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The Efficacy of a Group Visual Art Bereavement Intervention with Older Adults

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy at Virginia Commonwealth University.

by

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## Table of Contents

Acknowledgements.....	6
List of Tables .....	7
List of Figures .....	8
Abstract.....	10
Introduction.....	12
Review of the Literature .....	13
Terminology.....	13
Theoretical Frameworks of Grief.....	13
Stage and task models.....	13
Trajectory model of grief.....	15
Dual Process model of bereavement.....	16
Meaning Reconstruction Model.....	17
Grief theory integration.....	17
Bereavement Outcomes .....	18
Continuing bonds.....	18
Meaning making .....	19
Personal growth.....	20
Negative grief symptoms .....	21
Grief and the Expressive Arts .....	22
Visual art modalities in bereavement interventions.....	24
Bereavement Intervention Efficacy .....	26
Bereavement in Older Adulthood .....	27
Statement of the Problem.....	34
Method .....	37
Experimental Overview .....	37
Settings.....	40

Recruitment.....	41
Inclusion/Exclusion Criteria and Screening.....	43
Intervention Procedures .....	43
Visual Art Activities.....	45
Additional Session Components.....	48
Measures .....	48
Demographic Questionnaire.....	48
Characteristics of Loss.....	49
The Patient Health Questionnaire—2.....	49
Integration of Stressful Life Experiences Scale.....	50
Grief and Meaning Reconstruction Inventory.....	51
Inventory of Social Support.....	52
Creative Achievement Questionnaire.....	53
Kaufman Domains of Creativity Scale.....	54
Program Evaluation Questionnaire.....	54
Data Analyses .....	55
Results.....	58
Enrollment and Rates of Engagement.....	58
Sample Demographics .....	60
Loss Characteristics .....	63
Symptom Measures.....	65
Program Evaluation Questionnaire.....	69
Hypothesis Testing.....	71
Evaluation of assumptions .....	71
Hypothesis 1.....	71
Hypothesis 2.....	73
Hypothesis 3.....	74
Hypothesis 4.....	75
Hypothesis 5.....	79
Exploratory Analyses.....	82
Creative Self-Efficacy.....	82

Rates of Engagement .....	83
Intent to Treat (ITT) Analyses .....	85
Discussion .....	97
Hypothesis Testing.....	98
Exploratory Results.....	107
Study Limitations, Strengths and Future Directions.....	109
Sample Characteristics.....	109
Measures .....	111
Procedural Issues .....	112
Future Directions. ....	114
References.....	118
Appendix B: Dominion Place Recruitment Flyer.....	140
Appendix C: “Common Questions about Grief Support Groups” Flyer .....	141
Appendix D: Half Sheet Recruitment Flyer.....	142
Appendix E: Verbal Screening Script.....	143
Appendix F: Demographics Questionnaire.....	145
Appendix G: Characteristics of the Loss Questionnaire.....	146
Appendix H: The Patient Health Questionnaire (PHQ-2) .....	147
Appendix I: The Integration of Stressful Life Experiences Scale (ISLES) .....	148
Appendix J: Grief and Meaning Reconstruction Inventory (GMRI).....	150
Appendix K: Inventory of Social Support (ISS).....	152
Appendix L: Creative Achievement Questionnaire (CAQ).....	153
Appendix M: Kaufman Domains of Creativity Scale (K-DOCS) .....	154
Appendix N: Program Evaluation Questionnaire .....	155
Appendix A: Visual Art Bereavement Group Guidebook.....	157

## **Acknowledgements**

I would like to extend gratitude to my committee chair and members for providing their valuable time and insight to this project. Special thanks to Dr. Pam Parsons and Dr. Patty Slattum, the principal investigators of the Richmond Health and Wellness Program (RHWP), who introduced me to community-based participatory research. Thank you for allowing me to learn and work with your brilliant and compassionate team. To Kate Polak, my favorite friend. To Matt Siegel, my writing buddy and sounding board. Thank you both for your inextinguishable encouragement, editorial feedback, and late-night snack sharing.

## List of Tables

1. Site Descriptions .....	40
2. Intervention Session Overview .....	44
3. Demographic Variables of the Baseline Sample .....	61
4. Demographic Variables of the final Sample .....	62
5. Frequencies and Percentages for Characteristics of the Loss .....	64
6. Engagement in Grief Resources for the Loss .....	65
7. Full Sample Symptom Measurement Means by Time.....	66
8. Final Sample Symptom Measurement Means by Time.....	67
9. Pearson Correlation Matrix Among Outcome Measures.....	68
10. Program Evaluation Questionnaire Responses .....	69
11. Bonferroni Comparison for ISLES Scores by Time .....	72
12. Complicated Grief Symptoms by Time and Clinical Threshold .....	76
13. Pearson Correlation Matrix among Rates of Engagement and Loss Characteristics.....	84
14. Pearson Correlation Matrix among Rates of Engagement and Baseline Measures.....	84
15. Intent to Treat (ITT) Analyses .....	86



## List of Figures

1. Data Collection Timeline .....	39
2. Example of an Introducing the Loved One Collage .....	46
3. Example of a Loss Road Map.....	47
4. Example of a Virtual Dream Story Board.....	48
5. Enrollment and Rates of Engagement Consort Diagram.....	59
6. Rates of Engagement Across Sites .....	60
7. ISLES Scores Over time .....	72
8. Total GMRI Scores Over Time.....	73
9. Continuing Bonds (GMRI-CB Scores) Over Time .....	74
10. Depressive Symptom Severity Over Time .....	75
11. The Effect of Baseline Complicated Grief on ISLES Scores Over Time.....	77
12. The Effect of Baseline Complicated Grief on PHQ-2 Scores Over Time .....	79
13. Perceived Social Support for the Loss Over Time.....	80
14. Personal Growth (GMRI-PG Scores) Over Time.....	81
15. Creative Self-Efficacy Over Time .....	82
16. “Introducing Your Loved One Collage” Participant Artwork #1 .....	88
17. “Introducing Your Loved One Collage” Participant Artwork #2.....	89
18. “Introducing Your Loved One Collage” Participant Artwork #3.....	90
19. “Loss Road Map” Participant Artwork #1 .....	91
20. “Loss Road Map” Participant Artwork #2.....	92
21. “Loss Road Map” Participant Artwork #3.....	93
22. “Virtual Dream Story Board” Participant Artwork #1 .....	94

23. “Virtual Dream Story Board” Participant Artwork #2 .....95

24. “Virtual Dream Story Board” Participant Artwork #3 .....96

## **Abstract**

### **THE EFFICACY OF A GROUP VISUAL ART BEREAVEMENT INTERVENTION WITH OLDER ADULTS**

By Rachel E. Weiskittle, M.S.

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of  
Philosophy at Virginia Commonwealth University.

Virginia Commonwealth University, 2019.

Major Director: Sandra E. Gramling, Ph.D.  
Associate Professor of Psychology  
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Research on expressive art interventions for bereavement has burgeoned in recent years. Studies have supported their effectiveness in facilitating participants' adjustment to loss (e.g., Rosner, Kruse, & Hagl, 2010; Uttley, 2015) and have revealed the frequency with which they are clinically implemented (Thompson & Neimeyer, 2014). Clinicians and recipients of expressive art interventions advocate for their helpfulness in grief processing (e.g., Gamino, 2015). Publications have highlighted particular visual art modules that facilitate adaptive adjustment to loss by providing avenues for self-expression, meaning making and continuing bonds with the deceased (Neimeyer, 2016), but few studies have quantitatively investigated whether they improve bereavement outcomes. Efficacy of treatment modalities are especially warranted for bereaved subgroups at elevated risk for developing symptoms of complicated grief, such as socioeconomically vulnerable older adults, as they are among those most likely to benefit from

intervention but face the most barriers to accessible treatment (Ghesquiere, 2013; Newson et al., 2011). This longitudinal study investigated the feasibility and efficacy of a 4-week grief support group with visual art modalities for bereaved older adults residing in government subsidized independent living facilities in the community. Measured outcomes included meaning made from the loss, continued bonds with the deceased, perceived social support, personal growth, and negative bereavement experiences such as symptoms of complicated grief and depression. Findings from this study support the feasibility and acceptability of implementing an art-based grief support group for socioeconomically vulnerable older adults. Significant improvement was found in meaning made from the loss, personal growth, and negative grief symptoms. Depressive symptoms significantly decreased immediately following completion of the group, but these levels returned closer to baseline levels at one-month follow up. Participants who screened positively for complicated grief at baseline reported greater improvement in their negative grief symptoms and depression, consistent with the extant literature that the bereft in highest distress receive the most benefit from grief intervention. As complicated grief is more prevalent in the older adult population than other age groups, further investigation on the efficacy and effectiveness of targeted bereavement support is warranted.

## **Introduction**

The death of a loved one is a challenging and sometimes debilitating experience. Bereavement and related grief symptoms can result in severe emotional distress alongside adverse physical effects, sometimes leading to increased risk of suicide and mortality (Stroebe, Schut, & Stroebe, 2007). Reactions to loss are wide-ranging, and practicing clinicians and other providers of grief services offer a variety of treatment modalities in order to address the diverse needs of the bereaved community (Thompson et al., 2011). Many incorporate visual art modalities, and clinical application of art therapy techniques with the bereaved has been widely documented (e.g., Thompson & Neimeyer, 2014). Though the expressive arts in general have been suggested by many clinicians as useful tools to facilitate adaptation to loss, use of the visual arts has particularly burgeoned within the field in recent years. Visual arts such as drawing, painting, photography, and multimodal forms have become commonplace in grief therapy (Lister et al., 2008). Clinicians and recipients of these interventions advocate for their helpfulness in adapting to bereavement, but research investigating the efficacy of visual art modalities has produced equivocal results and has not yet been synthesized to establish empirical support across settings. Furthermore, few studies have investigated the applicability of this form of intervention with bereaved older adults, a population in particular need of intervention due to their vulnerability to negative grief outcomes such as the development of complicated grief and other psychological concerns (Shah & Meeks, 2012; Newson et al., 2011).

The following literature review provides a brief history of bereavement theory and the ways interventions for the bereaved have developed over time. Research on the efficacy of the most prominent bereavement interventions are also reviewed, and subgroups of the bereaved that find most benefit from these interventions are highlighted. This background serves to provide

relevant context for the subsequent sections that review the incorporation of expressive art modalities within bereavement interventions. Finally, the argument for empirical investigation of a visual art bereavement intervention with older adults is made, and detailed descriptions and rationale of a treatment manual adapted by the author to address this need is provided.

## **Review of the Literature**

### **Terminology**

The terms grief, bereavement, and mourning were used interchangeably in early psychological literature. As bereavement research has expanded, consensus definitions of these terms have been specified.

**Bereavement.** Stroebe, Hansson, Schut, and Stroebe (2008) define *bereavement* as the “objective situation of having lost someone significant through death.” A person of significance can refer to any personal loss experienced across the lifespan.

**Grief.** *Grief* is defined as the emotional reaction that accompanies the state of bereavement. This reaction is generally considered to include “diverse psychological...and physical manifestations,” including loneliness, anger, despair, yearning, withdrawal, and hallucinatory re-experiencing of the lost figure (Stroebe, et al., 2008).

**Mourning.** *Mourning*, although often used colloquially as a synonym for grief, is identified as the actions and manner in which one expresses their grief and incorporates the loss into their life, often taking the form of religious beliefs and social customs (Granek, 2010). *Mourning* may also be described as the way grief is displayed to the public.

### **Theoretical Frameworks of Grief**

**Stage and task models.** Early theoretical models of grief were influenced by the psychoanalytic interpretations of Freud (1924), which viewed the aftermath of loss as a

ubiquitous, linear process of suffering. Bereaved individuals were expected to complete stages of “grief work” in order to recover from their loss. Stages of grief work included openly mourning the deceased, exhibiting intense distress, and endorsing a period of depression. It was believed that experiencing positive emotions during the early stages of grieving was inappropriate or evidence of denial (e.g. Deutsch, 1937). Under this psychoanalytic model, the central goal of grief processing was the severance of emotional connection with the deceased in order to “move on” from the death and return to pre-loss levels of functioning (Freud, 1924).

Subsequent grief theories maintained the stage-model heuristic. The most recognizable and influential is that of Kubler-Ross (1969). Originally developed to describe how a dying individual relates to his or her own impending death, the model describes five stages of grief: denial, anger, bargaining, depression, and acceptance (Kubler-Ross, 1969). Clinicians applied these stages to the grief processing of the bereaved, and the model was so favorably received that it soon assimilated into the mainstream cultural cannon (Holland & Neimeyer, 2010; Maciejewski et al., 2007).

Worden (1996, 2009) introduced the first “task” model of bereavement. The difference between tasks and stages, Worden argued, is that individuals can complete *tasks* in any order but are restricted to sequencing when competing *stages*. Based on anecdotal evidence and clinical experience, Worden proposed that the following four tasks must be completed to adaptively process grief: 1) accept the reality of the loss, 2) experience the pain of grief, 3) adjust to an environment that does not contain the lost loved-one, and 4) emotionally relocate the deceased and move on with life (Worden, 1996). When the bereaved can “think of the deceased without pain” and “reinvest his or her emotions back into life and in the living,” the grieving process is over (Worden, 1996). Limitations of Worden’s task model present in its assumptions that

healthily adapting to loss requires significant emotional distress and purposeful disengagement with the deceased. However, Worden's model was progressive in its conceptualization of grief as a nonlinear process. By allowing the tasks of grief to be experienced in any order, this model was one of the first to acknowledge the influence of individual differences on bereavement responses.

**Trajectory model of grief.** A burgeoning of bereavement research over recent decades has dramatically contextualized our understanding of loss. Many assumptions of the stage and task models have been challenged or dismantled. This is evident perhaps most prominently in the field's paradigm shift away from models of ubiquitous grief steps. Longitudinal research has demonstrated that most individuals do not go through predictable stages when grieving (e.g., Holland, & Neimeyer, 2010). Most researchers today describe stage or task models as not particularly useful (Wortman, & Boerner, 2007). As the bereavement literature has expanded, a more nuanced conceptualization of grief has emerged. A large body of empirical evidence indicates multiple distinct trajectories of grief (e.g., Bonanno, 2004). Some people demonstrate considerable resilience when faced with loss, others experience significant but temporary impairment, and approximately 10—15% of the general bereavement population feel “stuck” in a persistent state of intense, complicated grief (Bonanno, 2004; Prigerson et al., 2009).

Characteristics of the bereaved and of their loss have been found to impact these grief trajectories. For example, relationship to the deceased and expectedness of the loss are particularly influential on the intensity of grief reactions (Holland & Neimeyer, 2011; Currier, Holland, & Neimeyer, 2006). As such, contemporary models of grief emphasize that the ways people adapt to loss vary as a function of individual differences. Grief is now viewed as an idiosyncratic process in that reactions to the loss of a loved one span a wide range of cognitive and emotional states (Wortman, & Boerner, 2007). Leaders in the field suggest that reactions to



loss can be as varied as the bereaved individuals themselves (Currier, Neimeyer & Berman, 2008). Researchers currently embrace a range of empirically-validated frameworks that account for the variegated trajectories of bereavement experiences (Neimeyer, 2014), but two theories have emerged as the most demonstrable in empirical promise: The Dual Process model of bereavement (Stroebe & Schut, 1999) and the Meaning Reconstruction Model (Neimeyer, 2001).

**Dual Process model of bereavement.** The Dual Process model (DPM) integrates cognitive stress theory and traditional grief theories (Stroebe & Schut, 1999). DPM was developed to address two categories of stressors and their corresponding bereavement-related coping strategies. According to the DPM, grief is the process of coping with both loss-oriented and restoration-oriented stressors. Loss-oriented coping focuses on the processing of the loss experience. Examples of loss-oriented coping include the expression of emotion related to the death and reconnecting with the memory of the loved one through dialogue or pictures. Restoration-oriented coping focuses on daily practical needs following the loss, such as problem-solving challenges resulting from the death, re-engaging relationships, pursuing enjoyable activities, and experimenting with new life roles. This model argues that bereaved individuals experience a natural oscillation between these two coping styles in varying patterns of confrontation and avoidance of their loss through their daily lives (Stroebe & Schut, 1999). Oscillation was defined as a dynamic coping process of alternation between and within each form of coping. The DPM argues that one's openness to this oscillation is important for optimal adjustment to loss. The DPM thus conceptualizes grief as the process of coming to terms with the loss (loss-oriented coping) while also taking time to participate in future-oriented experiences (restoration-oriented coping; Stroebe & Schut, 1999).

**Meaning Reconstruction Model.** The Meaning Reconstruction Model approaches grief from a cognitive constructivist perspective, which posits that people create and maintain a system of beliefs in order to anticipate and respond to their surroundings (Neimeyer, 2001). A person's system of beliefs can be challenged by events if the meaning an individual ascribes to them is incongruent with their overarching worldviews. Consequently, events' ascribed meaning must be either assimilated into the existing belief system or the system must be accommodated to make congruent meaning of the event (Neimeyer & Sands, 2011). This model can be used to explain the process of adjusting to a number of life stressors, but grief researchers have found it particularly useful in describing the mechanisms of healing following loss, as few experiences challenge our beliefs of meaning and purpose as significantly as the death of a loved one (Neimeyer, 2001). The Meaning Reconstruction model characterizes grief as the process of reaffirming or reforming a world of meaning that has been challenged by loss (Neimeyer, Baldwin, & Gillies, 2006; Neimeyer & Sands, 2011).

**Grief theory integration.** These two leading bereavement theories are complementary. Both models view grief as a life-long process of formulating meaning into life after the loss and renegotiating ties with the deceased (Lister et al., 2008). The Meaning Reconstruction Model proposes that the search for meaning is the bereaved individual's quest following loss, and the DPM's proposed oscillation between loss-focused and restoration-focused coping helps explain how that meaning is created (Stroebe & Schut, 2001). Both models address not only the importance of formulating meaning ascribed to the death experience but also of the assimilation of this meaning to future-oriented goals and developing identity of the bereaved. Additionally, both models offer frameworks describing the mechanisms by which grief is processed without diminishing the dramatically varied array of bereavement reactions. For these reasons, The DPM

and the Meaning Reconstruction Model are the theories most widely applied to bereavement interventions and investigative research.

