and grief to recognize that most studies, even in this specialized field, focus on children and adolescent loss of siblings. This article will focus on adult surviving siblings as a distinctive subgroup of the bereaved and will examine the effects of disenfranchisement from individual and larger systems viewpoints. Finally, the clinical implications for psychological treatment will be considered.

LACK OF RESEARCH IN EDUCATIONAL SYSTEMS

Despite the universal nature of death, dying, and grief, how people experience their grieving processes and construct their awareness of death has been, in general, omitted from the educational, clinical training, and professional experiences of the mental health and medical practitioner (Dickinson & Leming, 2007; Leviton, 1977; Mallory, 2003). Even the basics of thanatology (death, dying, and grief) are rarely covered in graduate school programs that train clinicians. Furthermore, a review of the literature regarding adult surviving siblings as a group reveals a significant dearth of research (Godfrey, 2002; Zampitella-Freese, 2005).

Comparatively few researchers have broached this topic, so psychologists, researchers, and others in the mental health and medical fields are poorly prepared to identify an adult surviving sibling's idiosyncratic understanding and expression of death, dying, and grief. Furthermore, they are unprepared to understand the effects of such a loss on the familial system. Without foundational knowledge and training, the practitioner may be unable to create an integrally informed individualized treatment plan for a bereaved sibling and his or her family, inadvertently pathologizing and disenfranchising the client's grieving process by confusing uncomplicated and complicated grief responses with mental health disorders.

THE RISK OF PATHOLOGIZING GRIEF

Owing to the lack of education and clinical training regarding death, loss, and grief, a clinician may not be aware that the well-known Kübler-Ross (1969) stage model of the grieving process is outdated and unsupported. If he or she treats bereaved clients with this model in mind, the result may be to pathologize a client's grieving process as a mental health disorder, such as adjustment or major depressive disorder, when it may in fact be an uncomplicated, or even complicated, grieving process. In the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM–IV–TR*; American Psychiatric Association, 2000), bereavement may only be diagnosed for two months following the loss, at which point, the clinician must identify a different diagnosis (i.e., acute stress disorder, major depressive disorder, etc.) to apply to the client and inform the treatment plan. Specific diagnostic criteria allow a clinician to make a differential diagnosis between complicated and uncomplicated grief, major depressive disorder, and posttraumatic stress disorder (Zampitella, 2009a).

However, this is not identified in psychology's classification system or in educational and training programs.

It is just recently that researchers who have been actively involved in the identification of pathological bereavement reactions are now campaigning for the inclusion of prolonged grief disorder (Prigerson, Vanderwerker, & Maciejewski, 2008) in the upcoming *DSM–V*, scheduled for release in 2013. The development of complicated grief criteria is being clarified in the hope of depathologizing normal and uncomplicated bereavement and correctly identifying complicated bereavement so that appropriate and effective treatment may ensue. However, this inclusion is meeting some significant barriers by the psychiatric board involved in developing current and future *DSM* editions.

SOCIOCULTURAL INFLUENCES

Thanatology is often relegated to a quiet corner in the fields of psychology, social work, counseling, and nursing. Ours is often a death-denying culture, so facing our mortality in scholarship, interpersonal communications, and public practices goes against the prevailing attitudes of "don't ask, don't tell." In a culture that emphasizes youth and vitality, Americans continue to push their own mortality out of their awareness, embracing death denial (Becker, 1973). The elderly are placed into nursing homes, are rarely seen in vibrant roles in the media, and are not considered useful contributors to society because of their decreased earning potential in a materialistic society. Death is, in American society, a threatening inevitability that remains hidden in the value system of industry and technology (Marrone, 1997).

The populations that are studied extensively in regard to sibling loss are those who are under the age of 18 years or over the age of 65 years (Balk, 1990; Batten & Oltjenbruns, 1999; Davies, 1995, 1998; Fanos & Nickerson, 1991; Moyer, 1992; Robinson & Mahon, 1997). Studies rarely focus on the experience of sibling loss when the individual is adult (aged 18–64 years) and still has one or both parents surviving (Birenbaum, 2000; Davies, 1988; McCown & Davies, 1995; Moyer, 1992; Worden, Davies, & McCown, 1999). This unexplored population faces a unique experience when one or both parents are surviving and an adult-aged person has lost an adult sibling.

DISENFRANCHISED GRIEVERS

Another essential topic is that of disenfranchised grieving. This occurs when a person experiences a loss that is not openly acknowledged, publicly mourned, or socially supported. The relationship is deemed unimportant, replaceable, or even stigmatized. As a result, the bereaved are not given full permission to grieve the loss publicly. They are denied the social support essential to overcoming their loss and the social validation needed to heal (Doka, 2002). The bereaved person is

expected to resume his or her life as though nothing has happened. The adult sibling relationship is one that is overlooked not only by society but also in the fields of psychology and medicine.

What we do know is that unsupportive, disenfranchised social interactions greatly increase avoidant coping, which in turn can result in complications as the individual is adjusting to the loss. According to Doka (1989), responses from others can be (a) avoiding contact, (b) discouraging communication or expressing feelings, (c) giving unsolicited advice, (d) making rude or insensitive comments, or (e) expressing inappropriate expectations about the person's grief responses.

The responses of the bereaved following the death of a sibling when his or her social support is not available, or when he or she is experiencing a disenfranchised loss, may therefore be complicated, resulting in the surviving sibling acting or feeling in maladjusted ways. Doka (1989) states that the following reactions are common to disenfranchised grievers:

1. not recognizing that they have the right to grieve
2. anger
3. guilt
4. desperation
5. loneliness
6. hopelessness
7. numbness
8. repression and denial
9. depression
10. isolation
11. preoccupation with the deceased
12. searching behavior
13. use of avoidant strategies (e.g., drugs)

MODELS OF THE GRIEVING PROCESS

A comprehensive exploration of all the models of the grieving process can be found in many books and journals (i.e., *Handbook of Bereavement Research,* 2001; *Handbook of Thanatology,* 2007). This article has space only to indicate the main models to ensure a general understanding of the current state of research and literature in the field of thanatology.

Stage Models

In the United States, practitioners and mainstream culture (pop culture) embraced the original stage model developed by Kübler-Ross (1969), despite its lack of empirical validation or evidence of corresponding subjective experiences of grief. It was

originally used to conceptualize the *dying,* rather than the *grieving,* process. Kübler-Ross stated later in her career that her model was not intended for the bereaved and was not as linear as many believed it to be. Some argue that stage models are too linear and simplified to embrace all the facets of the grieving process. They may suggest that if the griever does not experience a stage, perhaps his or her adjustment is maladaptive.

Task Models

Task models, such as Worden's (2008) four-task model, suggest that there are tasks that need to be worked through and completed for the resolution of grief and the formation of new relationships. This model stresses the active, individualistic nature of grieving, but it underestimates the cultural influences and the passive aspects of grieving. Stroebe, Hansson, Stroebe, and Schut (2001) state that

> it is clear that not all grievers undertake these tasks . . . [and] this formulation incorporates an implicit "time" dimension . . . which is a useful consideration in making predictions about adaptive coping. . . . Nevertheless, in our view, additional tasks need to be performed, such as working towards acceptance of the changed world, *not just the reality of the loss. . . . The subjective environment itself (not just* adjustment to the environment) needs to be reconstructed. Finally, we need to specify that bereaved people work toward developing new roles, identities and relationships, not just relocating the deceased and "moving on." (p. 388)

Phase Models

Phase models, such as those proposed by Marrone (1997) and Bowlby (1973), suggest a more flexible bereavement process. In Marrone's (1997) model, the bereaved moves back and forth among the phases (i.e., cognitive restructuring, emotional expression), depending on multiple individualistic factors and issues in his or her life. Adjustment of the family to a loss, for example, is addressed in this model. Bowlby (1973), and later, Parkes (1998), identified four phases, including numbness and shock, searching and yearning, despair and disorganization, and reorganization and recovery. However, this model does not address the systems that affect the griever, such as the family, in enough detail to be comprehensive.

Cognitive Process Models

In cognitive process models, coping with loss requires positive and negative appraisal of the loss and includes approach and avoidance of the feelings and reconstructions associated with adjustment. Rumination is one style of coping in which the individual focuses more on the "distressing aspects and the meanings in a repetitive and

passive manner . . . [which] was associated with higher depression levels months later" (Stroebe & Schut, 2001, p. 388). This style of coping is connected to more complicated grief outcomes. Confronting more positive aspects of the loss results in healthier adjustment, which is identified as "positive psychological states" (p. 389). This is associated with meaning making. However, these models focus on coping and are not a theory of treatment of the grieving process as it relates to therapy.

Social Construction Models

Social construction models have roots in family systems theory (Rosenblatt, 1983). The bereaved must reconstruct meaning between family members, understanding that this process continues as the course of the familial system shifts and develops. A narrative is developed regarding the nature of the deceased's life and death, and the construction around the narrative affects the outcome of the grief. The assumptions about the dynamic relationship are actively explored and adjusted (Stroebe & Schut, 2001). This model is also associated with meaning making, but within a familial system (Neimeyer, 2001).

Family Systems

The focus of the family systems approach is on impact and reorganization of roles, rules, and boundaries as they relate to the reconstruction of meaning (Nadeau, 2001). Multigenerational effects are revealed, and the adjustments of family and processes within are identified. In this model, the family is the first unit that tries to understand the loss, often developing co-constructed conclusions (something Nadeau calls *family meanings*). The role of an individual includes the expectations that individual holds within the family system (e.g., sibling). These roles are readjusted after a loss. Rules refer to how a family is expected to react to a loss; the wider the range of rules is, the better is the adaptation.

Integrative Models

Integrative models, such as Zampitella's (2009b) integral model of bereavement and Bonanno and Kaltman's (1999) four-component model, consider bereavement more comprehensively. Bonanno and Kaltman's model has four components: the context of the loss, the continuum of the meanings that the griever associates with the loss, the changing representations of the lost relationship over time, and the role of coping and emotional regulation processes, which include the griever's strategies. Zampitella's (2009b) integrative model is conceptualized in terms of Wilber's (2000) integral model of human experience and functioning. It includes assessment and treatment from four perspectives: individual subjective experience and influences,

individual objective experience and influences, collective internal experience and influences, and collective objective experience and influences. Not only the four quadrants but also how they influence one another are considered. If one of the quadrants is crippled, then the others suffer as well.