### **Bereavement Outcomes**

Through the lens of the DPM and Meaning Reconstruction Model, grief processing is evaluated by both positive and negative constructs. Today's interventions aim to provide avenues for bereaved individuals to explore particular domains that indicate successful adjustment to a loss and alleviate the effects of loss that impair or prevent adaptive processing. In order to assess the multidimensional conceptualization of grief espoused by the DPM and Meaning Reconstruction Model, bereavement outcomes in the literature include continued bonds with the deceased, personalized meaning behind the loss, cognitive understanding of the impacts behind the loss, reconstruction of purpose in a life without the loved one, and psychological or physiological distress related to the loss (Currier et al., 2008; Neimeyer et al. 2010). The domains most consistently and reliably measured in the literature are *continuing bonds*, *meaning making*, *personal growth*, and *negative grief symptoms* (Neimeyer et al. 2010).

**Continuing bonds.** Continuing bonds is a term that reflects the “ongoing attachment to the deceased” (Field, Gal-Oz, & Bonanno, 2003). Continuing bonds with the deceased can be experienced emotionally, through missing, yearning and feeling strongly connected to the loved one (Silverman, Nickman, & Worden, 1992, Stroebe, Schut, & Boerner, 2010), and cognitively, by thinking of and remembering the deceased person (Bonanno, Mihalecz, & LeJeune, 1999). Continuing bonds can behaviorally entail talking to the loved one, maintaining his or her belongings post-loss, feeling the presence of the loved one, and passing on the deceased's habits or virtues to others (Attig, 2000). Importantly, accepting the reality of the death and communicating the narrative of the loved one's life arc are also manifestations of adaptive

continuing bonds with the decedent (Field, Gal-Oz, & Bonanno, 2003). Continuing bonds with the deceased facilitate grief resolution by helping the bereaved to preserve a sense of identity and meaningful connection with the past (Field, 2008).

**Meaning making.** Meaning making, according to Thompson and Janigian (1988), is the “ability to develop new goals and purpose, or to construct a sense of self that incorporates the significance of an experience.” Drawing from this definition, Neimeyer and colleagues (Currier, Holland, Coleman, & Neimeyer, 2008; Gillies & Neimeyer, 2006) proposed that meaning making following loss is a cyclical course in which the pain of bereavement (i.e., negative grief symptoms) prompts efforts to find meaning in the challenging event of the loss, with new meanings forming and integrating into a system of beliefs. In sum, meaning making during bereavement refers specifically to the reconciliation or reconfiguration of pre-existing meanings with the death of a loved one.

When the bereaved are successful in finding meaning, evidence indicates that they fare better than their counterparts who struggle to make sense of the experience (Neimeyer, 2015). Studies report that finding meaning is related to higher subjective well-being and more positive immune system functioning (Bower et al. 2003). Research provides empirical support for the processes proposed by the field’s leading bereavement theories and suggests that bereaved people struggling to adjust to their loss could benefit from interventions driven around these two domains. Most empirically-informed grief therapies aim to provide avenues for patients to explore continued bonds with the deceased, the personalized meaning behind their loss, and a reconstruction of purpose in a life without their loved one (Currier, Neimeyer, & Berman, 2008).

Meaning making can be manifested in the following ways: sharing views that relate to the philosophical aspects of death and dying such as fairness (Nadeau, 2001), questioning,

examining and changing global meaning (Park, Edmondson, Fenster, & Blank, 2008); discussing topics of religious connotations (Nedeau, 2001); expressing lessons learned, new insights gained, or changes in self or family since the death (Nadeau, 2001); and expressing strengthened familiar relations following the loss (Davis & Nolen-Hoeksema, 2001). Qualitative investigation of meaning making during bereavement often prompts participants to describe their loss experience in their own words and codes responses on the presence of the aforementioned documentable manifestations. For example, Lichtenthal and colleagues (2010) assessed meaning making processes in parents who had lost a child with open-ended written prompts (e.g., have there been any ways in which you have been able to make sense of the loss of your child?). Similarly, Wheeler (2001) observed a “crisis in meaning” among bereaved parents in a qualitative study revealed themes of parents’ struggle to make sense of why the loss occurred, wondering what could have been done to prevent the loss, preserving the significance of their child’s life, and positive gains related to the loss.

**Personal growth.** Separate from continuing bonds and meaning making, studies have highlighted many other positive developments that may occur after a loss (Bonanno & Kaltman, 2001; Davis & Nolen-Hoeksema, 2001; Ho, Chu, & Yiu, 2008). These positive changes have been grouped together and labeled variously as personal growth, posttraumatic growth, or stress-related growth, (Helgeson, Reynolds, & Tomich, 2006; Park & Folkman, 1997; Tedeschi, & Calhoun, 2004). There are many examples of positive outcomes from bereavement. For example, bereavement can lead to a more fulfilling understanding of the external world. Frankl (1963) emphasized that suffering can facilitate the discovery of purpose in one’s life. Traumatic life events may lead to successful coping, learning lessons, and a fuller appreciation for life (Janoff-

Bulman, 2004). Newly recognizing that life is finite can lead individuals to believe their actions matter more (Nerken, 1993).

Bereavement can also result in deeper and more meaningful social relationships. Bereaved individuals often report an increase in compassion for themselves and others, as well as a greater sense of self-worth (Hogan & DeSantis, 1996). Experiencing a great loss can also result in resiliency, which is described as the ability to “maintain relatively stable, healthy levels of psychological and physical functioning” when confronted with loss and trauma (Bonnano, 2004). In a meta-analysis of the published research on personal growth in adults, Helgeson, Reynolds, and Tomich (2006) examined correlates of personal growth. They found that objective severity of the stressor, subjective perceptions of stress associated with the event, and greater intrusive and avoidant thoughts about the stressor were positively related to personal growth. In addition, personal growth was positively related to higher levels of positive affect, optimism, religiosity, and the coping strategies of positive reappraisal, acceptance, and denial. Personal growth has also been linked to improved physical health outcomes, such as decreased risk for heart attacks (Affleck, Tennen, Croog, & Levine, 1987) and lower AIDS-related mortality (Bower, Kemeny, Taylor, & Fahey, 1998).

**Negative grief symptoms.** Research supports that grief can negatively affect individuals affectively, emotionally, behaviorally, physiologically, cognitively, and socially (Worden, 2002). Along with heightened emotions and longing for the deceased, bereaved individuals can experience symptoms of depression, anxiety, and cognitive disorganization (Utz et al., 2002). Those bereaved may also endorse physical manifestations of their distress, such as increased fatigue, greater propensity for developing illness, and overall poorer physical health outcomes than their non-bereaved counterparts (Prigerson et al., 2001; Murphy et al., 1999). These

symptoms are can catalyze a myriad of functional complications, including decreased academic or occupational performance and quality of life (Servaty-Seib & Hamilton, 2006; Neimeyer et al., 2008).

### **Grief and the Expressive Arts**

As theories began to validate the variety of ways individuals react to loss, interventions for the bereaved similarly expanded in scope to include a range of treatment modalities (Neimeyer et al., 2012). Many practices have made alterations to traditional grief psychotherapy to avoid a “one-size fits all” approach to treatment (Thompson et al., 2011; Mancini & Bonanno, 2006; Miles-Mason, 2005). The incorporation of expressive arts modalities is one of the most frequently endorsed of these alterations. Expressive art modalities are defined as the use of dance, drama, drawing, music, painting, photography, sculpture, and writing within the context of psychotherapy, counseling, rehabilitation, or medicine (Malchiodi, 2008). Expressive arts can also be referred to as integrative or creative art therapies when purposively used in combination with treatment (Estrella, 2005).

Many manualized bereavement interventions incorporate expressive art techniques, such as Shear and colleagues’ treatment for complicated grief and Neimeyer’s Meaning in Loss Group (2001; Neimeyer, 2016; Shear, Frank, Houck, & Reynolds, 2005). Thompson and Neimeyer recently published a clinical manual with over 50 expressive art modules that facilitate adaptation to loss (2014). The authors encourage practicing grief therapists to adopt the therapeutic use of expressive arts to augment their existing clinical bereavement practice (Thompson & Neimeyer, 2014). Incorporating expressive arts into grief therapy has been hailed as a way for clinicians to take their “game” to the next level (Gamino, 2015).

Not only is the incorporation of expressive arts within traditional bereavement interventions increasingly documented, but it is also common for those seeking grief therapy to receive care from a certified art therapist. Over 80% of trained art therapists report working with bereaved individuals, and bereavement/grief is reported as one of the top 10 specialties of practicing art therapists (American Art Therapy Association, 2007). Peer-reviewed art therapy journals frequently publish educational editorial materials on grief theory in an effort to empirically inform art therapists' clinical practices (i.e., Lister, Pushkar, & Connolly, 2008). Collectively, bereaved individuals seeking therapeutic assistance for adjusting to their loss are likely to encounter expressive art modalities within a therapeutic context.

Theoretical support for the integration of expressive arts and bereavement within a therapeutic setting is evident in the fields' overlapping frameworks and treatment goals. Art therapists' orientation towards externalizing processes and facilitating insight meld naturally with meaning-focused therapeutic practice (Neimeyer, 2012). In fact, the creation of meaning is considered the leading mechanism of change by theories of both grief (i.e., Meaning Reconstruction Model; Neimeyer, 2001) and the expressive arts (i.e., the Expressive Therapies Continuum; Kagin & Lusebrink, 1978). Tenets of the DPM can also be found in the theoretical models of art therapy. For example, the therapeutic benefits of artistic creativity are attributed to its' dual purpose as both a restorative and assertive act (Levine, 2004). These constructs are central to DPM's suggestions for healthy adaptation to bereavement. Similarly, Malchiodi (2003) argues that therapeutic art making serves four purposes: creating meaning, confronting mortality, crisis resolution, and authentic emotional expression. These purposes reflect the DPM's proposed processes for the assimilation and accommodation of loss, and further emphasize the compatible theoretical frameworks of bereavement and the expressive arts.



Remarkably, despite the prevalence and theoretical support for implementing expressive art modalities with the bereaved, only recently have studies begun to investigate its efficacy. A 2014 literature review of expressive art therapies with bereaved samples reported preliminary evidence for music therapy's facilitation of emotional expressionism, feeling connected to the deceased, and finding comfort (Torres, Neimeyer, & Neff, 2014). The authors were unable to test for effect sizes or draw further conclusions on alternative forms of expressive arts due to low sample sizes (Torres, Neimeyer, & Neff 2014). The NIH recently conducted a comprehensive meta-analysis of art therapy interventions (Uttley, 2015). Included studies with a bereaved sample showed preliminary evidence of improvement, s but the studies' heterogeneity limited the finding's generalizability (Uttley, 2015). Visual art modalities, expressive writing, and music therapy were the most prevalent expressive art techniques used by the bereaved sample studies (Uttley, 2015). In a meta-analysis of 27 studies of expressive art therapies with bereaved children and adolescents, music therapy was reported as the "most promising venue" for grief intervention was when compared to talk therapy, psycho-education, play therapy, and trauma-focused school-based psychotherapy due to improved grief outcomes and increased socialization of participants (Rosner, Kruse, & Hagl, 2010). These studies offer promising glimpses of expressive arts' potential influence on bereavement outcomes, but further research is necessary to identify their distinctive contribution to bereavement interventions.

**Visual art modalities in bereavement interventions.** Though the expressive arts in general have been suggested by many clinicians as useful tools to facilitate adaptation to loss, the incorporation of visual art modalities has garnered particular interest. The visual arts are so often utilized as or adapted to bereavement interventions that they have been described as "commonplace" in grief therapy (Neimeyer & Thompson, 2014). Visual art modalities are

regularly included in manualized grief therapies (e.g., Shear et al., 2005) and are used in a myriad of clinical settings, including support groups, individual therapies, and prompts for independent completion (Neimeyer & Thompson, 2014). The American Art Therapy Association defines visual art as “drawing, painting, sculpture, and other art forms” (AATA; 2016). Cross-disciplinary publications elucidate further examples of visual art and include printmaking, crafts (e.g., collage, scrapbooking), graffiti, photography, and ceramics (Efland, 2002). Drawing, painting, and photography are among the forms most frequently applied by clinicians; specifically, the creation of mandalas, scrapbooks, and thematic collages. The visual arts are also used for grief processing outside of clinical practice. The creation of visual art in reaction to death can be found across cultures as expressions of loss, love, and remembrance (Malchiodi, 1998; McKissock & McKissock, 2012). Visual memorials are created at the individual, family, and community level, and can assist in the commemoration of the life lost and in the healing for those affected (Frankenstein & Brady, 1995).

The literature investigating the efficacy of visual art modalities within bereavement interventions is scant but budding. The majority of studies Collectively, treatment recipients overwhelmingly endorse a positive subjective impact of visual art modalities. Across several studies (e.g., McIntyre, 1990; Lu, 2007) participants rated their well-being as significantly improved. Though this finding is ineffectually captured with measurement of objective changes, it warrants further attention and perhaps speaks to the impact of visual art techniques witnessed by clinicians across disciplines. The use of positive or growth-oriented measures (e.g., personal growth, posttraumatic growth, benefit-finding, self-efficacy) could be an avenue of future research that provides insight into participants’ experiences and whether they translate to objective outcomes. Given the frequent clinical application of visual art modalities for those

bereaved, it is imperative that more investigative work be done to evaluate this method of treatment.

### **Bereavement Intervention Efficacy**

Bereavement interventions are evaluated for effectiveness by measuring the extent to which treatment recipients endorse changes in negative grief symptoms and in domains indicative of successful adjustment to a loss (i.e., continuing bonds, meaning making, and personal growth). Bereavement interventions demonstrate the greatest effects on domains that reflect growth, resilience, and adaptation to loss. Much of bereavement therapy aims to facilitate the strength-based approaches to grief; treatment foci are the positive outcomes and cognitive understanding of the impacts of the loss (Neimeyer et al. 2010). One therapeutic aim of bereavement interventions is for the treatment recipient to make meaning of their loss, as this process has been found to predict other positive outcomes across numerous studies (Neimeyer, 2015). Meaning-making is a difficult endeavor for the bereaved, but individuals are more likely to make meaning of their loss if they participate in evidenced-based grief therapies (Neimeyer, Burke, Mackay, & van Dyke Stringer, 2010).

The degree to which any intervention significantly alleviates negative symptoms within the range of normative grief reactions (as opposed to complicated grief) has been contended in the literature (e.g., Granek, 2010; Stroebe et al., 2000). A meta-analysis of bereavement interventions found that most treatment recipients experience only minimal improvement of negative grief symptoms (Currier et al., 2008). However, recent research offers some important considerations on the relationship between negative grief symptoms and bereavement interventions. Studies indicate that the absence of negative grief symptoms is not necessarily a marker of successful adaptation to loss. For example, common trajectories of grief include

delayed or inhibited grief, by which individuals either do not immediately or ever endorse traditional negative grief symptoms (Bonanno et al., 2004). There is also strong evidence against the idea that those who do not exhibit grief following a loss are insecurely attached and emotionally distant (Bonanno et al., 2002). These findings have led researchers to argue that the endorsement or expression of negative grief symptoms is not directly indicative of grief intensity or one's adaptation to loss as previous studies assumed (Shapiro, 2007). Thus, for the general bereavement population, interventions are considered a preventative approach that buffer possible manifestations of impaired functioning, rather than the traditional aims of psychotherapy for direct alleviation of targeted symptoms (Currier, Neimeyer, & Berman, 2008).

However, research has uncovered two circumstances in which professional treatment is appropriate and, at times, even essential for healthy adaptation to loss: 1) when the circumstances of the death put the bereaved at risk for adverse outcomes, and 2) when the bereaved are currently experiencing clinically significant distress (Currier, Neimeyer, & Berman, 2008). In these cases of selective or indicated treatment, therapy is substantially more effective in alleviating negative symptoms, in the latter case rivaling outcomes for the efficacy of therapy for other conditions (Currier, Neimeyer, & Berman, 2008). As such, researchers have emphasized the particular importance of evaluating treatment efficacy on populations at elevated risk for adverse grief outcomes.

### **Bereavement in Older Adulthood**

Grief is one of the most commonly experienced adverse events in older age (Bonanno, 2004). In addition to experiencing the widest variety of bereavement in terms of type of relationship to the deceased, older adults also most frequently endorse multiple losses (Shah & Meeks, 2012). By the age of 65, approximately 50% of women and 10% of men experience the

loss of a spouse; by age 85, these numbers rise to 80% and 40%, respectively (Rosenzweig, Prigerson, Miller, & Reynolds, 1997). The cumulative losses experienced by older adults dramatically surpass these figures, as the loss of siblings and friends exceeds spousal loss by a factor of three-to-one and nine-to-one, respectively (Hays, Gold, & Peiper, 1997). Other types of loss, though less common, can be especially difficult for survivors, such as the death of an adult child, experienced by 10% of older adults (Moss, Moss, & Hansson, 2001), and the sudden or violent death of a loved one through accident, suicide, or homicide (Currier, Holland, Coleman, & Neimeyer, 2007).

Although older adults experience the deaths of loved ones more often than younger adults, studies suggest that frequency of loss experiences is not necessarily indicative of the ability to adaptively cope with loss (Shah & Meeks, 2012). On the contrary, prior loss is an identified predictor of complicated grief (CG), a prolonged form of grieving characterized by intense separation distress, a sense of meaninglessness and purposelessness, excessive bitterness over the loss, and impairments in day-to-day functioning (Maercker, Neimeyer, & Similoa, 2016; Lob et al., 2010; Prigerson, Vanderwerker, & Maciejewski, 2008). CG is significantly more prevalent in the older adult population than other age groups. In the community population, estimates of grieving individuals who meet criteria for CG range from 7% (Kersting, Braehler, Glaesmer, & Wager, 2011) to 10-20% (Simon et al, 2007). The prevalence of CG rises to 15—30% within the older adult population (Fujisawa et al., 2010; Kersting et al., 2011; Newson et al., 2011); Ghesquiere, Shear, and Naihua, 2013). Further, a recent meta-analysis of the bereavement literature revealed higher mean age to be associated with higher prevalence of CG (Lundroff, Holmgren, Zachariae, Farver-Vestergaard, & O'Connor, 2017). In spite of these significantly higher reports of CG among the elderly, it is likely that these figures are underestimations.

Within the older adult population, CG is often underdiagnosed, undertreated, and minimized as an influential factor on mental health (Boelen & van den Bout, 2005; Ott, Lueger, Kelber, & Prigerson, 2007). This clinical “blind spot” in the identification of bereavement-related complications in older adults may be attributable to societal assumptions; namely, that the normality of losing loved ones in older age creates immunity to the pain and intrusiveness of grief (Newman et al., 2011).

When considering the severity of distress associated with CG symptomology, the implications of CG’s hidden prevalence in the older adult population are alarming. CG exhibits a range of symptoms that stem from an excessive preoccupation with the loss, including: intrusive memories of the loss, feelings of hopelessness, avoidance of memories or locations associated with the deceased loved one, and social withdrawal, among others (Dillen et al., 2009; Bonanno et al., 2007). Individuals with CG endorse impairments in day-to-day functioning and overall poorer quality of life (Boelen & van den Bout, 2005) with increased social relationship problems, sleep disturbances, and greater difficulty completing household tasks (Prigerson, Vanderwerker & Maciejewski, 2008). In addition, CG can contribute to the development of other psychological and physiological concerns (Ott, Lueger, Kelber, & Prigerson, 2007). CG has been associated with increased risk of cardiac disease, hypertension, cancer, depression, anxiety, and suicidality (Ott, Lueger, Kelber, & Prigerson, 2007; Bonanno et al., 2007; Mitchell, Kim, Prigerson, & Mortimer, 2005) as well as higher rates of hospitalization (Boelen & van den Bout, 2005).

In addition to CG, bereaved older adults are at increased risk for developing other negative grief outcomes. A meta-analysis found bereavement to be one of the most prominent and consistent risk factors for depression among the elderly (Cole & Dendukuri, 2003). Longitudinal analyses of the course of psychopathology in bereavement found that depression

sharply increases following a loss within the older adult age group (Norris & Murrell, 1990). In one review of depression and anxiety in the first year of widowhood in older age, 22% of participants met criteria for major depressive disorder and 12% were diagnosed with posttraumatic stress disorder (PTSD; Onrust & Cuijpers, 2006). Moreover, a large body of research has linked bereavement with a rapid decline in physical health in this age group, with comorbidities often appearing within weeks or months of loss (Stroebe, Schut, & Stroebe, 2007). Perhaps most concerning, bereaved older adults (particularly those widowed) are at significantly higher risk for mortality—a trend often referred to as the “broken-heart” phenomenon (Moon, Kondo, Glymour, & Subramanian, 2011). The precise mechanisms by which this increased mortality occurs are not yet fully understood (Moon, Kondo, Glymour, & Subramanian, 2011). The broken-heart phenomenon has been documented in the bereaved across the lifespan, but studies reveal that it is particularly pronounced within the older adult population (Bennett & Bennett, 2001).

Research has identified factors that impact grief symptoms and experiences in older adulthood. The importance of social support during bereavement is widely described (e.g., van der Houwen et al., 2010; Wilsey & Shear, 2007) and can provide a means to engage in restoration orientation processes per the Dual Process Model (Stroebe & Schut, 1999). Unfortunately, many older adults have limited social support, including during times of grief. Studies indicate that the elderly receive less consideration and support for their losses compared to their younger counterparts, especially when the loss is that of a friend or adult child (Newman et al., 2011). This may be attributable to the common assumption that the normality of losing loved ones in older age creates immunity to the pain and intrusiveness of grief (Newman et al., 2011). This assumption, described by researchers as a symptom of ageism, is pervasive in

society and reduces the social support offered to bereaved older adults (Ghesquiere, Shear, and Naihua, 2013). For example, family members may discuss their own grief in front of their elders but fail to ask them how they are coping with the shared loss (Breen & O'Connor, 2011). Perhaps as a result, studies have found that some older adults believe that their family members and friends do not understand their grief and underestimate the severity of their distress (Newson et al., 2011). The perception of being dismissed or overlooked can foster a reluctance in older adults towards expressing their grief or telling stories about their loss (Smith, Nunley, Kerr, & Galligan, 2011). Thus, even if older adults are connected with family or friends, they may not be receiving or asking for the level of social support that can be critical in facilitating long-term adjustment to loss. Social isolation has been characterized as a secondary consequence as older age, leading to grief of longer duration and poorer health and mental health outcomes than observed in younger persons (Supiano & Luptak, 2014). Researchers have called for studies evaluating the efficacy of increasing access to or perception of social support within the bereaved older adult population in order to attenuate their higher risk of negative grief outcomes (Smith, Nunley, Kerr, & Galligan, 2011).

Socioeconomic factors can place some older adults at even greater risk for developing negative bereavement outcomes. Studies have found that CG is associated with both lower income (Newson et al., 2011) and lower education (Tomarken et al., 2008). Feeling a lack of control due to limited financial or situational means has also been identified as a risk factor for negative health outcomes following loss (Schum, Lyness, & King, 2005). In fact, financial strain is associated with depressive symptoms across all trajectories of grief, including those who demonstrate resiliency, delayed grief responses, and complicated grief symptoms (Newson et al., 2011). Given older adults' overall elevated figures of bereavement-related distress due to



cumulative loss and documented limited social support, those with financial strain or lower socioeconomic status are among those at highest risk for developing CG and other negative health outcomes following the death of a loved one.

Additional sociodemographic characteristics are important to consider in the context of older adult bereavement and grief experiences. In the United States, grief theory has relied largely on the experience of the dominant white culture to explain how Americans grieve in general (Laurie & Neimeyer, 2008). Cultural subgroups, most notably African Americans, have been overlooked and largely ignored within the bereavement literature. Researchers have noted that bereavement theories often fail to acknowledge cultural differences that may affect the ways in which African Americans grieve, and only recently have studies focused on examining factors distinct to African Americans (Burke, Neimeyer, & McDevitt-Murphy, 2010; Rosenblatt & Wallace, 2005; Laurie & Neimeyer, 2008). For example, African American grief occurs in the context of a substantially shorter life expectancy than that of their Caucasian counterparts (Rosenblatt, 2013). Nationally, African-American men and women live approximately six fewer years than Caucasian men and women, with a mean age of 72 years for African Americans of both sexes (Olshanky et al., 2012). Further, African Americans experience pregnancy and infant loss at double the rate experienced by Caucasians (Goergen, & Drolet, 2002), and African American women are several times more likely to die in childbirth than are Euro-American women (Creanga, Syverson, Seed, & Callaghan, 2017; Creanga et al., 2012). Pursuant to a diminished lifespan and the expectation that their own lives may be shorter, African Americans are also more likely to experience the premature loss of a loved one (Rosenblatt & Wallace, 2005), which may increase their risk for developing negative health outcomes and increased psychological distress.

Another factor distinct to African Americans that may affect grieving experiences is that African-American families often rely on a large social support system that includes family, friends, and others who act as fictive kin; the term family often extends beyond the so-called nuclear family and includes multiple households (Rosenblatt, 2013). The role of “play family”—those members of the fictive kin network who are held as closely as immediate family but who are not related by blood or marriage—is distinct to African-American culture (Nobles, 2004; Rosenblatt & Wallace, 2005). Perhaps relatedly, African Americans are more likely than other cultural groups to give and receive intergenerational support (Rosenblatt, 2013) and more frequently offer assistance to those outside the bounds of immediate family (Sudarkasa, 1997). African Americans also report a high degree of religious participation, religious coping, and spirituality (Taylor, Chatters, & Jackson, 2007). Particularly among older African Americans, a link has been established between religious belief and psychological well-being (Frazier, Mintz, & Mobley, 2005).

Despite these important differences, only recently have researchers begun to investigate how ethnicity may influence the way one may experience bereavement. Race/ethnicity has traditionally been a variable in the bereavement literature whose variance researchers hope to minimize. Thus, ethnicity is often only used as a control to account for error variance in the sample or is not reported on at all. For example, in a recent qualitative study of African American older adults engagement in expressive arts, the authors make no reflection of how cultural factors may have influenced participants’ experience or study outcomes. despite the study’s title containing its aims of describing the creative process “...among African American older adults” (Johnson & Sullivan-Marx, 2006). Whether bereavement experiences are observed as a function of ethnicity or not, grief outcomes in African Americans are a clear priority.

## Statement of the Problem

Bereavement is a challenging human experience that often recurs throughout a lifetime (Hagman, 2001). Early grief theories (e.g., Freud, 1924; Kubler-Ross, 1969) paralleled the universalistic aspect of bereavement by conceptualizing grief as a predictable process of identifiable stages. However, research has increasingly informed a paradigm shift towards a more nuanced understanding of loss. A large body of empirical evidence indicates multiple trajectories of grief rather than one standardized process (e.g., Bonanno, 2004) and leaders in the field suggest that reactions to loss can be as varied as the bereaved individuals themselves (Currier, Neimeyer, & Berman, 2008). Theorists and researchers currently embrace a range of empirically-validated frameworks that account for the variegated trajectories of bereavement experiences, but two theories have emerged as the most demonstrable in empirical promise: the dual-process model bereavement (DPM; Stroebe & Schut, 1999) and the meaning reconstruction model (Neimeyer, 2001). Both models view grief as a life-long process of renegotiating continuing bonds with the deceased and formulating meaning into life after loss (Lister et al., 2008). As such, most empirically-informed grief therapies aim to provide avenues for patients to explore continued bonds with the deceased, the personalized meaning behind their loss, and a reconstruction of purpose in a life without their physically present loved one; reconstruction of purpose in life without their loved one physically present (Neimeyer, 2015).

Reflective of bereavement theory's evolution away from linear stage models towards more contextualized processing of individual loss, research supports a variety of effective treatment modalities offered to the bereaved (Neimeyer et al., 2012). A therapeutic avenue warranting particular consideration is the incorporation of expressive art modules. Theoretical support for the frequent combination of expressive arts and bereavement within a therapeutic

setting is evident in the fields' overlapping treatment goals of restoration, assimilation and meaning making (i.e., Neimeyer, 2012). Studies have recently begun to investigate the efficacy of using art modules with grief therapy and have reported preliminary, yet promising, results (e.g., Uttley, 2015; Gamino, 2015). However, a paucity of research has addressed the potential use of visual art modalities with bereaved older adults of low socioeconomic status, one of the most vulnerable subgroups to the development of complicated grief and other conditions of impairing distress (Ghesquiere, Shear, and Naihua, 2013). Investigation of the efficacy of potentially helpful interventions to at-risk groups of the bereaved is warranted.

The current study aimed to address this gap in the literature by conducting a prospective longitudinal study in which participants completed a 4-week grief support group that incorporated expressive art modalities. At the beginning of session one, participants completed a brief packet of questionnaires assessing grief symptoms, depressive symptoms, meaning made from their loss, continuing bonds with the deceased, perceived social support, and creative self-efficacy. Participants completed this survey packet and a program evaluation form at the end of session four and four weeks later to test for longitudinal effects of study participation. The following specific hypotheses were tested:

*Hypothesis 1: Meaning Made from the Loss.* It was hypothesized that participants would report increased rates of meaning made from their loss across study time points.

*Hypothesis 2: Continuing Bonds.* It was hypothesized that participants would report higher rates of adaptive continuing bonds with the deceased across study time points.

*Hypothesis 3: Depressive Symptoms.* It was hypothesized that participants would report lower rates of depressive symptoms across study time points.

*Hypothesis 4: Complicated Grief Symptoms.* It was hypothesized that participants who screened positively for complicated grief at baseline would demonstrate greater alleviation of their negative grief symptoms than participants who screened negatively for complicated grief at baseline. A comprehensive meta-analysis of bereavement interventions has revealed that treatment recipients with indications of complicated grief experience the greatest benefit and alleviation of negative grief symptoms (Currier, Neimeyer, & Berman, 2008).

*Hypothesis 5: Social Support.* Participants will endorse higher rates of perceived social support for their loss following their participation in the study when compared to their own perceived social support at baseline. Furthermore, research indicates that individuals with a perception of being socially supported in their grieving endorse higher rates of personal growth and fewer symptoms of complicated grief and depression (Hogan & Schmidt, 2002). It was therefore anticipated that higher perceived social support would be positively associated with personal growth across treatment groups. It was also anticipated that higher perceived social support will be negatively associated with negative grief symptoms across treatment groups. Lastly, higher perceived social support was predicted to be negatively associated with depressive symptoms across treatment groups.

*Exploratory Analyses: 1) Creative Self-Efficacy.* Per a thorough literature review, no bereavement studies to date have investigated participants' propensity for creative activities or artistic self-beliefs as potential predictors of expressive art treatment outcomes. Thus, exploratory data analyses examined the impact of participants' creative self-efficacy and artistic engagement on the following treatment outcomes: meaning made of the loss, continuing bonds with the deceased, negative grief symptoms, depressive symptoms, and perceived social support for the loss. Analyses were also conducted to explore possible associations between creative

self-efficacy/past artistic achievement and the Program Evaluation responses completed at the final session and four-week follow up. It was predicted that participants in the experimental group will endorse significantly higher rates of creative self-efficacy and artistic engagement following study completion across time points.

2) *Rates of Engagement.* Exploratory analyses will be run to investigate the impact of participants' demographics, loss characteristics and baseline outcome data on their rates of engagement in the study (as measured by number of sessions attended).

## **Method**

A pre-post group design was employed to test the aforementioned hypotheses. All participants received the art-based bereavement group therapy treatment. A weight-list control group was not implemented as originally proposed due to difficulty recruiting participants in a timely manner.

### **Experimental Overview**

Older adults residing in four government-funded independent living facilities in the Richmond community were invited to participate in the present study. The author met with potential participants on-site to introduce them to the study and screen for eligibility. If the individual was determined eligible to participate, they were provided additional information about the nature of the study and were invited to review and sign the study's written consent forms. Following acquisition of consent, the participant completed a Demographics questionnaire and a Characteristics of the Loss questionnaire.

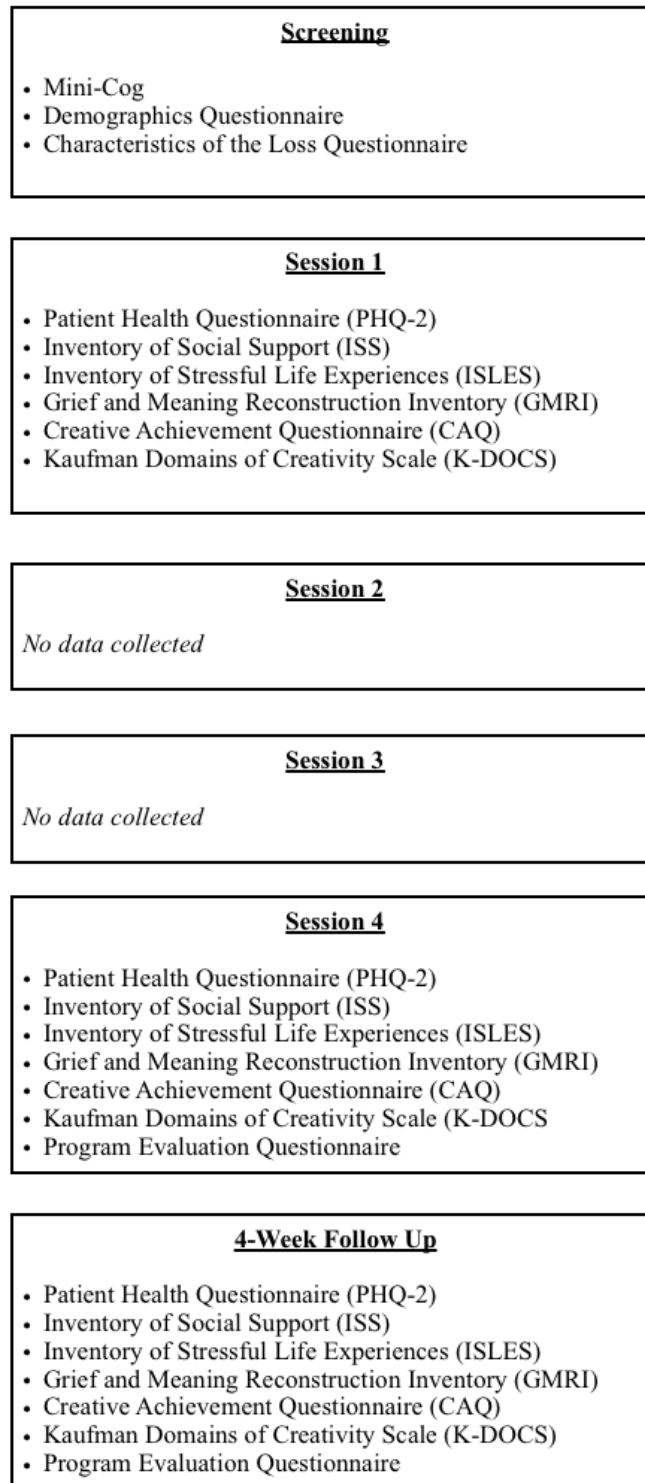
Participants completed four weekly 90-minute group session series based on Neimeyer and colleague's Meaning in Loss Group (Neimeyer et al., 2016). Neimeyer has encouraged creative adaptation of this evidenced-based group's basic structure; various trials of this group

model for the bereaved are currently under development, though to date none have focused on older adults (2016). The present study has adapted the Meaning in Loss group by incorporating visual art modules. Detailed explanation and empirical rationale for the present study's group development can be reviewed in the facilitation guidebook (Appendix A). Food, drinks, and supplies needed to complete session activities (e.g., scissors, paper, drawing utensils) were provided at each session by the author.