Fortunately, thanatologists who work with the dying and bereaved are starting to respond to the need for a more individualized, but systems-based, approach to evaluation and treatment (Doka, 2007) because the traditional views of bereavement are being challenged by those in the field (Jordan & Neimeyer, 2007). Regardless of the type of grief experience model, movement through the grieving process is seldom without challenges and very rarely—if at all—experienced in a strict linear progression.

Case Example

A clinical case study will be used to illustrate the impact of the death of an adult sibling on the family system. Throughout the subsequent sections of this article, it will be used to demonstrate the concepts introduced.

> Sara is a 26-year-old, African-American, single, heterosexual, Christian female who resides with her family of origin, which consists of her mother, her father, and her two siblings: a 15-year-old sister and a 20-year-old brother. Late in the evening in December, the family received a call from the police informing them that there had been an incident with her brother, Michael, and that they should go to the emergency room immediately. On arrival, they were informed that Michael, who had struggled with substance abuse for many years, had overdosed on heroin. Her parents decompensated in the emergency room, her sister withdrew, and Sara, as was often the pattern, became the "strong one" by interacting with the police and hospital staff. She felt sadness over the loss of her brother but also guilt because of the ambivalence she felt toward her relationship with him.
>
> The subsequent months following Michael's death proved to be very hard for the family. Her parents pulled back from both Sara and her younger sister, immersed in their own grief. She found herself taking care of her younger sister with little social support and/or direction from her immediate and extended family. At times, she was approached by others, who would ask, "That's horrible! How are your parents holding up?" Sara found herself becoming ignored and resentful, and she felt as though others did not recognize that she was missing work, that her grades were falling, that she had broken up with her boyfriend, that she was emotionally reactive, and that she refused to go to church, once an important part of her life. At the age of 30, Sara presented to therapy with symptoms of depression and anxiety.

SHIFTS IN THE FAMILIAL SYSTEM AND LOSS OF ADULT SURVIVING SIBLINGS

The internal balance of the familial structure after the death of an adult child can be significantly altered, shifting family dynamics and disrupting the stability of interrelated emotional roles for surviving members. Surviving siblings are in a position not only to carry unmet psychological needs from the parents but also to be personally susceptible to various psychological disturbances as adults, as in schizophrenia (Fanos, 1996) and depression. According to Lamers (2003),

> *the death of a sibling may be a double loss to the surviving siblings. Their parents* may become so involved in their own grief that they withdraw from the surviving children. Survivors may feel that they cannot show their grief because it will make their parents feel sadder. (p. 275)

Expectations for the care of surviving parents and even for the deceased's children will need to be addressed. Often one sibling was assumed to perhaps provide (or was actively providing) care for elderly parents and/or children. Therefore the surviving sibling will not only grieve but may also need to make significant shifts in his or her responsibilities. This was the case for Sara, whose role of the eldest child shifted into a parental role.

CLINICAL IMPLICATIONS

Because of the lack of research with this population, many of the clinical implications for adult surviving siblings and their families must be gleaned from the research on loss of less specific and unique relationships in adulthood, while considering the research gathered from child and adolescent sibling loss. Multiple studies suggest that ongoing bereavement counseling for surviving siblings is neglected (Arnold & Gemma, 1994; Fanos, 1996; McCown & Davies, 1995). Though a full review of how to conduct grief-specific therapy is beyond the scope of this article, considerations for grief groups for adult survivors of sibling loss will be presented later.

Thanatology as a Specialty

Clinicians need to become more aware that thanatology is an area of clinical specialization. In fact, several organizations, such as the Association of Death Education and Counseling, provide certification for those who wish to specialize. To receive certification or fellowship, one must pass a national test, meet educational and practice-level requirements, and maintain active thanatological continued education.

Adult Surviving Siblings

An area that clinicians serving this population may find helpful to appreciate is the unique experience that adult surviving siblings have in their grieving process. Adult sibling death is a disenfranchised loss that receives little, if any, research. However, according to Walter and McCoyd (2009), "this is a loss most adults face . . . and as they continue to live, one's siblings are [usually] a part of an adult's life longer than anyone else, making their eventual loss all the more significant" (p. 221). The therapist needs to understand that sibling relationships fall on a continuum from very little interaction to close and supportive relationships (Robinson & Mahon, 1997). In Sara's case, the ambivalence in her relationship with her brother and the embarrassment about how he died resulted in significant guilt, fear, anger, and confusion, which has complicated her grieving process and resulted in masked grief—she presented for depression and anxiety attacks, but she did not recognize these as connected to the grief she was unable to process in a healthy manner.

Additionally, those in the adult surviving sibling's social network "may be unaware of the special bond that may have continued for years [between adult siblings]. In mobile societies people may not live where they were born; thus present friends and potential support systems may not know what to say or do" (Humphrey & Zimpfer, 2008, p. 75). This can increase a sense of isolation. Therefore recognizing adult sibling loss as a unique loss will help validate the individual's experience and provide opportunities for healing and empowerment. Additionally, the clinician needs to help the bereaved sibling develop an ability to identify and communicate his or her feelings when others disenfranchise him or her and develop a support network of people who validate his or her loss.

In our case example, Sara's therapist educated her about disenfranchised grief and complicated grief responses, normalized her paradoxical feelings, worked on developing ways for Sara to assert herself when she felt unsupported, and connected her to a grief group specifically designed for adult surviving siblings so that she could feel less socially isolated. Specific grief group considerations will be addressed after family therapy is discussed.

Family Therapy

Family therapy could certainly help to address the specific roles, rules, and boundaries that have shifted as a result of the sibling's death. Because of the nature of the loss, it is essential that family members share and validate their experiences of loss and the changes in the family system. Robinson and Mahon (1997) state that the surviving sibling is often overlooked as a griever because the majority of support and attention focuses more on the parents, as was the case in our vignette. Sara's

parents' disengagement created a sense of resentment and made her feel jealous of her brother, who received more attention than she did after he died. Her therapist asked for her parents and sister to come to a conjoint session so that she could socialize them to the changes that occur at the family system level and begin to open up a dialogue between the family members. Although this was a painful session, it provided them with an opportunity to share their loss experiences with one another.

Researchers (Beavers & Hampson, 2003; Cook, 2007; Cook & Oltjenbruns, 1998) have documented the importance of families learning how to share the loss (i.e., postdeath rituals, reminiscence, etc.) to the degree of cultural acceptance. Families need to maintain open communication, which will allow for the development of shared meanings and perhaps even stronger bonds. They must also learn to "clearly identify and express emotions associated with the [loss] . . . and to verbalize their commitment to one another throughout the recovery process" (Barnes & Figley, 2005, p. 311). The focus shifts from the identified patient to how the family must face the loss together. Not only does the family need to adapt to the shifts of emotions, attitudes, beliefs, and loss or changes in roles, but it may need to deal with mundane changes such as who will care for elderly parents. The therapist also must investigate each family member's understanding of the loss and what the impact was for each person. Sara's therapist helped her sister share how she felt smothered by the increased attention of her parents, who attempted to avoid yet another loss via their overprotection. Her mother discussed how she felt sad, guilty, and angry toward her husband for what, she felt, was a lack of attention to her son's drug addiction. Sara's father explored his feelings of incompetence, failure, and fear of the increasing distance between him and his wife. As a result, Sara's understanding of the parental role she had to assume was clarified, and she felt less disenfranchised in the conflictual nature of her grief when her parents validated her loss of the adult sibling role. As a result, the family began to shift from a fatalistic frame of reference to a mastery orientation (Barnes & Figley, 2005).

Multicultural counseling competence is also important because relationships between family members are often prescribed by cultural and ethnic expectations (Shapiro, 2008). For example, perhaps there are traditional ancestral beliefs, expectations, and rituals that should be considered, but without knowledge of these, the clinician runs the risk of making assumptions counterproductive to the healing process. In our vignette, Sara's therapist was Caucasian, and owing to the history of turbulence between the Caucasian and African-American cultures, she was cautious about taking on too much of an expert role and shifted into a more egalitarian position to reduce the amount of inequality of power in the therapeutic setting.

Group Therapy

Support groups have been proven to be helpful to the bereaved. This is especially true when they are offered through the formal human service system and when there

is a "failure of existing family and other supports to give the help that is needed" (Parkes, 1998, p. 161). In our vignette, Sara's family did not offer the support needed for uncomplicated grief, and her counselor's suggestion of a grief group was then clinically indicated.

However, Corey and Corey (1997) state that "the training standards make it clear that mastery of the core competencies does not qualify a group worker to independently practice in any group work specifically. Practitioners must possess advanced competencies relevant to a particular area of group work" (pp. 8–9). This takes us to the previously mentioned need for clinicians to be trained specifically in thanatology, while also being well versed in group therapy skills. Too often do grieving individuals attend a linear and manualized grief support group that is informed by inaccurate, stagelike grief models.

Even the members may believe that grief is a linear process with a specific time trajectory. Therefore grief groups must also have a thorough psychoeducational component so that myths and misconceptions can be dispelled. A clinician running an adult surviving sibling support group needs to be versed not only in grief-focused group work and thanatology but also in the unique effects and experiences of loss of adult surviving siblings.

Regarding the question of having a closed or open-ended support group for the bereaved, Corey and Corey (1997) state that "hospices typically offer both closed and time-limited groups" (p. 431). Other researchers (Meert, Thurston, & Briller, 2005) agree that bereavement groups should be time limited: "Bereavement focus groups should not be too long and should have finite and predicable end points" (p. 264). As mentioned previously, grieving is nonlinear, and therefore "attention to time is particularly challenging. . . . For bereaved people who come together because of their losses, the ending of the focus group is an especially sensitive time" (Briller, Schim, Meert, Thurston, 2007–2008, p. 266). Therefore, because all members of the group must face the same end date, the shared experience of the ending of yet another important relationship (e.g., to the group and its members) could be a therapeutic opportunity. Groups that have flexible attendance could bring up painful thoughts and emotions that complicate an already difficult experience. For adult surviving siblings, the prospect of leaving the group after finally receiving the support needed to heal a specific loss may be especially daunting.