At the beginning of session one, participants completed a brief survey packet of empirically-validated questionnaires for baseline measurement of their negative grief symptoms, depressive symptoms, perceived social support, meaning made from their loss, and continuing bonds with the deceased. The survey packet consisted of the following questionnaires: The Inventory of Stressful Life Experiences (ISLES; Holland, Currier, Coleman, & Neimeyer, 2010), the Patient Health Questionnaire (PHQ-2; Kroenke, Spitzer, & Williams, 2003); The Grief and Meaning Reconstruction Inventory (GMRI; Gillies, Neimeyer, & Milman, 2015); the Creative Achievement Questionnaire (Carson, Shelley, Peterson, Higgins, & Daniel, 2005); Kaufman Domains of Creativity Scale (K-DOCS; Kaufman, 2012), and the Inventory of Social Support (ISS; Hogan & Schmidt, 2002). At the end of session four, participants completed the same battery as the baseline data, with the addition of a Program Evaluation Form. Participants again completed these questionnaires one month after session four. The background and empirical evidence for each questionnaire is explained in detail in the following Measures section.

Participants who attended all four sessions and the follow-up survey packet received reimbursement in the form of \$5.00 gift cards to the Dollar Tree. Figure 1 provides a visual demonstration of the data collection timeline.

Figure 1. Data Collection Timeline.





## Settings

Participants were recruited at four government-subsidized independent living facilities for older adults aged 55 years and above. Table 1 provides an overview of the four sites from which individuals were recruited. Groups were held in private community rooms on the first floor of the independent living facilities.

Table 1. Site Descriptions.

<b>Site Name</b>	<b>Address</b>	<b>Management</b>	<b>Population</b>	<b>Years with RHWP</b>
Dominion Place	1025 W. Grace St.	Beacon Community	247	4
4 <sup>th</sup> Avenue	1611 4 <sup>th</sup> Ave.	Richmond Redevelopment Housing Authority	105	2
Highland Park	1221 E. Brookland Park Blvd	Community Preservation and Development Corporation	80	2
Randolph Place	300 Randolph St.	Better Housing Coalition	50	2

These four sites have established long-standing, collaborative services with Virginia Commonwealth University (VCU) through the Richmond Health and Wellness Program (RHWP). RHWP is an interprofessional care coordination and wellness clinic led by a multidisciplinary team of VCU faculty. Faculty members include a pharmacist and director of VCU's geriatric pharmacotherapy program, a licensed nurse practitioner and assistant professor in the VCU school of nursing, a licensed clinical social worker and adjunct faculty member of the VCU school of social work, gerontologists, and a licensed clinical psychologist and assistant professor in the VCU department of psychology. These faculty members supervise graduate level students of various healthcare disciplines for the dual purpose of educating students and providing direct care to underserved older adults. Under the supervision of faculty members,

graduate students meet with residents in a multidisciplinary team format to provide coordination of care, medication management services, health literacy services (e.g., glucometer use), and brief medical services (e.g., blood pressure checks, blood glucose checks) to residents. RHWP provides these clinical services one site at a time; RHWP holds half day clinics at three sites each week (4<sup>th</sup> Avenue, Highland Park, and Randolph Place) and a full clinic day at one site each week.

**Recruitment.** Participants were recruited on-site through printed advertisements in the facility and brief in-person introductions to the study by the author and members of RHWP. Printed flyers for the study were posted on the public bulletin boards located in each site's lobby, first floor hallway, and community rooms. Approval was obtained by the site supervisors to post these flyers. The flyers were site specific; flyers across sites use nearly the same wording but differ in their title due to site name. An example of the Dominion Place flyer is located in Appendix B. Next to these flyers on the bulletin board the author posted a grief support group FAQ to provide background information on typical grief support groups for potential participants who were not familiar with the structure or content of support groups (Appendix C). Additionally, half sheet flyers were offered in-person to residents by the author and members of RHWP while on-site (Appendix D). Members of RHWP and the flyer clearly communicated that involvement or declined involvement in the research study did not influence their relationship with the RHWP clinic in any way, and that the groups were a separate service from the clinic. RHWP has similarly offered referrals and resources to residents in this same manner. For example, the clinic has served as a tool for reminding residents of available on-site programs organized by the facility's management (i.e., chair yoga, food donations), and activities run by

community partnerships (i.e., health literacy didactics, “friendship programs” of local older adult communities).

The author conducted “Town Hall” meetings at each site to provide residents with a brief introduction to general grief concepts and inform the residents of the upcoming research groups to be offered at their site. These Town Hall meetings are conducted an average of once a quarter at each site, though the frequency of these meetings is variable by site. Town Hall meetings are organized by site staff to provide residents with regular updates on programs and general housekeeping items. RHWP and other community partnerships have frequently collaborated with site staff on the content of these meetings to advertise upcoming activities or provide behavioral health techniques. Recent Town Hall didactics of this form include insomnia/sleep hygiene, tools for medication management, and a wide overview of cancer diagnosis terminology. The author conducted a Town Hall didactic on grief terminology and health effects of bereavement. Following the meeting, the residents were offered flyers for the current research project.

Both the flyers posted on the community bulletin boards and the half sheet flyers offered in person had a phone number for potential participants to call and set up a screening appointment to see if they are eligible to participate in the study. The phone number was created by the author using Google Voice, a free phone number that individuals can set up in order to answer calls through one’s personal cell phone without advertising one’s cell phone number. Potential participants set up a screening appointment by contacting the author through the Google Voice number or by approaching the author in person while she is on-site.

Finally, Dominion Place participates in a monthly newsletter program that is distributed to the residents. This newsletter includes a section describing upcoming site events and a monthly calendar of on-site activities. The author received permission from the newsletter’s staff

organizer to advertise the research study on both the upcoming event section and the calendar portion of this newsletter across the months of the research study.

**Inclusion/Exclusion Criteria and Screening.** Potential participants who expressed interest in the study were screened for eligibility with a brief in-person meeting with the author or research assistants of the author. Eligibility criteria were that the participants must be at least 55 years of age, living at the site in which the intervention was delivered, speak and read English, and had experienced the death of someone close to them. Participants were asked a verbal screening script (Appendix E) to assess their eligibility. If the potential participant was eligible, study staff administered the Mini-Cog, a brief neurocognitive screener developed to discern symptoms of dementia in community samples of older adults (Borson Scanlan, Brush, et al., 2000). The Mini-Cog is a composite of a three-item recall and a clock drawing task, with possible scores ranging from 0 to 5 and scores less than 3 indicating positive screens for dementia (Borson, Scanlan, Brush, et al., 2000). If the potential participant screened negatively for cognitive impairment on the Mini-Cog, they were given a brief overview of the study and invited to review and sign the study consent form. After consent, completion participants then completed the Demographics Questionnaire and the Characteristics of the Loss Questionnaire. These questionnaires are explained in further detail in the Measures section. Together, the recruitment and screening process was conducted over two weeks.

### **Intervention Procedures**

The present intervention consolidated the thematic arc of Neimeyer and colleague's Meaning in Loss Group (MLG; Neimeyer et al., 2016). Neimeyer has encouraged creative adaptation of the MLG's basic structure, and various trials of this group model for the bereaved are currently under development (2016). Please see Appendix A for the manual of the group

developed and a detailed explanation of its theoretical grounding. The adapted sessions and modules address the same major themes of the original MLG protocol. The intervention adjusts the original MLG modules to visual art modalities designed to promote the same themes. Table 2 provides a summary of the new group format, and the following sections detail the theoretical background of each visual art module incorporated into the adapted MLG format.

Table 2. Intervention Session Overview.

<b>Session</b>	<b>Phase</b>	<b>Visual Art Technique</b>	<b>Summary description</b>
1	Introduction, Reopening the Story	Introducing the Loved One Collage	Introductions, reminders regarding confidentiality, and group norm setting. Create collage that describes who the deceased was to the participant, their special qualities, and where the participant is right now in their grief. Optional sharing of collages.
2	Processing the Event-Story of the Loss	Loss Road Map	On paper draw metaphorical “road map” of loss, including significant points of transition, noting emotional response to each and symbolizing different life markers. Share with partner, who then reports to the group. Plan one concrete step to take in the next week in a hopeful or healing direction.
3	Exploring Sources of Meaning	Virtual Dream Story Board	Introduce and discuss the Dual Process Model and the Meaning Reconstruction Model as guides for interpreting and making meaning of the loss experience. Lead participants through the Virtual Dream Story Board. This exercise entails drawing a symbolic story about the loss to place the death in perspective and consider its implications for the future.
4	Consolidation, Mobilizing Systems, Termination	--	Recap the group members’ experiences. Revisit therapeutic goal sand discuss the future. Discuss mobilizing systems and provide participants with list of local grief resources. Participants fill out survey packet. Process end of group and future goals.

## **Visual Art Activities.**

*Introducing the Loved One Collage.* In early sessions of Neimeyer and colleagues' MLG, participants were *Reopening the Story* about their loss through *Introducing the Loved One* to members with dialogue. Participants were asked to introduce the group to the deceased, reviewing the character of the relationship during life and validating the loved one's special qualities. Group members were also invited to share meaningful objects related to the deceased. The present intervention adjusted this module by asking participants to attend to these prompts through the creation of a collage about their loved one (see Figure 2 for a completed example). Participants will glue magazine cut outs and other drawings to colored paper that represent their relationship with their loved one. Participants are then given the opportunity to share their collages with the group. Collage is a well-documented method of grief processing that promotes an effective, non-judgmental avenue for emotional insight, mindfulness, and meaning reconstruction (Strouse, 2014). Collages can serve as visual representations of important grief experiences, such as efforts to reaffirm or reconstruct a system of beliefs that has been challenged by loss (Sands, Jordan, & Neimeyer, 2012) and offer a creative process that facilitates the exploration of self-identity (Strouse, 2013). By adjusting the form in which participants are asked to introduce their loved one, participants receive the same prompts as the original MLG *Reopening the Story* preliminary session but explore its themes in an art activity of reflection and engagement.

Figure 2. Example of an Introducing the Loved One Collage.



*Loss Road Map.* The original MLG format uses the *Loss Time Line* module to help participants *Process the Event Story of the Loss*. Group members complete this module by plotting their life trajectory on paper, including significant points of transition and loss, noting emotional response to each and symbolizing or naming different life ‘chapters’ (Neimeyer, 2016). The present intervention adjusted this module to emphasize creative processing with metaphor, a technique used often in grief therapy to elucidate internalized experiences (Davies, 2014). See Figure 3 for a completed example. Visual metaphors have been documented as enhancements to traditional forms of self-narrative exploration (Davies, 2014). Participants will complete a visual art module in which they draw a “road map” of their loss experience. Participants are encouraged to implement metaphor into their road maps; for example, using the size of the road to indicate the strength of the relationship with the deceased, or drawing construction signs during times of adjustment.

Figure 3. Example of a Loss Road Map.

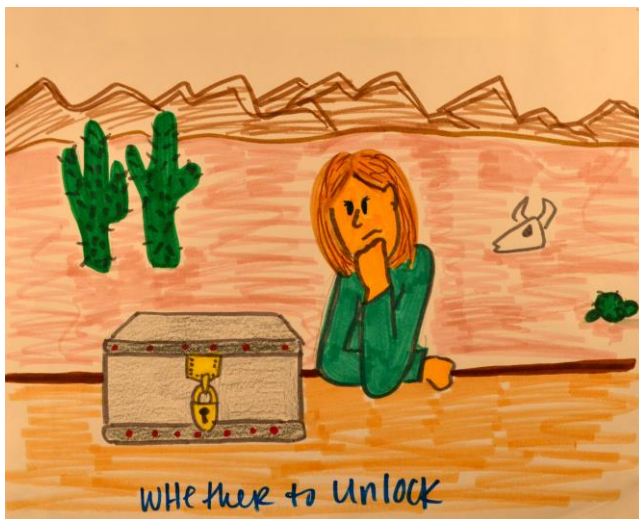


**Virtual Dream Story Board.** MLG provides the *Virtual Dream Story* module for participants to engage in the *Consolidation* of the meanings they construct about their loss (Neimeyer, 2016). This exercise entails writing a symbolic story about loss to place the death in perspective and consider its implications for the future. Facilitators guide the exercise by suggesting that writers include, in whatever way they choose, an assigned list of six elements, two of which typically refer to the setting of the narrative (e.g., a mountain trail, a tragi loss), two of which are figures with “voice” or intention (e.g., a crying child, a talking animal), and two of which represent potentially symbolic objects or events (e.g., an empty house, a rusted chest; Neimeyer & Young-Eisendrath, 2014). For example, participants might be invited to write a virtual dream story that contains the following elements: 1) a violent storm, 2) an empty playground, 3) a lonely wanderer, 4) a whispering wind, 5) a candle, 6) a full moon. Such stories nearly always reflect important themes in how the authors have dealt with their loss, even if the literal plot of the story differs greatly from their own (Neimeyer & Young-Eisendrath, 2015).



The present intervention adjusts this module by replacing its expressive writing modality with one of visual art. Participants are provided 6 elements, taken from the same published list of dream story prompts, and will be asked to draw a metaphorical picture or series of pictures about loss that includes visual depictions of these words. Figure 4 exhibits an example of a completed Virtual Dream Story Board.

Figure 4. Example of a Virtual Dream Story Board.



**Additional Session Components.** Sessions make use of a recurrent structure featuring dyadic interaction among members, followed by whole group processing to promote high levels of empathy and engagement, as well as homework of both a reflective and action-oriented character. Periodic psychoeducation about theories of grief (e.g., the DPM) and sources of meaning (e.g., creative and spiritual) are used to scaffold assignments to confront avoidance, extend the loved one's legacy, and rebuild a life of purpose and meaning.

## Measures

**Demographic Questionnaire.** (Appendix F). Contains general demographic information such as age, gender, ethnicity, marital status, religious affiliation, and years of education.

**Characteristics of Loss.** (Appendix G). A brief survey regarding the circumstances of their loss and their relationship with the deceased. These questioned will include: relationship to the deceased, age of the deceased at the time of death, time elapsed since the loss occurred, circumstances of the death (*accident, illness, homicide, or suicide*), grief support resources received for the loss (*grief support group, individual counseling, faith/prayer group, talked with a spiritual leader about my loss, talked with friends/family about my loss, none of these, other*), relationships to the decedent in other loss experiences, and number of total losses in the past two years.

**The Patient Health Questionnaire—2.** (Kroenke, Spitzer, & Williams, 2003; Appendix H). The Patient Health Questionnaire—2 (PHQ-2) inquiries about the frequency of depressed mood and anhedonia over the past two weeks. Participants are asked to rate how often they have been bothered by particular problems over the past two weeks on a Likert scale (not at all = 0, nearly every day = 3). The PHQ—2 asks about the following two problems: (1) little interest or pleasure in doing things; (2) feeling down, depressed or hopeless. A PHQ—2 score ranges from 0—6, and the authors have identified a PHQ—2 cutoff score of 3 as the optimal cut point for screening purposes (Kroenke, Spitzer, & Williams, 2003). The PHQ—2 was validated on a sample of 6000 patients in 8 primary care clinics and 7 obstetrics-gynecology clinics. Construct validity was assessed using the 20-item Short-Form General Health Survey, self-reported sick days and clinic visits, and symptom-related difficulty. Criterion validity was assessed against an independent structured mental health professional interview in a sample of 580 patients, which revealed that PHQ-2 scores equal or greater to 3 had a sensitivity of 83% and a specificity of 92% for major depression (Kroenke, Spitzer, & Williams, 2003).

**Integration of Stressful Life Experiences Scale.** (Holland, Currier, Coleman, & Neimeyer, 2010; Appendix I) The Integration of Stressful Life Experiences Scale (ISLES) was created as a general-purpose measure of meaning made of stress. Based on Park's (2010) integrated model of making meaning of stressful life events, the ISLES assess the degree to which there is (or is not) a discrepancy between the situational meaning made of a particular life event (i.e., appraisals and reappraisals of the event and its significance or meaning) and one's sense of global meaning (i.e., overall beliefs, goals, and worldviews). The ISLES has been shown to have great relevance for individuals who have lost a loved one in a number of studies (i.e., Burke et al., 2014; Holland, Currier, & Neimeyer, 2014; Holland et al., 2010; Lee, Feudo, & Gibbons, 2014; Lichtenthal, Burke, & Neimeyer, 2011). The ISLES is a theoretically derived measure, and candidate items were developed by considering the question, "If we wanted to assess meaning made of stress in a clinical context, what would we ask our clients?" This pool of items was then scrutinized by the research team, and items deemed to be not representative of the construct or overly redundant were removed. This process resulted in 30 candidate items for further investigation (Holland, Currier, Coleman, & Neimeyer, 2010). Following extensive psychometric analyses, the initial pool of 30 candidate items was then winnowed down to the 16 best-performing items, which make up the full version of the ISLES (Holland et al., 2010). Multiple studies have identified the presence of two related ISLES factors (Currier et al., 2013; Holland, Currier, Coleman, & Neimeyer, 2010; Holland, Currier, & Neimeyer, 2014). The first factor is labeled *Comprehensibility*, which assesses the extent to which someone has been able to make sense of a loss or other stressor and adaptively integrate it into some larger framework for understanding themselves, others, and the world around them. The second factor is *Footing in the World*, which may be conceptualized as an assessment of the extent to which the world in

general does or does not make sense in the aftermath of a significant life event like bereavement. The ISLES can be scored by summing items together after reverse-coding item 2. A total score of the ISLES or two separate subscale scores (for Comprehensibility or Footing in the World) may be derived. All items are scored so that higher scores indicate more adaptive meaning made of a stressful life event. Though clear cutoffs for the ISLES have yet to be established, unpublished data indicate that a total ISLES score of 52 or below can correctly classify bereaved individuals as having elevated complicated grief symptoms with 90% sensitivity and 74% specificity (Holland, 2016).

In its initial validation study, the ISLES was shown to have strong internal reliability ( $\alpha = .80$  to  $.92$ ), moderate test-retest reliability over 2-3 months ( $r = .48$  to  $.59$ ) and concurrent validity with other meaning-oriented measures (Holland et al., 2010). A factor analytic study has demonstrated the distinctiveness of ISLES scores from posttraumatic stress symptoms and general psychiatric distress (Currier et al., 2011). Preliminary findings also support the use of the ISLES as an assessment tool for tracking changes over time in meaning made of loss (Holland et al., 2010). The ISLES has been used in a recent clinical trial; in this study it was able to successfully detect treatment-induced changes in meaning made of a variety of stressors (Holland, Chong, Currier, O'Hara, & Gallagher-Thompson, 2015).