Also important is the need for those participating in a grief group to hold more egalitarian positions within the group. Briller and colleagues (2007–2008) state that "when starting the group, the facilitator needs to encourage an open and frank discussion of death-related experiences and prevent a hierarchical dynamic from developing between the bereaved participants" (p. 262). This is especially important with adult surviving siblings because many have taken on parental roles or have become invisible in the family system. The probability that bereaved siblings will reenact these dynamics within a heterogeneous group (i.e., a group of bereaved parents, among friends, etc.) is high, which could create difficulties because the

group is intended to be a counseling rather than a psychotherapy group. If a parent who lost a child were included in the support group, Sara might disenfranchise her loss by trying to be sensitive to a parent in the group who would never see his or her child meet adult developmental milestones. As a result, she might shut her grieving process down yet again or have a negative transference–related reaction that thwarts her healing process.

Furthermore, the use of specific terms must be considered. Because we are in a death-denying culture, finding terms to use in the group that are not calloused, inappropriate, or negative could be challenging and create additional disenfranchisement. This may be essential to a successful support group for bereaved adult siblings because their level of disenfranchisement is both familial and social. Pacing should also be carefully considered (Meert et al., 2005). For adult surviving siblings, discussing the loss and grief may have been disenfranchised for prolonged periods of time. Therefore finding words to express the complex emotions or to focus the attention of grief on themselves could take longer. There needs to be consideration for space in sharing their grief stories without unneeded interruption.

CONCLUSION

The loss of an adult surviving sibling is a unique, and often disenfranchised, loss. Not only must one consider the individualistic implications of this type of loss but one must also assess the impact of the loss on the family system in which the griever is embedded. It is important for the clinician to have specialized training in thanatology for successful individual and family therapy, and support groups, owing to the unique nature of the loss and the need to understand the cyclic, integrative, and distinctive experience of adult surviving siblings. Gaining knowledge and training in thanatology will help a clinician provide ethically sound and clinically accurate interventions.

REFERENCES

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: American Psychiatric Association.

Arnold, J., & Gemma, P. (1994). *A child dies: A portrait of family grief.* Philadelphia: Charles Press.

Balk, D. E. (1990). The self-concepts of bereaved adolescents: Sibling death and its aftermath. *Journal of Adolescent Research, 5,* 112–132.

Barnes, M., & Figley, C. (2005). Family therapy: Working with traumatized families. In J. Lebow (Ed.), *Handbook of clinical family therapy* (pp. 309–326). Hoboken, NJ: John Wiley.

Batten, M., & Oltjenbruns, K. (1999). Adolescent sibling bereavement as a catalyst for spiritual development: A model for understanding. *Death Studies, 23,* 529–546.

Beavers, W., & Hampson, R. (2003). Measuring family competence: The Beavers-system model. In F. Walsh (Ed.), *Normal family processes: Growing diversity and complexity* (3rd ed., pp. 549–580). New York: Guildford Press.

Becker, E. (1973). *The denial of death.* New York: Simon & Schuster.

Birenbaum, L. K. (2000). Assessing children's and teenagers' bereavement when a sibling dies from cancer: A secondary analysis. *Child: Care, Health, and Development, 26,* 381–400.

Bonanno, G., & Kaltman, S. (1999). Towards an integrative perspective on bereavement. *Psychological Bulletin, 125,* 760–776.

Bowlby, J. (1973). *Attachment and loss: Separation, anxiety, and anger.* New York: Basic Books.

Briller, S., Schim, S., Meert, K., & Thurston, C. (2007–2008). Special considerations in conducting bereavement focus groups. *Omega, 56,* 255–271.

Cook, A. S. (2007). The family, larger systems, and loss, grief, and mourning. In D. Balk (Ed.), *Handbook of thanatology: The essential body of knowledge for the study of death, dying, and bereavement* (pp. 165–171). Chicago: Association for Death Education and Counseling.

Cook, A. S., & Oltjenbruns, K. A. (1998). The bereaved family. In A. S. Cook & K. A. Oltjenbruns (Eds.), *Dying and grieving: Life span and family perspectives* (pp. 91–115). Fort Worth, TX: Harcourt Brace.

Corey, M., & Corey, G. (1997). *Groups: Process and practice* (5th ed.). Boston: Brooks/Cole.

Davies, B. (1988). The family environment in bereaved families and its relationship to surviving sibling behavior. *Association for the Care of Children's Health, 17,* 22–31.

Davies, B. (1995). Long-term effects of sibling death in childhood. In D. W. Adams & E. J. Deveau (Eds.), *Beyond the innocence of childhood: Helping children and adolescents cope with death and bereavement* (pp. 89–98). Amityville, NY: Baywood.

Davies, B. (1998). *Shadows in the sun: The experience of sibling bereavement in childhood.* Philadelphia: Brunner/Mazel.

Davies, B. (2003). The study of sibling bereavement: An historical perspective. In I. Corless, B. Germino, & M. Pittman (Eds.), *Dying, death, and bereavement* (pp. 287–302). New York: Springer.

Dickinson, G., & Leming, M. (2007). *Understanding dying, death, and bereavement.* Florence, KY: Wadsworth Cengage Learning.

Doka, K. (1989). *Disenfranchised grief: Recognizing hidden sorrow.* Lexington, MA: Lexington Books.

Doka, K. (2002). *Living with loss and grief.* Washington, DC: Hospice Foundation of America.

Doka, K. (2007). Challenging the paradigm: New understandings of grief. In K. Doka (Ed.), *Living with grief: Before and after the death* (pp. 87–102). Washington, DC: Hospice Foundation of America.

Fanos, J. H. (1996). *Sibling loss.* Mahwah, NJ: Lawrence Erlbaum Associates.

Fanos, J. H., & Nickerson, B. G. (1991). Long-term effects of sibling death during adolescence. *Journal of Adolescent Research, 6,* 70–82.

Godfrey, R. (2002). *Adult sibling loss.* Unpublished doctoral dissertation, University of Denver, CO.

Humphrey, G., & Zimpfer, D. (2008). *Counseling for grief and bereavement* (2nd ed.). Thousand Oaks, CA: Sage.

Jordan, J., & Neimeyer, R. (2007). Historical and contemporary perspectives on assessment and intervention. In D. Balk (Ed.), *Handbook of thanatology: The essential body of knowledge for the study of death, dying, and bereavement* (pp. 213–226). Chicago: Association for Death Education and Counseling.

Kübler-Ross, E. (1969). *On death and dying.* New York: Macmillan.

Lamers, E. (2003). Helping children during bereavement. In I. Corless, B. Germino, & M. Pittman (Eds.), *Dying, death, and bereavement* (pp. 267–286). New York: Springer.

Leviton, D. (1977). The scope of death education. *Death Education, 1,* 41–56.

Mallory, J. (2003). The impact of palliative care educational component on attitudes towards the dying in undergraduate nursing students. *Journal of Professional Nursing, 19,* 305–312.

Marrone, R. (1997). *Death, mourning, and caring.* Boston: Brooks/Cole.

McCown, D., & Davies, B. (1995). Patterns of grief in young children following the death of a sibling. *Death Studies, 19*(1), 41–53.

Meert, K. L., Thurston, C. S., & Briller, S. H. (2005). The spiritual needs of parents at the time of their child's death in the pediatric intensive care unit and during bereavement: A qualitative study. *Pediatric Critical Care Medicine, 6,* 420–427.

Moyer, M. S. (1992). Sibling relationships among older adults. *Generations, 16,* 1–7.

Nadeau, J. (2001). Meaning making in family bereavement: A family systems approach. In M. Stroebe, R. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement, research, and practice: Advances in theory and intervention* (pp. 329–347). Washington, DC: American Psychological Association.

Neimeyer, R. A. (2001). *Meaning reconstruction and the experience of loss.* Washington, DC: American Psychological Association.

Parkes, C. (1998). Helping the bereaved I & II. In C. Parkes (Ed.), *Bereavement: Studies of grief in adult life* (3rd ed., pp. 161–198). Madison, WI: International Universities Press.

Prigerson, H. G., Vanderwerker, L. C., & Maciejewski, P. K. (2008). A case for inclusion of prolonged grief disorder in *DSM–V.* In M. Stroebe, R. Hansson, W. Stroebe, & H. Schut (Eds.), *Handbook of bereavement, research, and practice* (pp. 165–186). Washington, DC: American Psychological Association.

Robinson, L., & Mahon, M. (1997). Sibling bereavement: A concept analysis. *Death Studies, 21,* 477–499.

Rosenblatt, P. (1983). *Bitter, bitter tears: Nineteenth century diarists and twentieth century grief theories.* Minneapolis: University of Minnesota Press.

Shapiro, E. R. (2008). Whose recovery of what? Relationships and environments promoting grief and growth. *Death Studies, 32*(1), 40–58.

Stroebe, M., Hansson, R., Stroebe, W., & Schut, H. (Eds.). (2001). Models of coping with bereavement: A review. In M. S. Stroebe, R. G. Hansson, & H. Schut (Eds.), *Handbook of bereavement research* (pp. 375–403). Washington, DC: American Psychological Association.

Stroebe, W., & Schut, H. (2001). Risk factors in bereavement outcome: A methodological

and empirical review. In M. S. Stroebe, W. Stroebe, R. O. Hansson, & H. Schut (Eds.), *Handbook of bereavement research* (pp. 349–371). Washington, DC: American Psychological Association.

Walter, C. A., & McCoyd, J. L. (2009). *Grief and loss across the lifespan.* New York: Springer.

Wilber, K. (2000). *Integral psychology: Consciousness, spirit, psychology, therapy.* Boston: Shambhala.

Worden, J. W. (2008). *Grief counseling and grief therapy: A handbook for the mental health practitioner* (3rd ed.). New York: Springer.

Worden, W., Davies, B., & McCown, D. (1999). Comparing parent loss with sibling loss. *Death Studies, 23,* 1–15.

Zampitella, C. (2009a). MDD, PTSD, and PGD: Making a differential diagnosis. *San Diego Psychologist, 24*(5), 6–8.

Zampitella, C. (2009b). The need for assessment of bereavement and death construct development in integral theory and practice. *Journal of Integral Theory and Practice, 4,* 162–176.

Zampitella-Freese, C. (2005). The experience of nature-based rituals in the management of mourning for adult surviving siblings. *Dissertation Abstracts International, 66*(9-B), 5111.

Restorative Retelling

Preparatory Entry

- Would it be a good time to talk about [loss incident] now?
- Supposed we start talking about [loss incident/the deceased], how would that be for you?
- You may share about the part that you are ready to, and pause at any point you need.
- If you want, you may close your eyes (with possible breathing/relaxation exercises as warm-up)… and slowly bring yourself back to that scene now.

Narrative Processes

1) External narrative – The objective or factual story of 'what happened?

   - When you're ready, you may tell me where you were and what you're doing at that point.
   - How did you get the death news? How did you react at that moment then?
   - Who else was with you at that time?
   - What did you do/what happened afterward?
   - How did you deal with the necessary arrangements thereafter?

2) Internal narrative – The emotion-focused story of 'what am I feeling?

   <u>During the loss event</u>

   - What do you recall about your body sensations/feelings when you received the news?
   - Suppose I took a picture of you during the incident, what do you think we would see in this photo? How would that reflect on your inner state at that moment?
   - If your body could say a word to describe how it was for you at that point, what would it say?

   <u>During the retelling process</u>

   - Now that you're in touch with that feeling again, how is it for you?
   - Now that you're recalling and telling this story again, how have your feelings changed, if at all?
   - How have you been getting along with your grief thus far?
   - If there's still a difficult feeling lingering in you, what could that be? How come it's difficult?
   - In which part of your body do you think that painful feeling resides? How would you describe it?

3) Reflexive narrative – The meaning-oriented story of 'what does this mean to me now?'

   - Which part of this story was the most painful for you to recall and share? Why? How have you been managing it then?
   - How did you make sense of the death now? As compared with the initial phase, has there been any shift in your perspectives?
   - How has this loss experience made a difference to your life?
   - Having gone through such a loss experience, and arriving at where you are now, what did you discover/learn about yourself? What does it say about you as a person?
   - If there is anything that could bring you comfort from this loss experience, what would that be?
   - "How did this incident change your priority and values in life and life outlook?

Appendix

Integration of Stressful Life Experiences Scale – Short Form (ISLES-SF)

Please indicate the extent to which you agree or disagree with the following statements with regard to [the stressful life event]. Read each statement carefully and please note that for these statements, a response of 1 indicates that you "strongly agree" and a response of 5 indicates that you "strongly disagree."

		Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
1.	I have difficulty integrating this event into my understanding about the world.	1	2	3	4	5
2.	This event is incomprehensible to me.	1	2	3	4	5
3.	I am perplexed by what happened.	1	2	3	4	5
4.	Since this event happened, I don't know where to go next in my life.	1	2	3	4	5
5.	I don't understand myself anymore since this event.	1	2	3	4	5
6.	This event has made me feel less purposeful.	1	2	3	4	5

Note: A sum of all items can be taken to compute a total Integration of Stressful Life Experiences Scale-Short Form (ISLES-SF) score. Likewise, Items 1, 2, and 3 can be summed to compute the Comprehensibility-SF subscale, and Items 4, 5, and 6 can be summed to compute the Footing in the World-SF subscale. The portion of the instructions in parentheses may be altered to make the measure applicable to different groups of interest. The numbering of items here does not correspond to the numbering used for the full version of the ISLES (Holland et al., 2010).

Reference:

Holland, J. M., Currier, J. M., & Neimeyer, R. A. (2014). Validation of the Integration of Stressful Life Experiences Scale-Short Form in a bereaved sample. *Death Studies*, *38*, 234-238.

The Sudden Bereavement Needs Inventory (SBNI)
(Bottomley & Smigelsky, 2022)

Instructions: Below you will find a generic list of grief-specific needs that individuals bereaved by the death of a loved one commonly express. We would like to know the role these needs play in your life *at this current time*. Please read each statement and select the response to indicate how important this need is to you.

	Not at all important	Somewhat important	Moderately important	Very important	Extremely important
1. To eat well	1	2	3	4	5
2. To sleep well	1	2	3	4	5
3. To exercise regularly	1	2	3	4	5
4. To successfully complete the task(s) of the day	1	2	3	4	5
5. To maintain financial balance	1	2	3	4	5
6. To receive valuable information and/or advice from professionals	1	2	3	4	5
7. To be walked through/introduced to various support resources	1	2	3	4	5
8. To better understand the grief journey following this type of loss	1	2	3	4	5
9. To have time to reflect on life	1	2	3	4	5
10. To have an ongoing connection with God	1	2	3	4	5
11. To have an ongoing connection with my spiritual self	1	2	3	4	5
12. To be with those who experienced a similar loss	1	2	3	4	5
13. To receive valuable information and/or advice from others who have experienced a similar loss	1	2	3	4	5
14. To express my thoughts and feelings regarding the loss with those who experienced a similar loss	1	2	3	4	5
15. To find some sort of benefit in the loss	1	2	3	4	5
16. To make sense of the loss	1	2	3	4	5
17. To understand who I am after the loss	1	2	3	4	5
18. To express my thoughts and feelings about the loss with those I love	1	2	3	4	5
19. To have my grief witnessed (acknowledged, respected, appreciated) by others	1	2	3	4	5
20. To be emotionally supported	1	2	3	4	5

All items should be summed within their respective factor.

Factor:	***Items:***
1. Pragmatic Needs	1, 2, 3, 4, 5
2. Informational Needs	6, 7, 8
3. Spiritual Needs	9, 10, 11
4. Relational Needs	12, 13, 14
5. Meaning Needs	15, 16, 17
6. Emotional Needs	18, 19, 20

Citation:
Bottomley, J. S., & Smigelsky, M. A.. (2022). Bereavement in the Aftermath of Suicide, Overdose, and Sudden-Natural Death: Evaluating a New Measure of Needs. *Assessment*, 107319112210811. https://doi.org/10.1177/1073191122108113 9

Acceptance and Commitment Therapy: Transcending Traditional Approaches

Jennifer L. Patterson, Psy.D., LCPC
Chicago, IL

1

Objectives Day One

- To explain the underlying theoretical and philosophical principles of the model
- Discuss the six basic tenets of ACT
- To layout the general clinical approach
- To give examples of the experiential techniques and concepts to gain some skill in using them
- To encourage you to explore this model experientially

2

Informed Consent

- At times, this workshop will ask for your willingness to engage in experiential exercises
- Your privacy will never be violated, but you will be invited to take a few risks
- For that reason, we must agree to confidentiality
- You may choose to decline participation

3

The Ubiquity of Human Suffering

The assumption of "Healthy Normality" is a myth

4

Alternative Assumption: Destructive Normality

Normal language and cognitive processes often are destructive and can amplify or exacerbate normal processes into pathological suffering.

5

Question:

If that is true, why don't we all struggle with anxiety, depressed moods, insecurities, fears, etc….?

6

What is "third wave" therapy

- First wave: behavioral therapy
- Second wave: cognitive behavioral therapy
- Third wave: acceptance-based behavioral therapy

7

All third-wave therapies are…

Grounded in an empirical, principle-focused approach, the third wave of behavioral and cognitive therapy is particularly sensitive to the context and functions of psychological phenomena, not just their form. Thus, it tends to emphasize contextual and experiential change strategies in addition to more direct and didactic ones (Hayes, 2004).

8

The third-wave therapies

- Dialectical behavioral therapy (DBT)
- Acceptance and commitment therapy (ACT)
- Mindfulness-based cognitive therapy (MBCT)
- Functional analytic psychotherapy (FAP)

9

Third-wave therapies are…

- More contextual and experiential, less didactic, and more focused on function over form
- Unlike CBT, there is little emphasis on changing the content of thoughts; instead, the emphasis is on changing awareness of and relationship to thoughts
- Help improve outcomes
- Help improve understanding of human behavior

10

All third-wave therapies include:

- Acceptance and mindfulness
- Spirituality
- Values
- Emotional deepening
- Genuineness, intimacy
- The present moment

11

The third-wave approach

COGNITIVE

- Develop awareness of getting hooked to negative thoughts and thinking patterns
- Develop balanced thinking by looking at the function of "buying into" negative thinking vs. learning to just "notice" thoughts
- Learn new skills i.e. acceptance, defusion, self-compassion, mindfulness

BEHAVIOURAL

- Clarifying what and who is important in life
- Commit to engaging in value-based behaviours.

12

Acceptance and Commitment Therapy (ACT)

- A form of third-wave experiential behavioral psychotherapy
- based on a relational frame approach to human language,
- and a resulting perspective on psychopathology

13

Acceptance and Commitment Therapy (ACT)

- Pronounced as one word ACT not "A-C-T"
- Emphasis on acceptance-willingness to have
- Approach to cognition
  - Not disputing "negative thoughts"
  - Not trying to change thoughts (though change sometimes happens)

(Hayes et al., 1989)

14

ACT…

- very experiential
- use of metaphors
- perception of both therapist and client as people struggling with what life offers
- ACT focuses on the individual's behavior and the context in which it occurs.
- Treatment success is the "successful working" of an individual's behavior according to that person's values and desired outcomes.

15

ACT suggests…

- psychological pain is normal
- *cannot* get rid of it
- *pain* is different from *suffering*
- accepting your pain reduces suffering

(Hayes and Smith, 2005)

16

ACT from the Beginning

- In the late 1970s / early 1980s, Steven Hayes et al. began to develop a view based on the behavioral literature on rule governance that psychopathology was often an issue of cognitive rigidity
- Hayes et al. developed and borrowed procedures to undermine attachment to verbal rules and to focus on behavior change instead
- They called it "Comprehensive Distancing"
- And they tested it

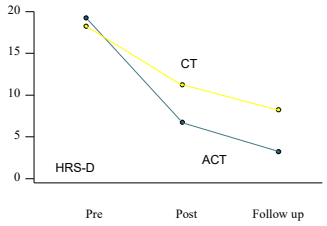
17

First Clinical ACT Study

- Very small (N = 18) randomized pilot with depressed subjects comparing Beck's CT and ACT in a 12-week study (3-month follow-up)
- Done at Beck's Center for Cognitive Therapy by a Beck-trained cognitive therapist
- With process measures

18

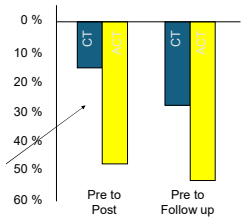
Difference in Outcome



19

With Different Change Processes

Reductions in the Believability of Depressive Thoughts (Frequency was not different)



20

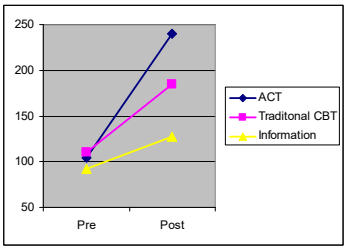
First ACT Component Study

- ❖Acceptance and defusion practice
- ❖CBT practice
- ❖Information about pain
- ❖32 subjects
- ❖Cold pressor task (up to 5 minutes)

(Hayes et al., Psych Record, 1999)

21

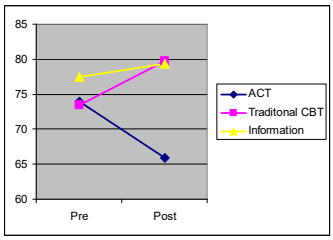
Results – Seconds of Pain Tolerance



Cohen's d at post = .5 (CBT) and .97 (AP)

22

Results – Believability of Emotional and Cognitive Reasons



Cohen's d at post = .89 (CBT) and .91 (AP)

23

Then they did something strange…

- Hayes et al. stopped doing ACT research for nearly 15 years and in fact, did not even publish the pain study until 15 years later
- During that time, they worked on the philosophy of science – coming up with functional contextualism
- And they worked on a basic theory of language and cognition

24

As of mid-2024, there are nearly 1,050 ACT randomized controlled trials.