**Grief and Meaning Reconstruction Inventory.** (Gillies, Neimeyer, & Milman, 2015; Appendix J) The Grief and Meaning Reconstruction Inventory (GMRI) was developed to assess the degree and type of meanings made in the wake of loss for use in research and clinical settings. The content for the GMRI was derived from a purposive sample of 162 bereaved adults who were selected to ensure considerable diversity in ethnicity, age, cause of death, and level of grief distress. Their narrative responses to questions about their meanings made about their loss

were categorized (Gillies et al., 2014) and 65 representative Likert scale items were constructed to capture the range of meanings made across these categories (Neimeyer, Gillies, & Milman, 2016). A second sample of 332 adults bereaved in the last two years completed this preliminary version of the GMRI, and a subsequent factor analysis, along with validity and reliability testing, winnowed the responses to the finalized version of 29 items (Gillies, Neimeyer, & Milman, 2015). Items are rated on a 5-point Likert scale, ranging from Strongly Disagree to Strongly Agree. The items factor into the five following subscales: Continuing bonds, personal growth, sense of peace, emptiness and meaninglessness, and valuing life. The total score on the GMRI represents the sum of all items, with Factor 4 items reverse scored so that higher values on all factors represent better adjustment. The validity of the GMRI is supported by its significant negative correlation with the HGRC factors measuring grief-related Despair ( $r = -.29$ ), Blame and anger ( $r = -.26$ ), Detachment ( $r = -.32$ ), and Disorganization ( $r = -.25$ ). Significant positive correlations were found between the HGRC's Personal growth factor and both the GMRI total ( $r = .35$ ), and GMRI Factor 2, Personal growth ( $r = .54$ ; Gillies et al., 2014). In addition to its use in research on the process and outcome of meaning-making in bereavement and the efficacy of grief therapy, the GMRI has been found useful in both documenting therapeutic progress through its periodic administration across treatment and in targeting areas deserving of closer clinical assessment and intervention (Neimeyer, Gillies, & Milman, 2016).

**Inventory of Social Support.** (Hogan & Schmidt, 2002; Appendix K). The Inventory of Social Support (ISS) is a brief unidimensional measure that captures social support for grieving as experienced by the bereaved individual. The measure consists of five items that tap the attributes of this support. These include content related to (a) others taking the time to listen to the bereft, (b) the opportunity to express feelings openly and honestly, (c) a nonjudgmental

stance of others, (d) the availability of at least one person to the bereft, and (e) getting help for grieving. Items are scored using a 5-point Likert-type scale. Respondents are asked to use the prior two weeks as a time dimension in rating the items. The measure is scored by adding the response values for each item and dividing this value by the number of items in the scale.

Cronbach's alpha internal consistency for this scale was .76 in a sample of 209 bereaved parents (Hogan & Schmidt, 2002). The correlation between responses over a 14-day period was .86. In a separate study, the ISS was compared to the HGRC and other grief measures in a sample of family members who experienced the loss of a loved one over a period of 25 months (Hogan, Schmit, & Coolican, 2014). A positive association between social support and personal growth was found across time, the strongest occurring at the 13-month time point ( $r = .53, p < .001$ ), followed by 6 months ( $r = .43, p < .001$ ) and 25 months ( $r = .30, p = .006$ ). Social support was negatively related to the core grief variables of despair and detachment at all time points (despair:  $r = -.24, r = -.33, r = -.32$ ; detachment:  $r = -.35, r = -.29, r = -.36$ , all  $p < .05$ , at 6, 13, and 25 months, respectively). The mean values from the ISS did not change significantly over time  $F(2, 38) = 2.00, p = .154$  (Hogan et al., 2014).

**Creative Achievement Questionnaire.** (Carson, Shelley, Peterson, Higgins, & Daniel, 2005; Appendix M). The Creative Achievement Questionnaire asks participants to indicate the extent to which their creative achievements have been recognized across 10 domains (visual arts, music, dance, architectural design, creative writing, humor, inventions, scientific discovery, theater/film, culinary arts). It is a self-report measure consisting of 96 items. The current study will administer only the items factoring on to the visual arts domain. Participants are asked to check mark besides sentences that apply to them (i.e., I have no training or recognized talent in this area; I have taken lessons in this area). Cronbach's alpha internal consistency for this scale

was .81 in a sample of 117 college students (Carson, Shelley, Peterson, Higgins, & Daniel, 2005). Test-retest reliability was consistent with standard levels of acceptance ( $r = .81$ ).

**Kaufman Domains of Creativity Scale.** (Kaufman, 2012; Appendix M). The Kaufman Domains of Creativity Scale (K-DOCS) assess self-perceptions of domain-specific creative ability. Rather than focusing on straightforward reporting of participation in creative activities, the K-DOCS focuses on self-beliefs about one's creative abilities in the context of one's peers. For example, the K-DOCS asks, "Compared to people of approximately your age and life experience, how creative are you at \_\_\_\_\_?" The K-DOCS is comprised of five subscales: Self/Everyday, Scholarly, Performance (music and writing), Mechanical/Scientific, and Artistic. The present study will collect only the Artistic domain of the K-DOCS, as it focuses exclusively on visual art activities. The overall measure produces a score of self-perceptions of creativity by adding the response values for each item within the factors, produced from a factor analysis of 2,318 college student responses. Coefficient alpha reliabilities for the five scales were all at least .80, indicating adequate internal consistent reliability (Kaufman, 2012). Similar to the other domains, test-retest reliability is moderate for the Artistic domain: ( $r = .81$ ).

**Program Evaluation Questionnaire.** (Appendix N). Participants completed a brief questionnaire about their experiences participating in the study on the last day of the intervention and at follow up. Participants were asked to rate how strongly they agree (on a scale of *Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, and Strongly Disagree*) with the following statements: I enjoyed my participation in this program; I learned new ways to cope with my grief; This program provided a safe place to talk about my grief with others; I feel more comfortable talking about my loss than before this program; I feel more confident in my ability to cope with my grief than before this program. Participants were also asked to what extent each

group activity helped them explore their goals for the future, make sense of their loss, and reflect on their relationship with their loved one. Participants were provided space on the questionnaire to write additional comments, reflections, or questions about their experience in the present study.

### **Data Analyses**

**Hypothesis 1: Meaning Made from the Loss.** Participants will report increased rates of meaning made from their loss across study time points.

**Statistical Test.** A repeated measured analysis of variance (ANOVA) was conducted to test the effects of time on meaning made as measured by total ISLES scores. Similarly, a repeated measured ANOVA was conducted to test the effects of time on meaning made as measured by total GMRI scores.

**Hypothesis 2: Continuing Bonds.** Participants will report higher rates of adaptive continuing bonds with the deceased across study time points.

**Statistical Test.** A one-way repeated measured analysis of variance (ANOVA) was conducted to test the effects of time on continuing bonds as measured by the *Continuing Bonds* subscale of the GMRI.

**Hypothesis 3: Depressive symptoms.** Participants will report lower rates of depressive symptoms across study time points.

**Statistical test.** A one-way repeated measured analysis of variance (ANOVA) was conducted to test the effects of time on depressive symptoms as measured by the Patient Health Questionnaire—2 (PHQ-2).



**Hypothesis 4: Complicated Grief Symptoms.** Participants who screened positively for complicated grief will demonstrate greater alleviation of their negative grief symptoms than participants with lower rates of complicated grief symptoms.

**Statistical Test.** Bivariate Pearson's correlations were conducted on negative grief symptoms and treatment outcome variables. The tests were two-tailed because there are no strong theoretical rationales for predicting directionality. Alpha levels of .05 were used as this is considered a conservative level in psychological research. No variables were controlled for due to lack of literature to support such a decision.

**Hypothesis 5: Social Support.** Participants will endorse higher rates of perceived social support for their loss following their participation in the study than at baseline. Higher perceived social support will be positively associated with personal growth, as measured by the *Personal Growth* subscale of the GMRI. Higher perceived social support will be negatively associated with functionally impairing grief symptoms, as measured by the *Emptiness and Meaninglessness* subscale of the GMRI. Lastly, higher perceived social support will be negatively associated with depressive symptoms, as measured by the PHQ-2.

**Statistical test.** A one-way repeated measured analysis of variance (ANOVA) was conducted to test the effects of time on perceived social support as measured by the ISS. Bivariate Pearson's correlations were conducted to test for relationships between the scores of the ISS, *Personal Growth* subscale of the GMRI, and the *Emptiness and Meaninglessness* subscale of the GMRI. The tests were two-tailed.

**Exploratory Analyses: Creative Self Efficacy.** Per a thorough review of the literature, no bereavement studies to date have investigated participants' propensity for creative activities or artistic self-beliefs as potential predictors of expressive art treatment outcomes. Thus,

exploratory data analyses examined the impact of participants' creative self-efficacy, as measured by the Kaufman Domains of Creativity Scale (K-DOCS), on outcome measures. The following treatment outcomes were examined: meaning made of the loss (total scores of the ISLES and GMRI); continuing bonds with the deceased (*Continuing Bonds* subscale of the GMRI), negative grief symptoms (*Emptiness and Meaninglessness* subscale of the GMRI), depressive symptoms (PHQ-2), perceived social support (ISS), and Program Evaluation scores.

**Statistical Test.** Bivariate Pearson's correlations were conducted on the K-DOCS, total scores on the ISLES and GMRI, *Continuing Bonds* subscale of the GMRI, *Emptiness and Meaninglessness* subscale of the GMRI, PHQ-2, ISS scores, and Program Evaluation responses. The tests were two-tailed because there were no strong theoretical rationales for predicting directionality.

**Exploratory Analyses: Rates of Engagement.** Exploratory analyses will be run to investigate the impact of participants' loss characteristics and baseline outcome data on their rates of engagement in the study, as measured by number of sessions attended.

**Statistical Test.** Two-tailed Bivariate Pearson's correlation were conducted to explore possible association between participants' rates of engagement (as measured by number of sessions attended), continuous characteristics of the loss variables (e.g., expectedness of the loss, decedent age), and the following outcome measures at baseline: K-DOCS, total scores on the ISLES and GMRI, *Continuing Bonds* subscale of the GMRI, *Emptiness and Meaninglessness* subscale of the GMRI, PHQ-2, and ISS scores. An independent samples t-test was conducted to explore whether participants who screened positively for complicated grief at baseline (as measured by a  $\leq 52$  ISLES score) had significantly different rates of study engagement than their subthreshold counterparts.

## Results

### Enrollment and Rates of Engagement

A total of 562 individuals reside in the four apartment complexes that served as recruitment and intervention sites for this study. Recruitment material was hung in the first-floor common areas of the sites and was included in a quarterly newsletter administered to all residents by site staff. As summarized in Figure 5 (enrollment and rates of compliance consort diagram),  $n = 32$  (6% of total residents across sites) proceeded to the study screen. To determine study eligibility, those interested were screened for age and endorsement of experiencing the death of a loved one using open-ended interview-format questions (see Appendix E, Verbal Screening Script). Among those screened, 84% met eligibility criteria and were administered the Mini-Cog (Borson et al., 2000) to screen for cognitive capacity to consent to the study. All potential participants who completed the Mini-Cog scored below the clinical threshold for cognitive impairment and were invited to review informed consent about the study. Of these, 93% ( $n = 25$ ) provided written consent to the study. Across all sites, nearly all individuals who provided verbal consent attended Session One ( $n = 24$ ; 96%). As depicted in Figure 6, rates of compliance across all sites were quite high, with 83% of participants ( $n = 20$ ) completing more than one session. A majority of participants ( $n = 19$ ; 79%) completed three or more sessions. Seventy nine percent of participants ( $n = 15$ ) completed the one-month follow-up after attending all four sessions.

Figure 5. Enrollment and Rates of Engagement Consort Diagram.

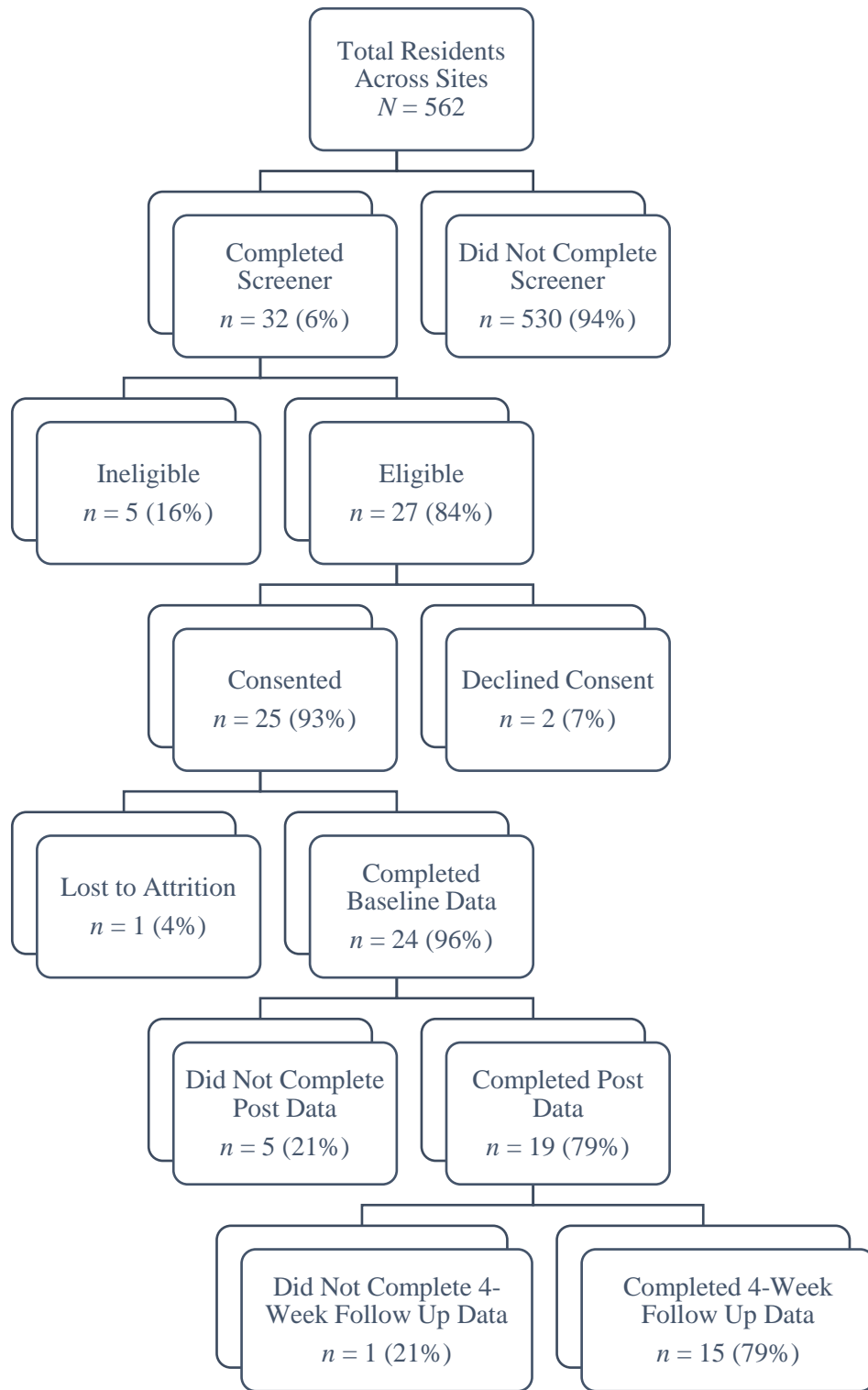
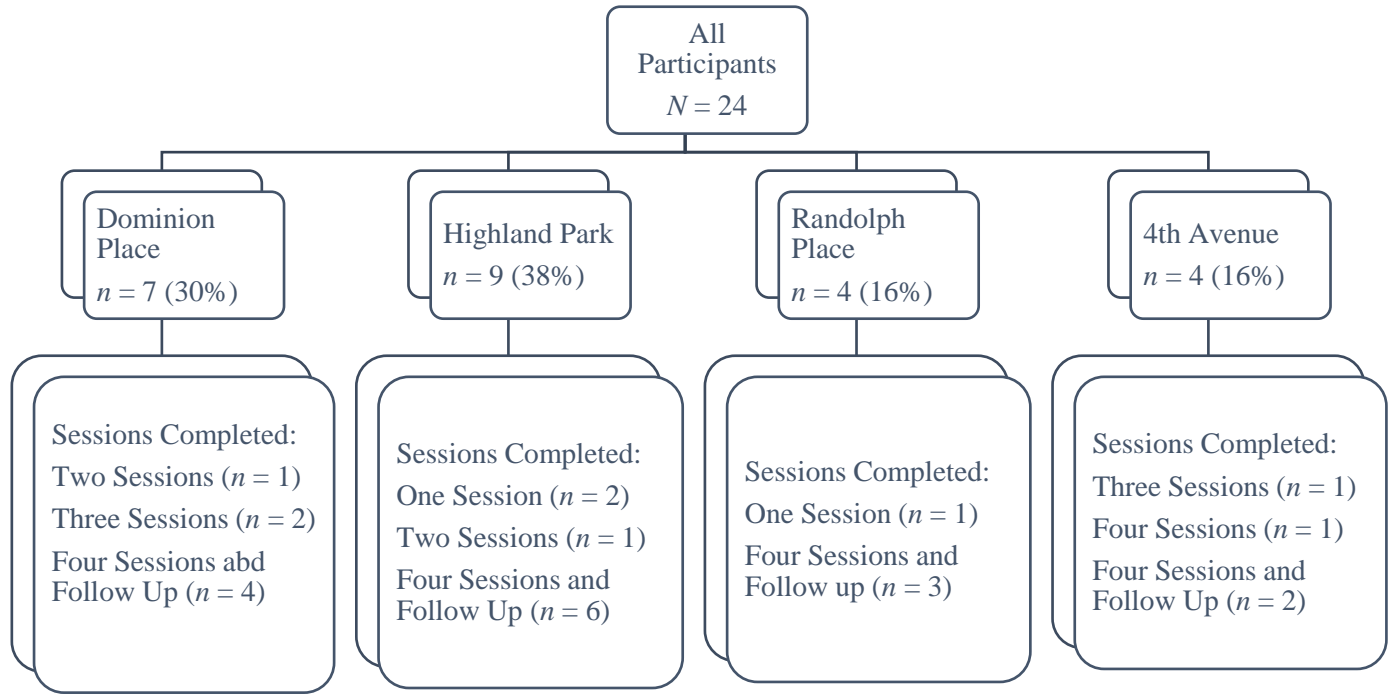


Figure 6. Rates of Engagement Across Sites.



### Sample Demographics

Separate descriptive statistics were calculated for the continuous demographic variables of both the original baseline sample ( $n = 24$ ) and the final sample of participants who completed all four sessions with follow-up ( $n = 15$ ). Of note, all individuals in the latter sample were also represented in the original baseline sample given the cohort's 100% attendance rate.

In regard to the demographics of the original baseline sample (summarized in Table 3), age of participants ranged from 59 to 75 with a mean of 68.4 years based on the inclusion criteria chosen for the study sample. Age was the only analyzed variable that was skewed or kurtotic. Frequencies were calculated for each of the categorical demographic variables gathered in this study. These variables included gender, ethnicity, class rank, marital status, and religious affiliation. The original baseline sample was predominantly female (83%). The majority of this sample identified as Black/African American (83%), and 17% of participants identified as

White/Caucasian. Baseline participants' years of education ranged from 8 to 21 years with a mean of 12.4 ( $SD = 3.5$ ). Most individuals described their marital status as single (46%) with the remaining participants reporting as divorced/separated (33%) or widowed (21%). The baseline sample participants were evenly split in reporting whether they were religiously affiliated (50%) or unaffiliated (50%). Specifically, they identified as Baptist (13%), Non-Denominational Christian (2%), and "Hebrew/Jewish" (2%).

Table 3.

<i>Demographic variables of the baseline sample</i>			
Variable	Frequency	Percentage	M (SD)
<b>Gender</b>			
Female	20	83	
Male	4	17	
<b>Age</b>			68.4 (4.9)
<b>Ethnicity</b>			
Black/African American	20	83	
White/Caucasian	4	17	
<b>Years of Education</b>			12 (3.5)
<b>Marital Status</b>			
Single	11	46	
Divorced/Separated	8	33	
Widowed	5	21	
<b>Religious Affiliation</b>			
Affiliated	12	50	
Unaffiliated	12	50	

*Note:* Calculation of percentages are based on the sample ( $N = 24$ ). There were no missing data present for the frequencies above.

In regard to the final sample of participants who completed all four sessions and follow-up ( $n = 15$ ), the age of participants ranged from 59 to 75 with a mean of 69.5 years. Age was the only analyzed variable that was skewed or kurtotic. As seen in Table 4, the final sample is predominantly female (87%). The majority of the sample identified as Black/African American (93%), and 7% of participants identified as White/Caucasian. The final sampled participants' years of education ranged from 8 to 21 years with a mean of 13.5 ( $SD = 3.6$ ). Most of the

individuals in this sample described their marital status as single (53%) with the remaining participants reporting as divorced/separated (33%) or widowed (13%). Participants were nearly evenly split in reporting whether they were religiously affiliated (53%) or unaffiliated (47%).

Table 4.

*Demographic variables of the final sample*

Variable	Frequency	Percentage	M (SD)
<b>Gender</b>			
Female	13	87	
Male	2	13	
<b>Age</b>			69.5 (4.4)
<b>Ethnicity</b>			
Black/African American	14	93	
White/Caucasian	1	7	
<b>Years of Education</b>			13.5 (3.6)
<b>Marital Status</b>			
Single	8	53	
Divorced/Separated	5	33	
Widowed	2	13	
<b>Religious Affiliation</b>			
Affiliated	8	53	
Unaffiliated	7	47	

*Note:* Calculation of percentages are based on the sample ( $n = 15$ ).

There were no missing data present for the frequencies above.

One-way ANOVA analyses were used to determine if differences existed between sites for continuous demographic variables (i.e., participant age, years of education) and continuous loss characteristic variables (i.e., months since loss, age of decedent, closeness to the deceased) for the full original baseline sample ( $N = 24$ ) and the final sample of participants who completed all time points ( $n = 15$ ). No significant differences in these variables were found between sites for either sample group. Chi-Square Tests of Independence were used to determine if differences existed between sites for categorical demographic variables (i.e., gender, ethnicity, marital status). No comparisons of difference scores for these categorical variables by site group were significant within either sample group.

## Loss Characteristics

Descriptive statistics were calculated for characteristics of the loss based on items developed for the study by the researchers (Appendix G). The questionnaire instructed participants to respond regarding their most significant loss experience if they had experienced the death of more than one loved one, and participants were asked to respond in accordance to whose death currently most affects them. Variables included the participants' relationship to the deceased, the time since loss, circumstance of the loss, and expectedness of the death, among others. Table 5 summarizes the descriptive and frequency data for these variables.

Most participants identified their loss figure as an immediate family member or spouse/partner (84%). The remaining participants reported having lost an extended family member or friend (16%). Decedent age at their time of death varied widely across participants, ranging from one year to 89 years old with a mean of 61 years ( $SD = 24.2$ ). The majority of participants reported that the death of their loved one occurred as the result of an illness (75%), with the remainder of participants reporting the loss occurring as a result of an accident (12.5%) or homicide (12.5%). Using these types of loss to categorize the loss as violent (i.e., suicide, homicide, or accident) or non-violent (i.e., illness), the majority of participants reported a non-violent loss (75%). In reporting the expectedness of their loss, most participants reported their loss as unexpected (47%).



Table 5.

<i>Frequencies and Percentages for Characteristics of the Loss</i>			
Variable	Frequency	Percentage	M (SD)
<b>Relationship to the Deceased</b>			
Parent	10	42	
Sibling	4	16	
Spouse/Partner	3	13	
Child	3	13	
Niece/Nephew	2	8	
Friend	1	4	
Grandchild	1	4	
<b>Circumstance</b>			
Illness	18	75	
Accident	3	12.5	
Homicide	3	12.5	
<b>Expectedness of the Loss</b>			
Very Expected	4	16	
Expected	5	21	
Unexpected	11	47	
Very Unexpected	4	16	
<b>Time Since Loss (Years)</b>			10.2 (11.6)
<b>Closeness to the Deceased</b>			9.1 (1.4)

*Note:* All percentage values are calculated based on the full sample ( $N = 24$ ). There were no missing data present for the frequencies above.

As summarized in Table 6, participants were asked about the supportive resources they had participated in as a means of coping with their loss. Participants could choose multiple resources they had engaged in. The majority of participants reported that they had not participated in any form of grief support for their loss, though 32% of participants reported that they had talked with friends or family about their loss.

Table 6.

<i>Engagement in Grief Resources for the Loss</i>		
Variable	Frequency	Percentage
Grief Support Group	1	4
Individual Counseling	3	13
Faith/Prayer Group	3	13
Talked with a Spiritual Leader about the Loss	2	8
Talked with Friends/Family about the Loss	8	32

*Note:* All percentage values are calculated based on the full sample ( $N = 24$ ). There were no missing data present for the frequencies above.

Participants were asked whether they had experienced other losses that had caused them significant distress. Seventy five percent of participants reported affirmatively; 39% of participants reported one additional loss, 21% reported two additional losses, and 25% reported five or more additional losses that had caused them significant distress. Participants' reported relationships to these decedents included parents, children, siblings, spouses, extended family members and friends.

One-way ANOVA analyses were used to determine if differences existed between sites for continuous loss characteristic variables (i.e., months since loss, age of decedent, closeness to the deceased) for the full original baseline sample ( $N = 24$ ) and the final sample of participants who completed all time points ( $n = 15$ ). No significant differences in these variables were found between sites for either sample group.

### **Symptom Measures**

Descriptive analyses ( $M$ ,  $SD$ ) were conducted on the full attendance sample on symptom measures across time points (see Table 7). Descriptive analyses were also conducted on symptom measures across time points for the 15 participants who attended all four sessions and follow up (see Table 8). Two-tailed Bivariate Pearson's correlation analyses were conducted to explore possible association between outcome measures for the full sample (see Table 9).

Table 7.

*Full Sample Symptom Measurement Means by Time*

	Baseline ( <i>N</i> = 24)	Session Four ( <i>n</i> = 19)	Follow-Up ( <i>n</i> = 15)
PHQ-2	2.08 (1.86)	1.42 (1.71)	0.93 (1.28)
ISS	16.04 (4.97)	17.11 (5.11)	17.20 (4.56)
ISLES	53.91 (12.87)	62.42 (9.97)	56.87 (14.06)
Comprehensibility	15.79 (3.81)	17.16 (3.50)	16.33 (4.10)
Footing in the World	38.00 (9.56)	44.42 (7.62)	40.5 (10.40)
GMRI (total)	69.88 (7.49)	73.58 (6.41)	76.13 (7.04)
GMRI-CB	21.79 (2.72)	22.84 (1.86)	23.4 (2.47)
GMRI-PG	16.00 (2.02)	15.16 (2.75)	23.4 (2.47)
GMRI-SoP	15.13 (2.56)	15.58 (1.61)	16.13 (2.97)
GMRI-EM	12.42 (3.27)	15.16 (3.19)	13.4 (2.10)
GMRI-VL	8.33 (1.23)	8.95 (1.18)	9.20 (1.08)
CAQ	1.61 (0.57)	1.52 (0.22)	1.60 (0.22)
K-DOCS	19.50 (6.35)	24.00 (5.64)	22.13 (6.96)

*Note:* PHQ-2 = Patient Health Questionnaire; ISS = Inventory of Social Support; ISLES = Inventory of Stressful Life Experiences; GMRI = Grief and Meaning Reconstruction Inventory; GMRI-CB = Continuing Bonds subscale; GMRI-PG = Personal Growth subscale; GMRI-SoP = Sense of Peace subscale; GMRI-EM = Emptiness & Meaninglessness subscale; GMRI-VL = Valuing Life subscale; CAQ = Creative Achievement Questionnaire; K-DOCS = Kaufman Domains of Creativity Scale.

Table 8.

*Final Sample Symptom Measurement Means by Time*

	Baseline ( <i>n</i> = 15)	Session Four ( <i>n</i> = 15)	Follow-Up ( <i>n</i> = 15)
PHQ-2	1.80 (1.86)	1.47 (1.55)	0.93 (1.28)
ISS	16.53 (5.42)	17.00 (5.67)	17.20 (4.56)
ISLES (total)	56.13 (11.65)	63.87 (8.89)	56.07 (14.14)
Comprehensibility	16.53 (3.31)	17.33 (3.18)	16.33 (4.10)
Footing in the World	39.60 (8.75)	45.47 (7.32)	40.5 (10.40)
GMRI (total)	72.27 (7.74)	74.13 (6.48)	76.13 (7.04)
GMRI-CB	22.33 (2.72)	23.00 (1.93)	23.4 (2.47)
GMRI-PG	16.80 (1.66)	15.27 (2.74)	23.4 (2.47)
GMRI-SoP	15.53 (2.56)	15.60 (1.77)	16.13 (2.97)
GMRI-EM	12.80 (3.76)	15.33 (2.87)	13.4 (2.10)
GMRI-VL	8.53 (1.19)	9.00 (1.00)	9.20 (1.08)
CAQ	1.62 (0.03)	1.48 (0.24)	1.60 (0.22)
K-DOCS	21.20 (5.16)	24.27 (5.32)	22.13 (6.96)

*Note:* PHQ-2 = Patient Health Questionnaire; ISS = Inventory of Social Support; ISLES = Inventory of Stressful Life Experiences; GMRI = Grief and Meaning Reconstruction Inventory; GMRI-CB = Continuing Bonds subscale; GMRI-PG = Personal Growth subscale; GMRI-SoP = Sense of Peace subscale; GMRI-EM = Emptiness & Meaninglessness subscale; GMRI-VL = Valuing Life subscale; CAQ = Creative Achievement Questionnaire; K-DOCS = Kaufman Domains of Creativity Scale.

Table 9.  
*Pearson Correlation Matrix Among Outcome Measures*

	1	2	3	4	5	6	7	8	9	10
1. PHQ-2	-									
2. ISS	-0.14	-								
3. ISLES (total)	-0.41**	0.06	-							
4. ISLES: Comp	-0.32*	0.08	0.92**	-						
5. ISLES: Footing	-0.43**	0.05	0.99**	0.85**	-					
6. GMRI (total)	-0.30*	0.29*	0.32*	0.23	0.34*	-				
7. GMRI-CB	-0.58	0.30*	0.12	0.04	0.15	0.75**	-			
8. GMRI-PG	-0.22	0.08	-0.06	-0.08	-0.05	0.56**	0.43**	-		
9. GMRI-EM	-0.41**	0.10	0.67**	0.56**	0.68**	0.34**	0.01	-0.07	-	
10. CAQ	-0.12	-0.24	-0.09	-0.07	-0.11	-0.15	-0.17	0.02	-0.24	-
11. K-DOCS	-0.03	-0.14	0.17	0.73	0.20	0.01	-0.16	0.03	0.29*	0.01

*Note:* \* $p < 0.05$ ; \*\* $p < 0.01$ ; PHQ-2 = Patient Health Questionnaire; ISS = Inventory of Social Support; ISLES = Inventory of Stressful Life Experiences; ISLES: Comp = Comprehensibility subscale; ISLES: Footing = Footing in the World subscale; GMRI = Grief and Meaning Reconstruction Inventory; GMRI-CB = Continuing Bonds subscale; GMRI-PG = Personal Growth subscale; GMRI-SoP = Sense of Peace subscale; GMRI-EM = Emptiness & Meaninglessness subscale; GMRI-VL = Valuing Life subscale; CAQ = Creative Achievement Questionnaire; K-DOCS = Kaufman Domains of Creativity Scale.

## Program Evaluation Questionnaire

Participants completed a program evaluation questionnaire created by the authors for the present study. Participants were asked to what extent they agreed or disagreed (one a scale of 1 [Strongly Agree] to 5 [Strongly Disagree]) with evaluative statements about their participation in the study groups. Participants were also asked to what extent each group activity helped them explore their goals for the future, make sense of their loss, and reflect on their relationship with their loved one (see Table 10 for more detail).

Table 10.

<i>Program Evaluation Questionnaire Responses</i>		
	<i>M</i>	<i>SD</i>
I enjoyed my participation in this group.	1.2	0.4
This group provided a safe place to talk about my grief with others.	1.2	0.4
I feel more comfortable talking about my loss than before this group.	1.3	0.5
I feel less alone in my grief than before this program.	1.2	1.2
I feel more confident in my ability to cope with my grief than before this program.	1.5	0.8
The collage I made in the first week of this group...		
helped me reflect on my relationship with my loved one.	1.3	0.5
helped me make sense of my loss.	1.4	0.5
helped me explore my goals for the future.	1.5	0.6
The Loss Road Map activity...		
helped me reflect on my relationship with my loved one.	1.6	0.5
helped me make sense of my loss.	1.5	0.5
helped me explore my goals for the future.	1.7	0.6
The Virtual Dream Story Board activity...		
helped me reflect on my relationship with my loved one.	1.5	0.6
helped me make sense of my loss.	1.5	0.5
helped me explore my goals for the future.	1.7	0.6

*Note:* Values were calculated from the sample that completed all four sessions ( $n = 15$ ). There were no missing data present. Scores were based on the following response scale: 1 = Strongly Agree, 2 = Agree, 3 = Neither Agree nor Disagree, 4 = Disagree, 5 = Strongly Disagree.

One hundred percent of participants who attended all four sessions ( $n = 19$ ) responded that they either “Strongly Agree” or “Agree” with the following items on the Program Evaluation Questionnaire: I enjoyed my participation in this group; This group provided a safe place to talk about my grief with others; I feel more comfortable talking about my loss than before this group. When asked which art activity was found to be most helpful in processing their grief, 90% ( $n = 17$ ) reported that all of the art activities helped them process their grief equally. Participants were provided space on the questionnaire to write additional comments, reflections, or questions about their experience in the present study. Ten participants (67% of those who completed the questionnaire) participants wrote the following reflections:

*“This group open [sic] my eyes to things that I didn’t think much about.”*

*“I hope it helped other people as much as it helped me. I hope others were able to learn from each other and I was able to help others with their grief.”*

*“This was a unique experience.”*

*“This class really helped me express my loss. There were people in the class that felt the same way I did about their loss. I would recommend this class to everyone.”*

*“I realized we all grieve in our own way. Doing the activities with picture and talking help [sic] me to understand about grief.”*

*“This group talked well about goals I hope to make.”*

*“I really fine [sic] it very comfortable in sharing my loss, also I feel a lot better in sharing and being open with people in the group. This has been helpful for me.”*

*“I really open up about the loss in my life. I know how to cope with it better now.”*

*“Was a support in opening up and sharing my feelings.”*

*“We should have programs like this one not only for the loss of our loved but for the loss of residents that live in Dominion Place as well.”*

## Hypothesis Testing

**Evaluation of assumptions.** Outliers, skewness and kurtosis were examined using SPSS 25.01 (IBM Corp, 2017) on measures of meaning made from the loss, continuing bonds with the deceased, negative grief symptoms, depressive symptoms, personal growth, and perceived social support for the loss for each data collection timepoint. No significant outliers were detected on these measures and kurtosis was within acceptable limits considering the sample size (Tabachnick & Fidell, 2001). One-way ANOVA analyses were run with baseline scores as dependent measures to examine whether there were significant differences in baseline measure responses between participants at different sites. No significant differences were found between sites on outcome measures. As previously noted in the demographic results section, analyses found no differences between sites in participants' demographic variables or loss characteristics. Thus, site was not determined to have a significantly influential impact on outcomes and subjects across sites were combined for analyses.