Details of each of these studies, along with links to the original research articles, can be found on:

https://contextualscience.org/ACT_Randomized_Controlled_Trials

25

American Psychological Association, Society of Clinical Psychology (Div. 12), Research Supported Psychological Treatments:

- Chronic Pain - Strong Research Support
- Depression - Modest Research Support
- Mixed anxiety - Modest Research Support
- Obsessive-Compulsive Disorder - Modest Research Support
- Psychosis - Modest Research Support

26

Book reviewing ACT Research

Hooper, N., & Larsson, A. (2015) The research Journey of Acceptance and Commitment Therapy (ACT). London: Palgrave Macmillan

http://www.palgrave.com/gp/book/9781137440150#otherversion=9781137440167

27

Limitations of Research

Limitations of the Research and Potential Risks

- Acute, florid hallucinations
- Catatonic depression
- Individuals with an adverse reaction to mindfulness exercises

28

ACT: The Foundation
Philosophy and Theory

-Functional Contextualism (FC)

-Relational Frame Theory (RFT)

29

Why Learn Functional Contextualism and RFT?

- Understand how language is the source of our suffering
- Use language as an intervention
- Helps to become a more competent ACT clinician!

30

What is Functional Contextualism?

A modern philosophy of science rooted in philosophical pragmatism and contextualism. It is most actively developed in behavioral science in general and the field of behavior analysis and contextual behavioral science.

31

In other words,

1. **Context Matters**: Imagine you're solving a puzzle. Instead of examining individual pieces, functional contextualism encourages you to consider the whole picture—the context. It's like understanding a word by examining its sentence.
2. **Useful Insights**: Functional contextualism focuses on **valuable insights**. It's not about being perfectly accurate; it's about what helps you take effective action. Think of it as finding practical solutions rather than just theoretical answers.
3. **Behavior and Language**: This idea is used in psychology and therapy. Therapy is about understanding how our thoughts and feelings affect our actions. It's like figuring out how words (language) impact our behavior.

32

Functional Contextualism

- Functional Contextualism is the underlying philosophy of ACT
- What is the "function" of any particular behavior?
- Core focus of Act becomes "workability"

33

Context

- Anything that influences behavior
- Can be anything that precedes behavior (Antecedent)
- Can be anything that comes after behavior (Consequence)

34

ALWAYS ASK YOURSELF WTF?!

(What the function)

35

What are the Functions of Human Behavior?

- Escape/Avoidance – escaping or avoiding pain or a demand situation.
- Attention – a behavior done to gain the attention of others.
- Access – a behavior to access a tangible object or situation.
- Sensory – a behavior that is self-stimulatory to feel good.

36

Example:

Eating a piece of candy (Behavior)

Can be influences by being hungry (Antecedent)

AND

Can be influenced by the taste of candy in the mouth (Consequence)

37

What Contexts Exist?

- Situational
- Physiological
- Genetic
- Epigenetic
- Cognitive
- Social Cultural
- Emotional
- Interpersonal
- Development and learning history

38

Example:

- Situational – Place where the behavior of eating candy is influenced
  - Trick-or-Treating
  - Birthday Party
- Interpersonal – Thoughts and emotions that may influence the behavior of eating candy
  - I want candy too!
  - I'm bored

39

IF our behaviors are influenced by the context…

THEN

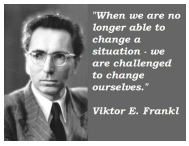
we can change the context to change our behaviors

40

Two Main Ways of Changing the Context

Concrete AKA Direct

Symbolically



41

Relational Frame Theory: The Role of Language

- Language is a double edge sword
- Light and dark side of human language
- Language is the reason for the ascendance of species AND the primary cause of our suffering

42

43

44

Receptive language - the understanding that words have meaning

Expressive language - the ability to say words with meaning

As we develop, we start to understand that sounds become words and words are given meaning.

45

Learning through language and cognition is secondary to learning through experience.

46

We learn through arbitrary and non-arbitrary means

Non-Arbitrary

Arbitrary

Repulsed
Disgusted
Queasy
Nauseated

47

Non-Arbitrary

Arbitrary

Yummy
Sweet
Good
Delicious

48

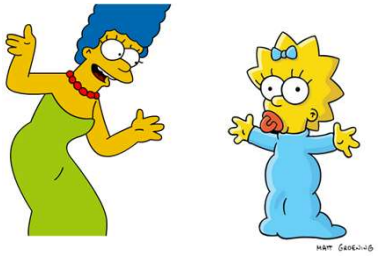
Function of Behavior

Aversive Stimulus

Appetitive Stimulus

49

Foundation of Language



50

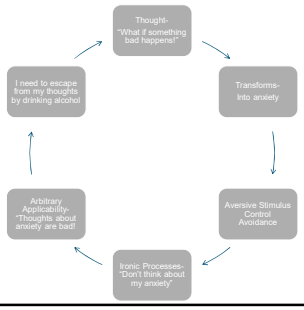
51

 = “Pacifier”

“Pacifier” = 

52

RFT Model of Psychopathology



53

Ironic Processes

The more you scratch the more you itch!

Trying not to think about X…
Tends to evoke X

54

In summary…

- When people feel bad, they carry around verbal descriptions of the hurt
- These descriptions keep the person in contact with the hurt
- People don't like hurting
- They want to avoid the hurt
- They try to control their thinking about the hurt

55

ACT tries to undermine ...

- The domination of literal, evaluative, and temporal language
- Connect instead with our values
- Behave more flexibly and effectively, focused on our values, not our fear

56

ACT Stance on Disorders

- Attempts to "get rid of" painful private experiences can be the underpinning of mental health issues…
- "Painful" thoughts and emotions do not produce mental disorders in and of themselves.

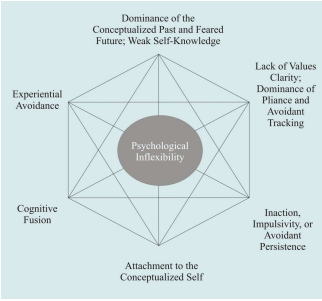
57

Psychological Inflexibility

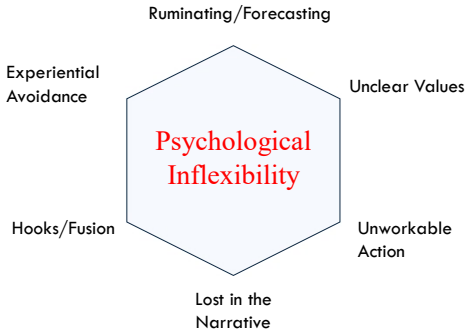
- Clients need to get rid of negative private experiences
- This is best achieved by experiential avoidance
- Experiential avoidance is the core problem most clients face

58

Psychological Inflexibility
"Inflexahex"



59



60

The six core processes are interconnected and maintain psychological inflexibility

61

Transdiagnostic Approach

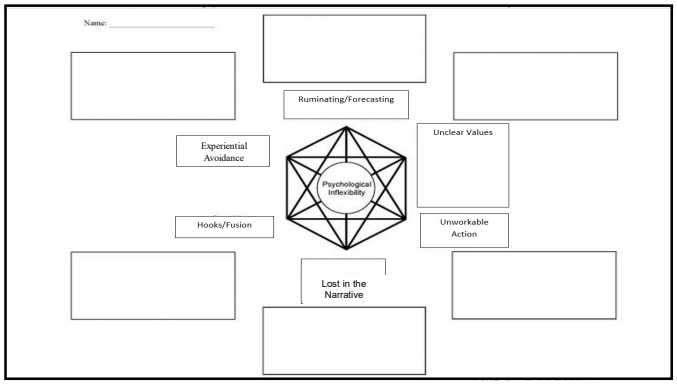
- Transdiagnostic approaches that target underlying psychological processes (rather than symptom constellations) are increasingly becoming the new gold standard of evidence-based treatment.
- Process-based treatment bridges clinical science and practice, can target a broader range of problems than diagnosis-based protocols, and is more easily individualized and administered to the client.

62

Assessment phase

- Transdiagnostic Approach
- Using the ACT conceptualization model – Inflexahex
- Target core processes regardless of symptoms and co-morbidity

63



64

Experiential Avoidance

65

Experiential Avoidance

- Individuals often try to decrease negative private experiences through “experiential avoidant” behaviors, which can be overt or covert.
- This is a common occurrence in all of us… ignoring, distracting, forgetting, etc.

66

Higher Avoidance Scores Are…

- Associated with:
  - Distress intolerance
  - Higher anxiety
  - Substance abuse
  - More Depression
  - More overall pathology
  - Poorer work performance
  - Inability to learn
  - Lower quality of life
  - History of sexual abuse
  - High-risk sexual behavior
  - BPD symptomatology and depression
  - Thought suppression
  - Alexithymia
  - Anxiety sensitivity
  - Long term disability
  - PTSD following trauma

67

Common overt avoidant behaviors

- Excessive use of alcohol
- Substance abuse
- Excessive sleeping
- Zoning out in front of the TV
- Excessive Videogaming
- Compulsive Shopping
- Sleeping too much

68

Avoidance is also experiential…

- Attempting to change emotions' form, frequency, or situational sensitivity, especially those that are universal and contextually appropriate.

69

Experiential avoidance is…

Cognitive modification - Excessively trying to control or change thoughts and emotions

Cognitive reappraisal - Trying to see things in a positive light

Suppression – trying to suppress thoughts and emotions

=

Elimination Agenda!

70

"The single most remarkable fact about human existence is how hard it is for humans to be happy."

(Hayes, Strosahl, & Wilson, 1999)

71

What Exactly is "Happiness"?

"Happiness" has two very different meanings

1. The common meaning – is to "feel good."

Feeling a sense of pleasure, gladness, or gratification. However, like all human emotions, feelings of happiness don't last.

(Harris, 2008)

72

2. Far less common meaning – is "living a rich, full, and meaningful life."

When we take action on the things that truly matter deep in our hearts, move in directions that we consider valuable and worthy, clarify what we stand for in life, and act accordingly…

Then, our lives become rich and meaningful, and we experience a powerful sense of vitality.

(Harris, 2008)

73

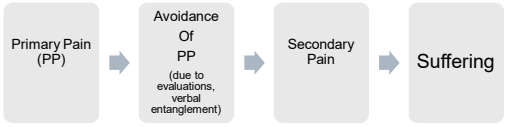
Four Myths of Happiness

1. Happiness is THE natural state for ALL human beings
2. If you're not happy, you're defective
3. To create a better life, we MUST get rid of negative feelings
4. You SHOULD be able to CONTROL what you think and feel

(Harris, 2008)

74

Avoidance = Suffering



75

Primary Pain vs. Secondary Pain

- Lost job due to economy = sadness, frustration, and irritability "How am I going to feed my family?"(Primary)
- Negative evaluation of the primary pain "I'm a loser," "I'll never find a job" "I can't handle this!" = and leads to Avoidant behavior (e.g., Drinking excessively)
- Which can then lead to further problems = guilt over avoidant behavior, family members upset, etc. (Secondary)

76

"***Suffering usually relates to wanting things to be different than they are." ~Allan Lokos***

77

Fusion
AKA
Getting Hooked

78

Fusion

- Inflexible behavior influenced more by verbal networks.
- Thoughts, feelings, judgments and memories have more influence over responding than direct experience with the world.
- Most clients believe what their mind is telling them, not what their experience has been.

79

Fusion

- Look for instances where responding is guided by evaluations and inflexible rules.
- This will look like ‘cognitive distortions’ in CBT.

80

Clinical Examples

- “I’m such an idiot”
- “Nothing will EVER change”
- “I’m unlovable”
- “I am broken”
- “I will ALWAYS screw up”

81

Experiential Avoidance and Fusion

- Experiential avoidance increases the impact and even frequency of avoided thoughts, feelings, and sensations
- Cognitive fusion increases the impact and even the frequency of entangling, negative thoughts

82

Fusion measures

- Automatic Thoughts-Believability (ATQ-B)
- Believability of Anxious Feelings and Thoughts Questionnaire (BAFT)
- Cognitive Fusion Questionnaire
- Stigmatizing Attitudes–Believability (SAB)

83

Attachment to conceptualized self AKA Lost in the Narrative

84

Three Senses of Self

- Conceptualized Self
- Self-as-Context
- Self-as-process

85

The conceptualized self

- The conceptualized self is the same thing as self-as-content and attachment to the conceptualized self is usually related to fusion with content.

86

Pros

A conceptualized self is useful

It allows us to participate in a verbal social community and answer questions such as:

- What is your name?
- What do you do for a living?
- Where do you live?
- Is that your son?
- How old are you?
- Tell me about your hobbies?

87

Attachment to the conceptualized self

During case conceptualization, look for statements such as:

- I am too…
- If only I did…(or didn't…) then I would
- My problem is that I…
- I am a (failure, loser, wimp, druggie, etc.)
- I am not (smart, pretty, strong) enough
- I can't…

88

Defectiveness/worthless	"I'm not good enough" "I'm a bad person" "I'm worthless"
Unlovable	"I'm lone" "I don't fit in" "I'm always rejected"
Abandonment	"People I love will leave me" "My partner is not interested in me"
Helpless/dependent	"I'm weak" "I'm vulnerable" "I'm needy"
Entitlement/high standards	"I'm better than everyone else" "I'm superior" "If I don't succeed, I'm worthless/a failure"
Self-sacrifice	"I'm responsible for everyone" "My needs are unimportant" "I'm only valuable as a person if I'm helping others"

89

Example

"I was traumatized" (historical fact) gets used in a cause-and-effect relationship like *"My trauma causes me to not be safe in the world"* and serves as an explanation for current behavior: *"So, because I can't trust, I can't live my life."*

90

Dominating Concept of the Past and Feared Future, AKA Ruminating/Forecasting

91

Dominating concept of the past and/or feared future

- Fusion with the verbally constructed past or future means that one is not in contact with the present moment
- Words pull us into the past and future
  - Rumination about the past or feared future
  - Anticipatory anxiety and avoidance

92

Mindfulness Measures

- Five Facet Mindfulness Questionnaire (FFMQ)
- Freiburg Mindfulness Inventory
- Mindful Attention Awareness Scale (MAAS)

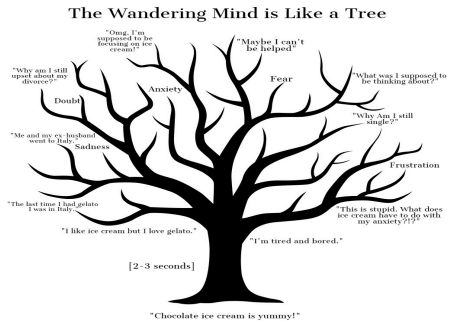
93

About 47% of waking hours is spent thinking about what isn't going on

(Killingsworth and Gilbert, 2010)

94

95



96

Lack of Values Clarity AKA Unclear Values

97

Lack of values clarity

- The client may describe a general lack of vitality and be vague about values and goals.
- The client may misunderstand the difference between values and goals.

98

Listen for…

What's the point?
Nothing matters.
I don't know where I'm going.
I don't know what to do.
What should I do with my life?
Everything seems meaningless…I feel disillusioned.
Ever since (my divorce, my illness, I started using drugs, etc), my life has been going nowhere.

99

- Personal Values Questionnaire
- The Survey of Guiding Principles questionnaire and card sort
- VLQ - Valued Living Questionnaire
- Values Bull's Eye
- Values Compass pictures
- Valuing Questionnaire (VQ)

100

The ACT Clinical Interview

- The client's presenting concerns
- Past experiences that have shaped the client's current behavior
- Current context/experiences that maintain the client's clinical issues

(Patterson & Rowland 2016)

101

Experiential Avoidance – (administer the AAQ)

- What have you been doing to cope with your (anxiety, depression, clinical issues)?

  Listen for avoidant, compulsive behaviors (Excessive use of alcohol, substance abuse, excessive sleeping, zoning out in front of the TV, etc.)
- What have you done internally to control unwanted thoughts, memories, images, and emotions?

  Listen for instances of suppression, minimization, distraction, ignoring, etc.

102

- What unwanted thoughts, memories, images, and emotions are most present for you daily?
- How much time and energy do you spend trying not to think of painful thoughts, memories, images, or emotions?
- Give me an example of something painful you have recently experienced and how you respond to it. Cope with it?

  Listen for workable and unworkable strategies.

103

Fusion – (administer the CFQ)

- Do you believe your unwanted thoughts to be true? Especially the ones that are self-critical, judgmental, and evaluative.

  Listen for 'I am' statements, irrational beliefs, cognitive distortions, etc.
- When you believe your thoughts, do you act on them?
- How workable is your behavior when you act on negative thoughts?

104

Dominating Concept of Past and Fear Future – (follow up with administering the MAAS)

- How often do you find yourself thinking about the past? What do you think about the past?
- How often do you think about the future? What do you think will happen in the future?

Listen for excessive rumination and or anticipatory anxiety 'what if" statements.

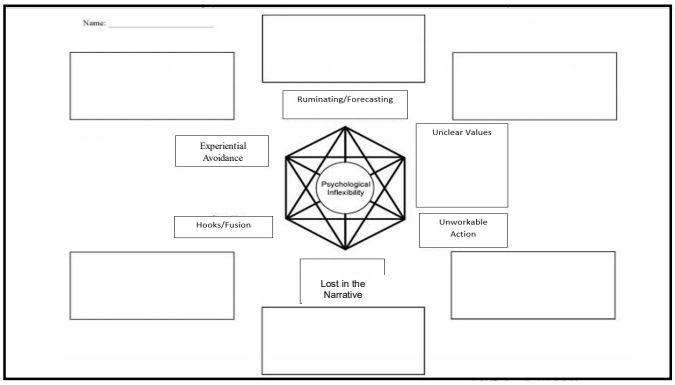
105

Lack of Values Clarity – (follow up with administering a values assessment; VLQ,)

- What are some things that are important to you? What gives your life meaning and vitality?
- What do you value?

Listen for statements What's the point? I have no idea, Nothing really…

106



107

Case Conceptualization

Rick, 29 single Caucasian male, lives alone in a two-bedroom condo.

He works as an engineer and is dissatisfied with his career path but loves and is good at programming

History of social anxiety – smokes marijuana

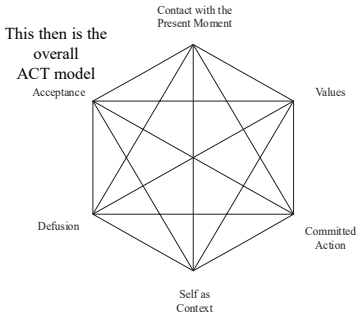
Adopted at age three (father is deceased, mother is in a nursing home)

Presenting complaints – The reason I need counseling is pretty apparent. I hate my job and get paid squat, but at the same time, I won't quit, ask for a raise, or pitch my ideas. It's the same with getting high. I don't even enjoy it. I do it to take the edge off. I don't have any friends, nor a girlfriend. The future is bleak. I'm fucking loser with no end in sight!