**Hypothesis 1: Participants will report increased rates of meaning made from their loss across study time points.** A one-way repeated measured analysis of variance (ANOVA) was conducted to examine the effects of time on meaning made as measured by total scores on the Integration of Stressful Life Experience Scale (ISLES). Assumptions of linearity, multivariate normality, and heteroskedasticity were examined prior to analysis. The repeated measures ANOVA determined that mean ISLES scores differed statistically significantly between time points,  $F(2, 28) = 4.77, p < .05$ ). As summarized in Table 11, post hoc tests using the Bonferroni correction revealed that ISLES scores significantly increased by an average of 7.7 points between baseline ( $M = 55.9, SD = 11.7$ ) and session four ( $M = 63.7, SD = 9.2; p < .05$ ), and significantly reduced by an average of 7.60 points between session four and the follow up



survey four weeks later ( $M = 56.1, SD = 14.1; p < .05$ ). No significant difference was found in ISLES scores between baseline and one-month follow up ( $p = .10$ ). Figure 7 provides a visual representation of scores over time.

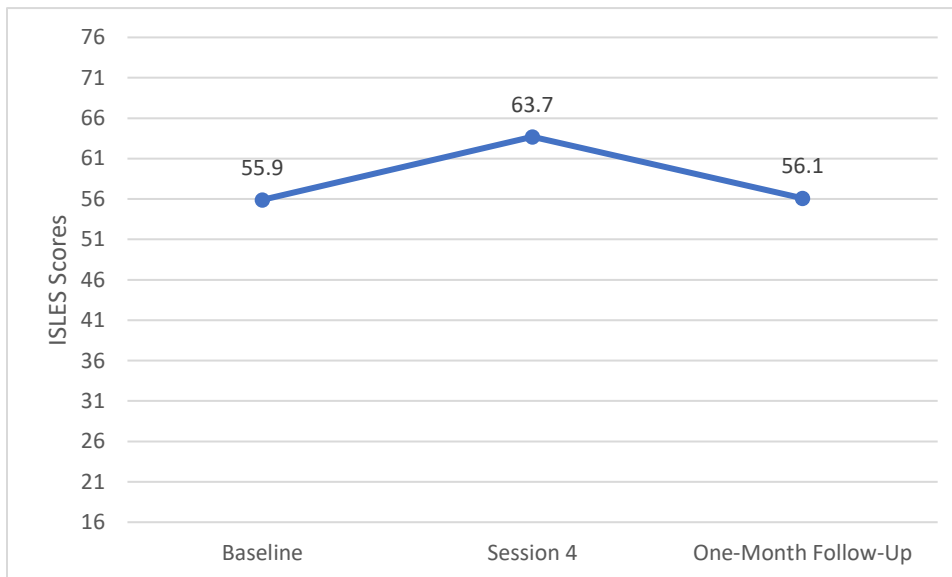
Table 11.

*Bonferroni Comparison for ISLES Scores by Time*

Comparisons	Mean Difference	Std. Error	95% CI	
			Lower Bound	Upper Bound
Baseline vs. Session Four	-7.73*	2.84	-15.47	0.01
Session Four vs. Follow-Up	7.60*	3.23	-1.17	16.37
Baseline vs. Follow-Up	-0.13	2.48	-6.87	6.61

Note: \*  $p < 0.05$

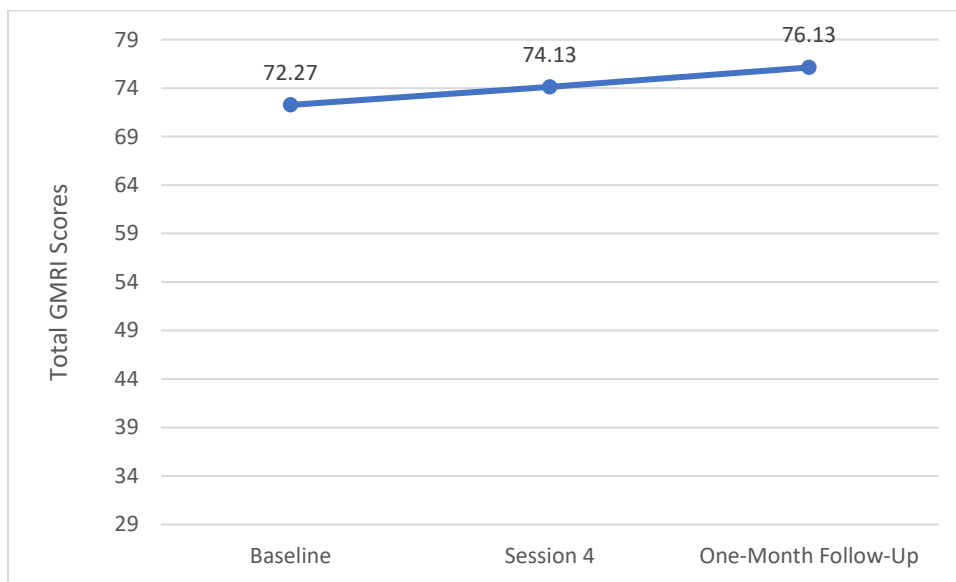
Figure 7. ISLES Scores Over Time.



Similarly, a repeated measured analysis of variance (ANOVA) was conducted to test the effects of time on meaning made from the loss as measured by total GMRI scores. Assumptions of linearity, multivariate normality, and heteroskedasticity were examined prior to analysis. The repeated measures ANOVA determined that there were no significant differences in total GMRI

scores at the different time points of the study,  $F(2, 28) = 2.71, p = .08$ . However, as Figure 9 shows, changes in means trended in the hypothesized direction: total GMRI scores increased from baseline ( $M = 72.27, SD = 7.74$ ) to session four ( $M = 74.13, SD = 6.48$ ) to four-week follow up ( $M = 76.13, SD = 7.03$ ), in that order. Given the exploratory nature of this study, we examined whether there was a significant difference in total GMRI scores between baseline and session four. A repeated measures t-test revealed that participants reported significantly higher GMRI scores at follow up ( $M = 76.13, SD = 7.03$ ) than at baseline ( $M = 72.27, SD = 7.74; t(14) = -3.04, p < .01$ ).

Figure 8. Total GMRI Scores Over Time.

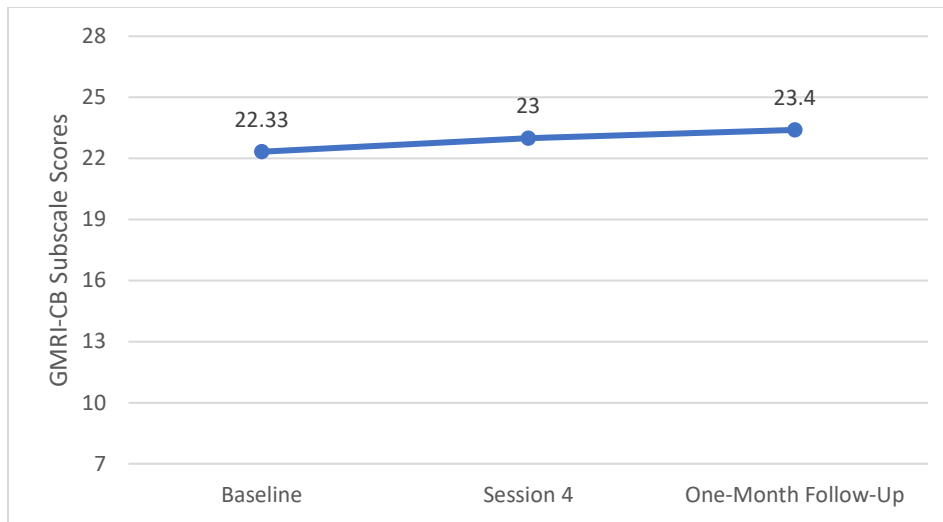


**Hypothesis 2: Participants will report higher rates of adaptive continuing bonds with the deceased across study time points.** A repeated measured analysis of variance (ANOVA) was conducted to test the effects of time on continuing bonds as measured by the *Continuing Bonds* subscale of the Grief and Meaning Reconstruction Inventory (GMRI). Assumptions of linearity, multivariate normality, and heteroskedasticity were examined prior to analysis. The repeated measures ANOVA determined that there were no significant differences

in GMRI *Continuing Bonds* subscale scores between time points,  $F(2, 28) = 1.87, p = .17$ ).

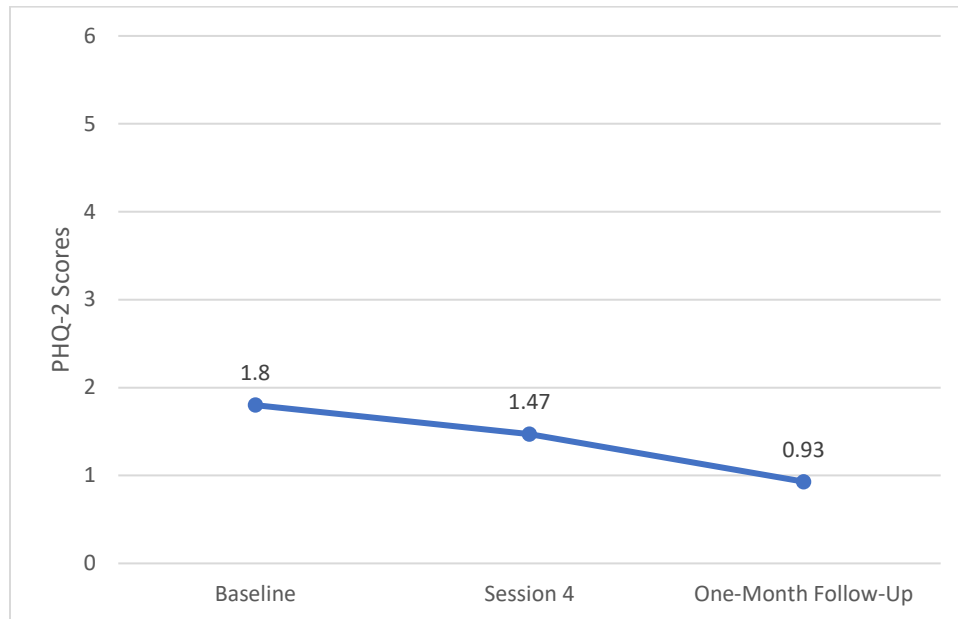
However, as Figure 9 shows, changes in means trended slightly in the hypothesized direction: rates of continuing bonds increased from baseline ( $M = 22.33, SD = 2.72$ ) to session four ( $M = 23.00, SD = 1.93$ ) to four-week follow up ( $M = 23.40, SD = 2.47$ ), in that order.

Figure 9. Continuing Bonds (GMRI-CB Scores) Over Time.



**Hypothesis 3: Participants will report lower rates of depressive symptoms across study time points.** A repeated measured analysis of variance (ANOVA) was conducted to test for the effect of time on depressive symptoms as measured by the Patient Health Questionnaire (PHQ-2). Assumptions of linearity, multivariate normality, and heteroskedasticity were examined prior to analysis. No statistical difference was found between time points on depressive symptoms  $F(2,28) = 2.03, p = .15$ ; see Figure 10). However, the changes in means of PHQ-2 scores trended in the right direction in that participants reported fewer depressive symptoms from baseline ( $M = 1.80, SD = 1.86$ ) to session four ( $M = 1.47, SD = 1.55$ ) to four-week follow up ( $M = 0.93, SD = 1.28$ ), in that order.

Figure 10. Depressive Symptom Severity Over Time.



Given the exploratory nature of this study, we examined whether there was a significant difference in PHQ-2 scores between baseline and follow up. A repeated measures t-test comparing PHQ-2 scores at baseline and follow up revealed no statistically significant difference in scores between the two time points  $t(14) = 2.05, p = .06$ .

Research has evidenced a PHQ—2 cutoff score of 3 as the optimal cut point for screening of major depression (Kroenke, Spitzer, & Williams, 2003). Using this cutoff guideline, the descriptive statistics of depressive symptoms in the final sample indicate that six participants (40%) scored above the cutoff for depression at baseline, five participants (33%) scored above the cutoff for depression at session 4, and two participants (13%) scored above the cutoff for depression at follow up. The averaged sample score was below the cut off at each time point.

**Hypothesis 4: Participants endorsing complicated grief symptoms at baseline will demonstrate greater alleviation of their negative grief symptoms than participants with subthreshold levels of complicated grief symptoms.** To test this hypothesis, participants were categorized into two groups: those who screened positively for complicated grief at baseline (as

measured by a  $\leq 52$  ISLES score) and those who screened negatively for complicated grief at baseline (as measured by a  $\geq 52$  ISLES score; Holland, 2016). Outcome measures of negative grief symptoms included total ISLES scores (with lower scores indicating greater grief-related distress), *Emptiness and Meaninglessness* GMRI subscale (GMRI-EM) scores, and Patient Health Questionnaire-2 scores (PHQ-2). As only five participants (33%) of the final sample ( $n = 15$ ) screened positively for complicated grief at baseline, and with the provision of this study's exploratory nature, the following analyses for this hypothesis were run on the full sample ( $n = 24$ ) after adjusting for missing data. Please refer to Table 12 for descriptive analyses of the outcome measures used for these analyses categorized by complicated grief subgroups and time.

Table 12.

*Negative Grief Symptom Outcome Measures by CG Subgroups and Time*

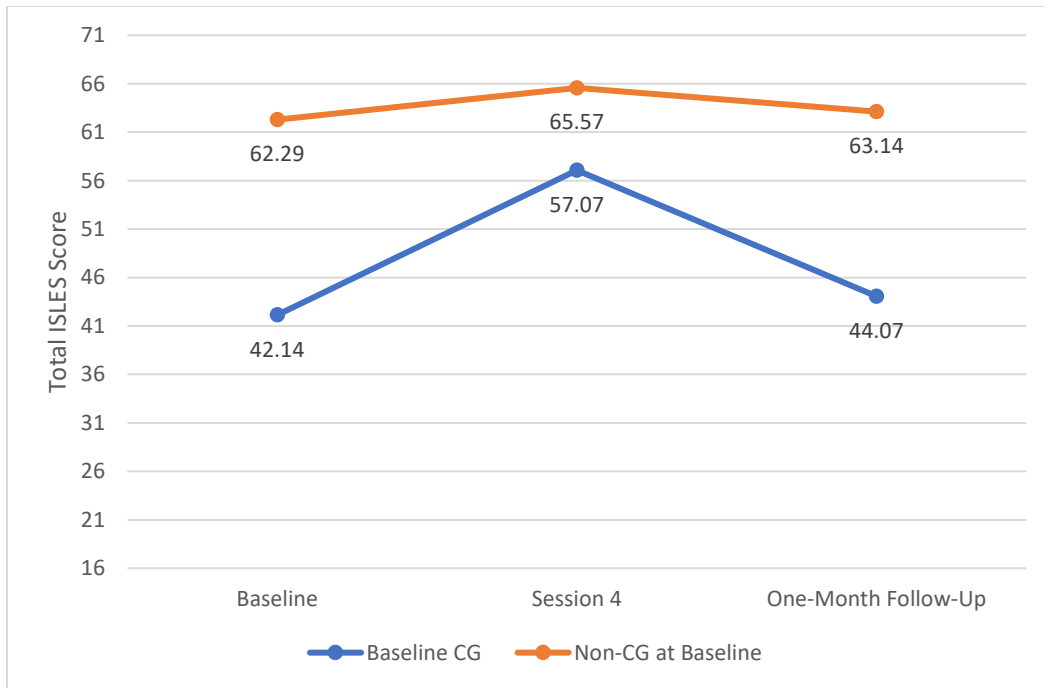
	Baseline		Session Four		Follow-Up	
	CG	Non-CG	CG	Non-CG	CG	Non-CG
ISLES (total)	42.14 (9.45)	62.29 (4.78)	57.07 (8.30)	65.57 (6.71)	44.07 (7.53)	63.14 (7.97)
GMRI-EM	11.10 (3.38)	13.36 (2.95)	14.86 (3.72)	15.33 (2.99)	12.20 (1.64)	14.00 (3.39)
PHQ-2	3.00 (1.71)	1.43 (1.45)	1.07 (1.01)	1.64 (1.74)	1.86 (0.95)	0.71 (0.83)

*Note:* CG = Baseline Complicated Grief; Non-CG = No Baseline Complicated Grief; PHQ-2 = Patient Health Questionnaire; ISLES = Inventory of Stressful Life Experiences; GMRI-EM = Emptiness & Meaninglessness subscale.

A two-way repeated measures ANOVA was run to determine the effect of baseline complicated grief over time on total ISLES scores. Assumptions of linearity, multivariate normality, and heteroskedasticity were examined. Analysis of the studentized residuals showed that there was normality, as assessed by the Shapiro-Wilk test of normality, and no outliers. There was sphericity for the interaction term, as assessed by Mauchly's test of sphericity ( $p > .05$ ). There was a statistically significant two-way interaction between baseline complicated grief and time,  $F(2, 26) = 3.16, p < .01$ . Therefore, simple main effects were run. As displayed in

Figure 11, participants with baseline complicated grief had significantly lower ISLES scores than their subclinical counterparts at each time point: baseline, ( $F(2, 13) = 44.55, p < .01$ ), session four, ( $F(2, 13) = 8.99, p < .01$ ), and one-month follow-up, ( $F(2, 13) = 55.31, p < .01$ ), with a mean difference of 19.07, 95% CI [24.61, 13.53]. Neither those who screened positively ( $F(2, 8) = 4.01, p = .06$ ) or negatively ( $F(2, 18) = 1.14, p = .34$ ) for complicated grief at baseline reported significantly differently in their averaged ISLES scores across time. However, the rate of change within the complicated grief subgroup approached significance, and their averaged scores rose above the clinical cutoff for complicated grief at session four before dipping below it again at follow up.

Figure 11. The Effect of Baseline Complicated Grief on ISLES Scores Over Time.