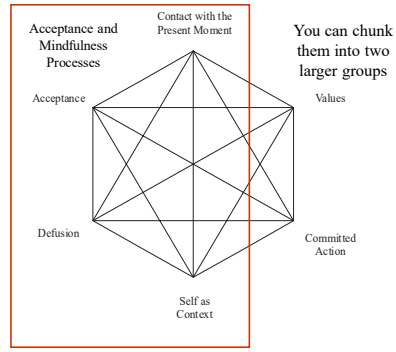
108

Rick: I got stoned last night after staying clean for four days. We had a staff meeting, and I wanted to suggest that new product again; I've been thinking about it for a year and can't get up the balls to talk about it…But then, when I thought about speaking up, my hands started to shake, my face got hot, and my mind started blank. I knew I wouldn't be able to say anything without looking like an asshole, so I just kept my mouth shut. And then, while I was thinking about this stuff, I didn't hear the boss ask me a question, and suddenly, everyone was staring at me, waiting for me to say something. I know I turned all red, and I heard someone snickering when I had to ask the boss to repeat the question. And then I just mumbled something stupid. I wanted to disappear. And then the real kicker ---Adam suggested the product I was going to suggest, and everyone said what a great idea it is. Now he, as usual, gets all the kudos while I'm the one who looks like a loser. I was driving home just thinking, "I'm such an asshole; nothing is *ever* going to change. And I couldn't stop thinking about that damn meeting. And then, when some neighborhood kid asked if I wanted to score some good weed, I was like, "What the hell? Nothing's ever going to change." So I bought a half-ounce and got stoned. It felt great until I woke up the next day, and now it's still like, "Nothing is ever going to change! I'm always going to screw up. What's the point in staying off of the marijuana?" It's, like, the only thing worthwhile in my life. Why should I quit it just because some shrink thinks I should? No one else cares if I smoke the shit or not. Why should I care?

109

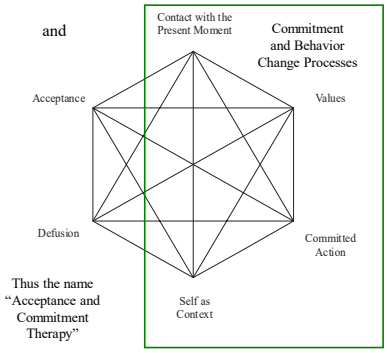


110



111

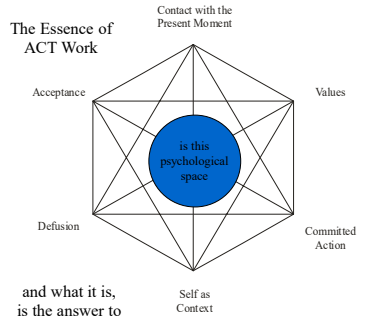
and



Thus the name "Acceptance and Commitment Therapy"

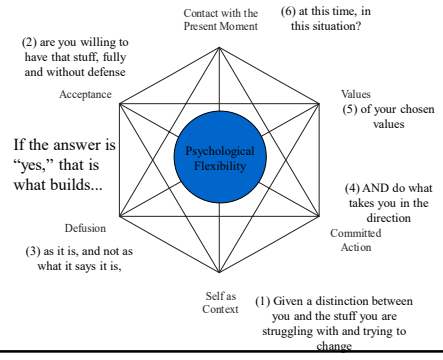
112

The Essence of ACT Work



and what it is, is the answer to this central ...

113



If the answer is "yes," that is what builds...

114

Psychological flexibility is:

…contacting the present moment fully

…as a conscious, historical human being,

…and based on what the situation affords

…changing or persisting in behavior

…in the service of chosen values.

115

SYSTEM	PSYCHOLOGICAL FLEXIBILITY PROCESS
Affective	Acceptance
Cognitive	Defusion
Attentional	Present moment
Self	Transcendent self
Motivational	Values
Overt behavioral	Committed action

116

Informed Consent

1) Address alternative therapies

2) Address risks and benefits

3) Propose a specific time frame

4) Orient person to therapist, client roles

5) Give general descriptions of operating principles

https://contextualscience.org/informed_consent_for_act

117

ACT in Action

Typically, you do not 'teach' ACT.

1. Give clients an experience of the ACT processes.
2. In session, you model the ACT processes.

118

The Therapeutic Relationship

•The six core ACT flexibility processes (transcendent self, defusion, acceptance, present moment, values, and committed action) are central to the therapeutic relationship.

•If we model psychological flexibility in the therapy room, clients internalize it, just as you internalize it.

•The betweenness of the therapist and client interactions is central.

119

Therapeutic Relationship: EXTREMELY IMPORTANT

1. Needs to be safe and supportive
2. Give lots of positive support and feedback
3. Lots of validation of pain
4. Lots of validation of difficulty in making changes
5. Self–disclosure in the interest of validation
6. Explain the rationale behind techniques.

120

Sessions should follow the following format:

- Brief Update and Mood Check
- Bridge from Previous Session
- Set Agenda
- Review Homework
- Potential supporting exercises (see below)
- Final Summary
- Assign Homework
- Feedback

121

"We can shift our work from something that looks more like fixing a problem to something that looks more like building a life."

~ Steve Hayes

122

Acceptance

123

Acceptance

Actively contacting psychological experiences directly, fully, and without needless defense while behaving effectively.

Hayes, Wilson, Gifford, Follette, & Strosahl, 1996, p. 1163

Colloquially, Acceptance is a *willingness to have the capacity to feel so that you can learn from your experiences.*

GRANT ME THE SERENITY
TO ACCEPT THE THINGS I CANNOT CHANGE, THE COURAGE TO CHANGE THE THINGS I CAN, AND THE WISDOM TO KNOW THE DIFFERENCE.
-NIEBUHR-

124

ACCEPTANCE is *not*:

- Tolerating, putting up with
- Resignation
- Defeat, a “less than” alternative
- Passive

125

What helps willingness to accept?

- Creative Hopelessness” —engendering a posture of giving up strategies when giving up is what is called for in service of larger goals.
- We help clients understand that the alternative to control is willingness.
- “Are you willing to have what shows up?”

126

Creative Hopelessness

- Making the client aware of an 'unworkable' change agenda.
- Workability = the extent to which a behavior 'works' in the long term to create a rich, full, meaningful life.
- The client is trying to improve their life by using emotional control strategies in contexts where they don't work and/or reduce their quality of life.
- Q: What have you tried? How has it worked *in the long term*? What has it cost?

127

Building Willingness

- Explore how the steps the client took have worked or not
- Don't imply their coping strategies were wrong
- VALIDATE whatever the client did to survive.
- VALIDATE that these control strategies are often helpful in the short term.
- GENTLY, COMPASSIONATELY get the client in touch with the reality that these strategies are NOT HELPFUL in the long term.

128

Learning to Say "Yes"

In ACT work, we encourage clients to deliberately seek out or imagine situations they avoid and *change their relationship* to the thoughts, feelings, and memories that arise.

129

The Miracle Question

What would you do if a miracle happened and all the things you are struggling with were instantly solved?

130

Creative Hopelessness Metaphors

- Quicksand
- Person in the hole
- Tug-of-war with a Monster
- The Struggle switch

131

Willingness Exercises

- Ball-in-a-Pool
- Unwelcomed Party Guest
- Finger Trap
- Holding the Cactus Lightly
- Turn up the Willingness knob

132

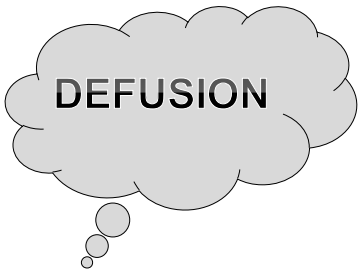
Goals for Clinicians

- ✓Help clients let go of the agenda of control as applied to internal experiences.
- ✓Help clients see experiential willingness as an alternative to experiential control.
- ✓Help clients come into contact with willingness as a choice, not a desire.
- ✓Help clients to understand willingness as a process, not an outcome.

133

DeFusion AKA Unhooked

134



We are NOT our Thoughts…

135

How to help clients

Use defusion exercises in session such as:

- Deliteralizing language
  - Lemon…Lemon…Lemon
  - Another Voice

136

Focus on functionality

- "And what is that story in the service of?"
- "Is this helpful, or is this what your mind does to you?"
- "What's useful about believing this thought?"
- Buying a thought vs. Having a thought
- Thank your mind for that thought.

137

"How old is that thought?"

"If that thought had a voice, how would it sound?"

"What does that thought remind you of?"

"Just say that thought again slowly and let's watch what shows up."

"In a normal mode of mind, what does that thought usually pull from you?"

"Can we distill that thought down to its simplest form or theme? The core theme of that thought is _____?"

"If that thought were an object, how big would it be?"

"What other thoughts do you have in association with that thought

138

Metaphors/analogies

- Clouds in the sky
- Leaves on a stream
- Sushi Train
- Passengers on the bus

139

Defusion Exercises

- Thoughts on Post-It notes
- Defusing Storytelling

140

SELF AS CONTEXT
AKA FLUID SELF

141

Self-as-Context

It is experienced when we notice our own private or public experience in the present moment

- I feel sad (or hungry, tired, anxious, happy)
- I am thinking about what to have for dinner
- I am walking to the coffee shop
- I am typing an email message to my boss
- I am having the thought, “I don’t want to go.”
- I am having a panic attack
- I am obsessing about germs

142

How to help clients

- Discuss evaluations vs descriptions
  - Good Cup Bad Cup
- Looking at thoughts as just thoughts
  - “I am having the thought, “I’m a bad person” vs “I’m a bad person”
- Metaphors

143

The sense of self is a consistent perspective from which to observe and accept all changing experiences.

144

Activities

- Touch your nose, your toes, your clothes…
- You as a baby, as a little kid, you as you are NOW
- Your box of stuff
- Chessboard metaphor

145

Contacting the Present Moment

146

Mindfulness:
...is much easier learned by experience
...involves:
paying attention in a particular way;
on purpose,
in the present moment,
and nonjudgmentally
-Jon Kabat-Zinn

147

Why do we teach clients to be in contact with the present moment?

To help clients…

- discover that life is happening right now
- to return to "now" from a conceptualized past or future…whether it be filled with sorrow or happiness
- to notice what is happening in their relationships now
- To accept moment-to-moment emotional experiences

148

Mindfulness

The official ACT definition of mindfulness is:

As a conscious human being, defused, accepting, and open contact with the present moment and the private events it contains is experientially distinct from the content being noticed.

149

It also helps to undermine avoidance and struggle…

If we are presently focused, we usually have nothing against which to fight; we only have what is present.

150

Goals of Mindfulness

✓Come into contact with the present moment willingly, in the services of greater vitality and psychological flexibility.

✓Establish observation and awareness skills.

✓Continue practicing these skills so they are honed.

✓Contact the present moment in the presence of an aversive experience that constricts behavior.

151

How Do We Teach Clients To be Mindful?

- As clinicians, we need to encourage clients to observe and notice what is present in their environment and their private experience.
- Clinicians should encourage their clients to label and describe what is present without excessive judgment or evaluation.

Linehan, 1993

152

Observe and notice
+
label and describe
=
"Mindfulness"

Linehan, 1993

153

It is an active process of moment-to-moment awareness of your:

Surroundings

"I am here in this room listening to Jennifer talk about Mindfulness."

AND

Private Events

"I am bored, I feel tired, I need more coffee…"

154

Obstacles in trying to teach mindfulness

Clients and clinicians can misunderstand the goal of mindfulness.

- Mindfulness is NOT a technique to diminish an undesirable feeling such as anxiety.
- MINDFULNESS and RELAXATION are not the same. They are separate techniques with separate goals.

155

Best Mindfulness Apps

- Headspace
- Smiling Mind
- Insight Timer
- Mindfulness Daily
- Calm
- ACT coach
- Stop, Breathe & Think

Information from: Mani M, Kavanagh DJ, Hides L, Stoyanov SR. Based on I Phone Apps. JMIR mHealth 2015; 3 (3): e82. Available at URL: http://mhealth.jmir.org/2015/3/e82

156

Values Clarification

157

VALUES ASSESSMENT: DIRECT MEANS

- Personal Values Questionnaire (Blackledge & Ciarrochi, 2005)
- Valued Living Questionnaire (Wilson & Groom, 2002)

158

Intimate relationships
Family relations
Social relations
Employment
Education and training
Recreation
Spirituality
Citizenship
Health/physical well-being

159

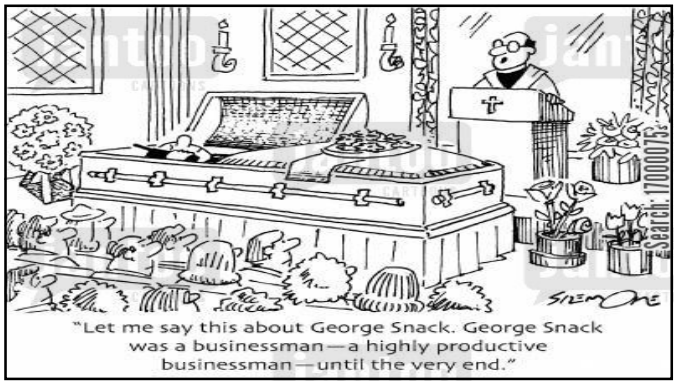
Values Questions

Start with what they care most about

- ✓ If they say, "to feel better," I ask, "If you felt better, what would life look like for you?" "If I had a magic wand…"

- Other ways to start
  - ✓ Say, "For me to help, I need your help first. I want to know what it is like to be you and walk around in your shoes."
  - ✓"In a world where you could choose any direction, what would you want your life to stand for? And are you doing that now? "Are you willing to do whatever needs to be done to move in that direction?"

160



161

Values activities

- The Dash Poem
- Epitaph exercise
- Eulogy exercise

162

Committed Action

163

Committed Action

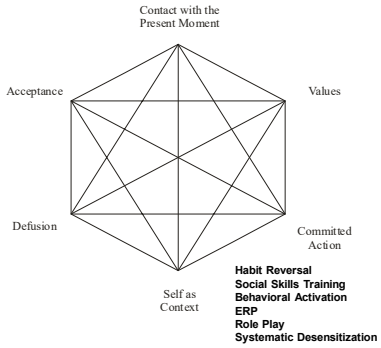
- Committed action is a step-by-step process of acting to create a whole life, a life of integrity, true to one's deepest wishes and longings.
- Commitment involves both persistence and change – whichever is called for in living one's values.
- Committed action is inherently responsible – based on the view that there is always an ***ability*** to ***respond*** in any situation.

164

How to help clients…

- Stick with ESTs
- In session committed action
- Homework between sessions

165



166

Committed Action

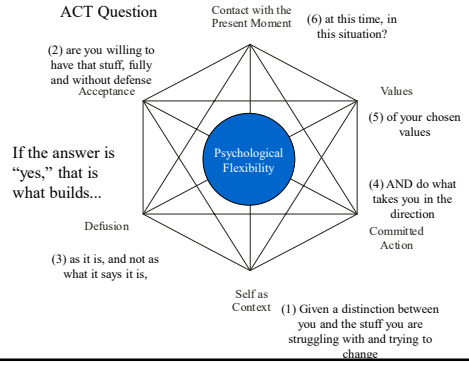
- Specific and measurable in some way
- Practical and within the client's abilities
- Avoid "dead men's goals"
- Linked to their values

167

Committed Action

- Lots of contracts (for home, for work, with the therapist)
- Practice doing things when mad, sad, hyper, as well as happy (sometimes had to "pretend" felt specific ways, and other times this naturally occurred)
- Talk about how it feels either easier or more challenging – noting consequences in the short- and long-term either way

168



169

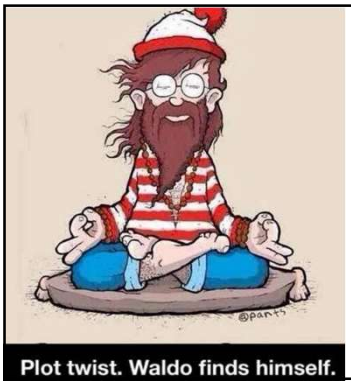
ACT Apps

- ACT-companion (iOS & Android), http://www.actcompanion.com/
- ACT Coach (iOS & Android), https://itunes.apple.com/us/app/act-coach/id804247934?mt=8
- ACT Mindfully (Android), https://play.google.com/store/apps/details?id=it.marcoturi.actmindfully
- ACTive: Value-based living (iOS), https://itunes.apple.com/us/app/active-value-based-living/id1343994479
- Blue Life Coach (iOS & Android) http://bluelifecoach.com
- I Here Now (iOS), https://itunes.apple.com/se/app/iherenow/id872764840?mt=8
- Learn2ACT (iOS & Android), http://www.learn2act.net
- The Sleep School App (iOS & Android), https://my.thesleepschool.org/category/insomnia/
- 2Morrow Health (suite of ACT-based apps for various health issues), https://www.2morrowinc.com/2morrow-health/

170

Questions?

171



Thank you!

Patterson-
Jennifer@comcast.net

172

Useful Resources

- Drjenniferlpatterson.com
- Patterson-jennifer@comcast.net
- Association for Contextual Behavioral Sciences www.contextualscience.org
- https://www.praxiscet.com/
- https://contextualscience.org/ACTinPractice

173

References

- Bach, P., & Moran, D. (2008). *ACT in practice: Case conceptualization in Acceptance and Commitment Therapy*. Oakland, CA: New Harbinger.
- Bullis, J. R., Boettcher, H., Sauer-Zavala, S., Farchione, T. J., & Barlow, D. H. (2019). What is an emotional disorder? A transdiagnostic mechanistic definition with implications for assessment, treatment, and prevention. *Clinical Psychology: Science and Practice, 26(2), e12278.*
- Eifert, G.H.; Forsyth, J.P. (2005). *ACT for Anxiety Disorders.* Oakland, CA: New Harbinger Publications, Inc.
- Eifert, G. H., Forsyth, J. P., Arch, J., Espejo, N., Keller, M., & Langer, D. (2009). Acceptance and Commitment Therapy for anxiety disorders: Three case studies exemplifying a unified treatment protocol. *Cognitive and Behavioral Practice,* 16, 368–385.

174

- Hayes, S. C., Strosahl, K., & Wilson, K. G. (1999). *Acceptance and Commitment Therapy: An experiential approach to behavior change*. New York: Guilford Press.
- Hayes, S. C., Luoma, J. B., Bond, F. W., Masuda, A., & Lillis, J. (2006). Acceptance and commitment therapy: Model, processes and outcome. *Behaviour Research and Therapy, 44*, 1-25.
- Hayes, S.C.; Smith, S. (2005). *Get Out of Your Mind and Into Your Life*. Oakland, CA: New Harbinger Publications, Inc.
- Harris, R. (2008). *The Happiness Trap*. Boston, MA: Trumpeter Books.
- Killingsworth, M.A, Gilbert, D.T. (2010). A wandering mind is an unhappy mind. *Science, volume* 330, Issue 6006, pp. 932 DOI: 10.1126/science.1192439
- Linehan, M. (1993) *Skills Training Manual for Treating Borderline Personality Disorder*. New York, NY: The Guilford Press.

175

- McKay, M; Lev, A; Skeen, M. (2012*). Acceptance and Commitment Therapy for Interpersonal Problems*. Oakland, CA: New Harbinger Publications, Inc.
- McKay, M.; Fanning, P.; Lev, A., Skeen, M. (2013). *The Interpersonal Problems Workbook*. Oakland, CA: New Harbinger Publications, Inc.
- Neff, K. (2011). Self-Compassion: The Power of Being Kind to Yourself. New York, NY: HarperCollins Publishers.
- Neff, K. (2016) The Self-Compassion Scale is a valid and theoretically coherent measure of self-compassion. *Mindfulness*. 7 (1), 264-274.

176

- Stahl, B.; Goldstein, E. (2010). *A Mindfulness-Based Stress Reduction Workbook*. Oakland, CA: New Harbinger, Inc.
- Stoddard, J.A.; Afari, N. (2014). *The Big Book of ACT Metaphors*. Oakland, CA: New Harbinger, Inc.
- Zettle, R.D. (2007). *ACT for Depression*. Oakland, CA: New Harbinger Publications, Inc.
- Zettle, R. D., Rains, J. C., & Hayes, S. C. (2011). Processes of change in acceptance and commitment therapy and cognitive therapy for depression: A mediation reanalysis of Zettle and Rains. *Behavior Modification, 35*, 263-283.

177