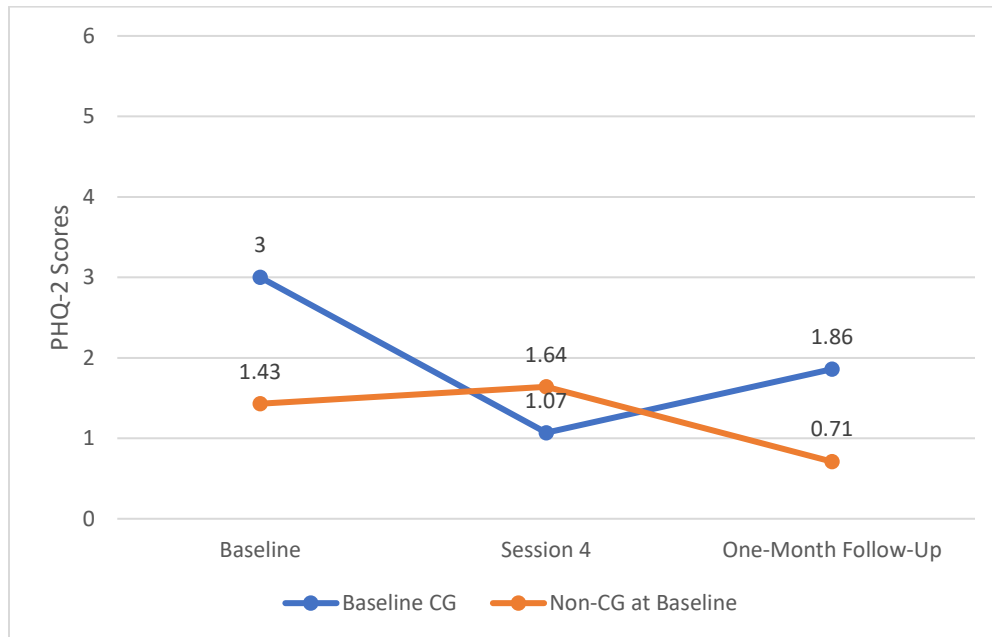


A second two-way repeated measures ANOVA was run to determine the effect of baseline complicated grief on scores on the *Emptiness and Meaninglessness* GMRI subscale (GMRI-EM) over time. Assumptions of linearity, multivariate normality, and heteroskedasticity

were examined. Analysis of the studentized residuals showed that there was normality, as assessed by the Shapiro-Wilk test of normality, and no outliers. There was not a statistically significant two-way interaction between baseline complicated grief and GMRI-EM scores,  $F(1.40, 18.24) = 2.47, p = .16$ . Therefore, simple main effects were not run.

Lastly, a two-way repeated measures ANOVA was run to determine the effect of baseline complicated grief on depressive symptoms over time. Assumptions of linearity, multivariate normality, and heteroskedasticity were examined. Analysis of the studentized residuals showed that there was normality, as assessed by the Shapiro-Wilk test of normality, and no outliers. There was sphericity for the interaction term, as assessed by Mauchly's test of sphericity ( $p > .05$ ). There was a statistically significant two-way interaction between baseline complicated grief and time on depressive symptoms,  $F(2, 26) = 3.44, p < .05$ . Therefore, simple main effects were run. As highlighted in Figure 12, participants with baseline complicated grief had significantly higher depressive symptoms than their subclinical counterparts at baseline, ( $F(2, 13) = 6.47, p < .05$ ), and one-month follow-up, ( $F(2, 13) = 13.42, p < .01$ ), but there was not a significant difference in depressive symptoms between the two groups at session four, ( $F(2, 13) = 55.31, p = .26$ ). The two groups had a mean difference of 1.29, 95% CI [-2.29, 0.28].

Figure 12. The Effect of Baseline Complicated Grief on PHQ-2 Scores Over Time.



Participants who scored negatively for complicated grief at baseline did not have significant differences in their depressive symptoms across time,  $F(2, 26) = 2.74, p = .083$ ).

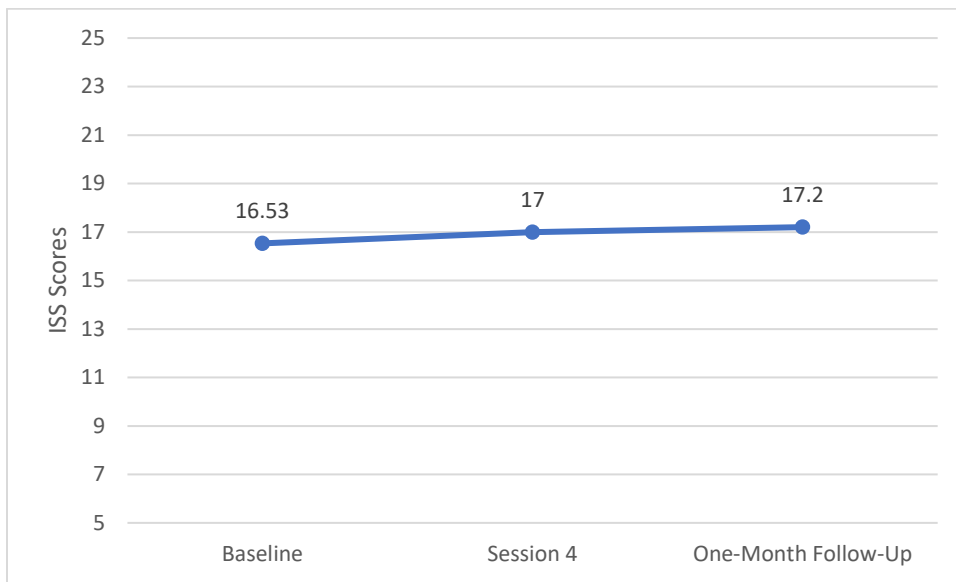
Participants with baseline complicated grief had significantly decreased depressive symptoms from baseline ( $M = 3.0, SD = 1.71$ ) to session four ( $M = 1.07, SD = 0.10; F(2, 26) = 13.61, p < .001$ ). Their scores returned closer to baseline levels at follow up ( $M = 1.86, SD = 0.25$ ) though this difference was statistically insignificant ( $p = 0.11$ ), as was the difference between their baseline and follow up scores ( $p = .09$ ).

**Hypothesis 5: Participants will report higher rates of perceived social support for their loss across study time points.** A repeated measured analysis of variance (ANOVA) was conducted to test for the effect of time on perceived social support for the loss as measured by the Inventory of Social Support (ISS). Assumptions of linearity, multivariate normality, and heteroskedasticity were examined prior to analysis. No statistically significant difference was found between time points on perceived social support for the loss,  $F(2,28) = .08, p = .93$ .



However, as Figure 13 shows, changes in means trended in the right direction: ISS scores increased slightly from baseline ( $M = 16.53, SD = 5.42$ ) to session four ( $M = 17.0, SD = 5.67$ ) to four-week follow up ( $M = 17.2, SD = 4.55$ ), in that order. Given the exploratory nature of this study, we examined whether there was a significant difference in total ISS scores between baseline and session four. A repeated measures t-test revealed no significant difference between ISS scores at baseline ( $M = 16.53, SD = 5.42$ ) and session four ( $M = 17.00, SD = 5.67$ ) or between session four and follow up ( $M = 17.20, SD = 4.55; p = .93$ ).

Figure 13. Perceived Social Support for the Loss Over Time.

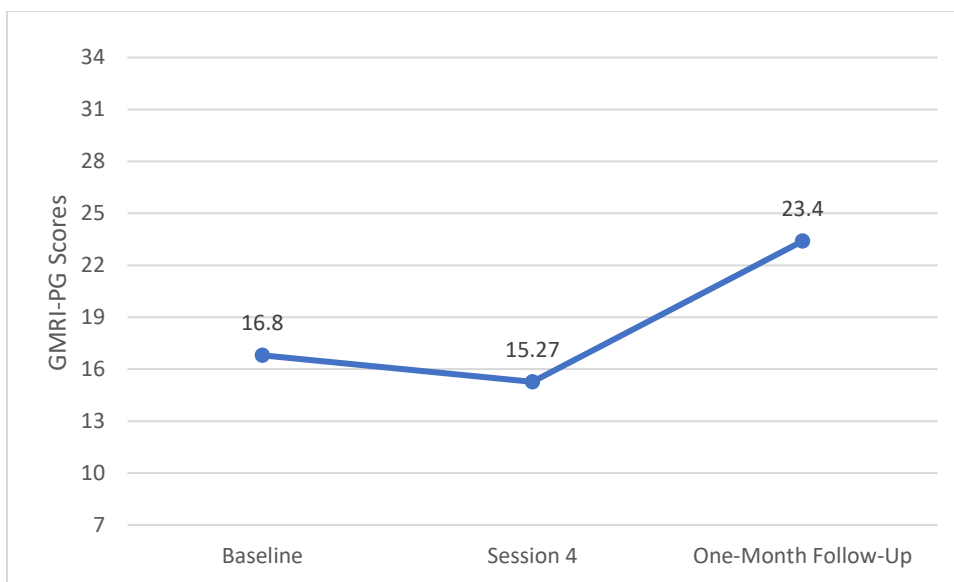


It was also hypothesized that participants with a perception of being socially supported in their grief would endorse higher rates of personal growth (as measured by the *Personal Growth* subscale of the GMRI) and fewer negative grief symptoms (as measured by the *Emptiness and Meaninglessness* subscale of the GMRI) and depression (as measured by the PHQ-2). Bivariate Pearson’s correlational analysis was conducted to test for the effect of social support on personal growth and did not reveal a significant relationship between these variables, though findings trended in the hypothesized direction in that they were positively correlated, with participants

who reported higher perceived social support for their loss were more likely to report higher personal growth, ( $r = 0.08, p > .05$ ).

Furthermore, exploratory analyses were conducted on the measure of personal growth to test for the effect of time. A one-way repeated measured analysis of variance (ANOVA) was conducted to examine the effects of time on meaning made as measured by scores on the *Personal Growth* subscale of the GMRI. Assumptions of linearity, multivariate normality, and heteroskedasticity were examined prior to analysis. As summarized in Figure 14, the repeated measures ANOVA determined that mean personal growth scores differed statistically significantly between time points,  $F(1.31, 18.39) = 57.81, p < .001$ . Post hoc tests using the Bonferroni correction revealed that personal growth significantly increased by an average of 6.6 points between baseline ( $M = 16.8, SD = 1.66$ ) and follow up ( $M = 23.40, SD = 2.47; p < .001$ ). No significant difference was found in ISLES scores between baseline and session four ( $p = .09$ ), but they did increase significantly between session four ( $M = 15.27, SD = 2.74$ ) and follow up ( $p < .001$ ).

Figure 14. GMRI-PG Scores Over Time.

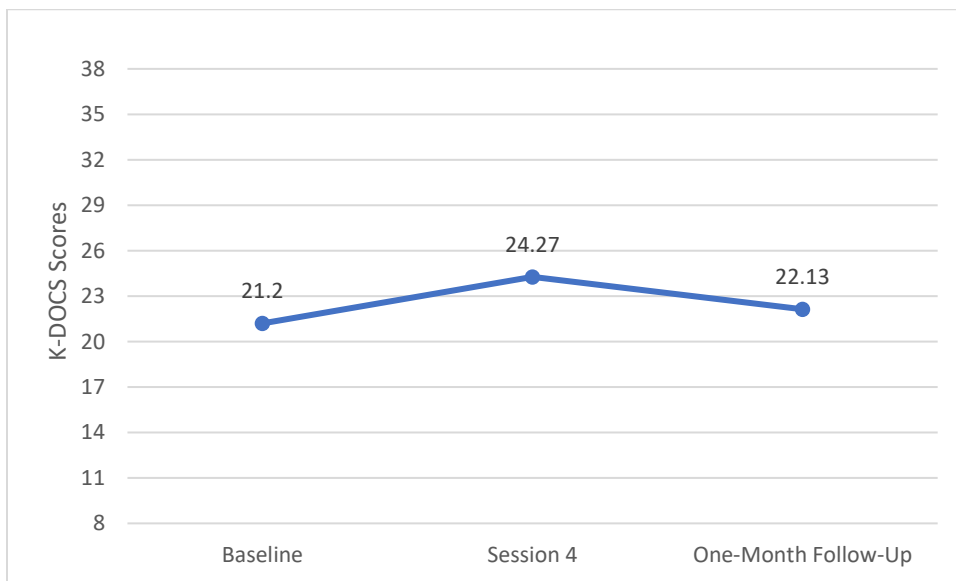


Bivariate Pearson’s correlation analysis was conducted to test for the effect of social support on negative grief symptoms, as measured by the *Emptiness and Meaninglessness* subscale of the GMRI, and did not find a significant relationship between these variables, ( $r = 0.10, p > .05$ ). Bivariate Pearson’s correlational analysis revealed a significant negative relationship between perceived social support and depressive symptoms, as measured by the PHQ-2, though findings trended in the hypothesized direction in that they were negatively correlated, with participants who reported higher perceived social support more likely to report fewer depressive symptoms ( $r = -0.14, p > .05$ ).

### Exploratory Analyses

**Creative Self-Efficacy.** A repeated measured analysis of variance (ANOVA) was conducted to test for the effect of time on creative self-efficacy as measured by the K-DOCS. Assumptions of linearity, multivariate normality, and heteroskedasticity were examined prior to analysis. As displayed in Figure 15, no statistical difference was found between time points on creative self-efficacy as measured by the K-DOCS,  $F(2,28) = 1.62, p = .22$ .

Figure 15. Creative Self-Efficacy Over Time.



Two-tailed Bivariate Pearson's correlation analyses were conducted to explore analyses examined the impact of participants' baseline creative self-efficacy on meaning made of the loss (as measured by total GMRI scores), continuing bonds with the deceased (as measured by the *Continuing Bonds* subscale of the GMRI), personal growth (as measured by the *Personal Growth* subscale of the GMRI), depressive symptoms (as measured by the PHQ-2), and perceived social support for the loss (as measured by the ISS). No statistically significant associations were found between creative self-efficacy and meaning made of the loss ( $r = -0.06, p > .05$ ), continuing bonds ( $r = -0.37, p > .05$ ), personal growth ( $r = 0.23, p > .05$ ), depressive symptoms ( $r = -0.22, p > .05$ ), or perceived social support for the loss ( $r = -0.17, p > .05$ ). Bivariate Pearson's correlation analyses were also conducted to explore possible associations between creative self-efficacy and the Program Evaluation responses completed at session four; no statistically significant associations were found.

**Rates of Engagement.** Two-tailed Bivariate Pearson's correlation analyses were conducted to explore possible association between participants' rates of engagement (as measured by number of sessions attended) and continuous characteristics of the loss variables for the full sample (Table 13). Session attendance was significantly negatively correlated with expectedness of the loss ( $r = -0.43, p < .05$ ), such that participants who described the death of their loved one as less expected attended fewer group sessions. Session attendance was also significantly negatively correlated with number of additional losses as tabulated by the item eight of the Characteristics of the Loss questionnaire, in which participants responded to the open-ended questions, "What other losses have you experienced that have caused you significant distress?" Participants who reported a higher number of additional losses attending significantly fewer group sessions ( $r = -0.48, p < .05$ ). Decedent age was significantly positively correlated

with session attendance ( $r = 0.41, p < .05$ ), such that participants who had experienced the death of older loved ones attended more group sessions than those whose loved ones had passed away at younger ages.

Table 13.

*Pearson Correlation Matrix among Rates of Engagement and Loss Characteristics*

	1	2	3	4	5
1. Session attendance	-				
2. Expectedness of the loss	-0.43*	-			
3. Closeness to the deceased	-0.10	-0.07	-		
4. Months since loss	0.31	-0.34	0.08	-	
5. Decedent age	0.41*	0.44*	-0.38	-0.01	-
6. Additional losses	-0.48*	0.18	0.54*	0.26	-0.62**

Note: \* $p < 0.05$ ; \*\* $p < 0.01$

Two-tailed Bivariate Pearson's correlation analyses were conducted to explore possible association between participants' rates of engagement (as measured by number of sessions attended) and outcome measures (PHQ-2, ISS, ISLES, GMRI, CAQ, and K-DOCS) at baseline for the full sample. As summarized in Table 14, no statistically significant associations were found between outcome measures at baseline and participant attendance, indicating that baseline symptom severity did not significantly impact participants' group attendance.

Table 14.

*Pearson Correlation Matrix among Rates of Engagement and Baseline Outcome Measures*

	1	2	3	4	5	6
1. Session attendance	-					
2. PHQ-2	-0.26	-				
3. ISS	0.14	-0.48	-			
4. ISLES	0.33	-0.42*	-0.06	-		
5. GMRI	0.34	-0.22	0.49*	-0.01	-	
6. CAQ	0.23	-0.57**	0.09	0.26	-0.62**	-
7. K-DOCS	0.26	0.04	0.06	0.16	-0.29	0.13

Note: \* $p < 0.05$ ; \*\* $p < 0.01$

An independent samples t-test was conducted to explore whether participants who screened positively for complicated grief at baseline (as measured by a  $\leq 52$  ISLES score) had significantly different rates of engagement than their subthreshold counterparts. There was not a significant difference in the number of sessions attended between participants who screened positively for complicated grief at baseline ( $M = 3.83$ ,  $SD = 1.5$ ) and those who scored below the cutoff for complicated grief at baseline ( $M = 4.33$ ,  $SD = 1.63$ ;  $p = .58$ ).

### **Intent to Treat (ITT) Analyses**

A set of intent-to-treat (ITT) analyses were carried out to further test the effects of attrition (Yelland et al., 2015). It has been recommended that clinical studies provide separate ITT reports for participants with complete and incomplete data (Alshurafa et al., 2012), as it is among the most conservative estimates of treatment effects (Abraha et al., 2015). Thus, the following section reports results for the 24 participants who attended the first (baseline) group session. For ITT analyses, if participants had missing data at session four or follow up, their recorded scores were carried forward. This is in contrast to previous analyses, which only examined the data of the 15 participants who completed all group sessions and one-month follow up. ITT analyses were conducted for each hypothesis and exploratory aim in replication of the statistical methods earlier described, except for exploratory analysis of attrition correlates. Table 15 summarizes the ITT results and whether each result's level of significance (i.e.,  $p$  value greater or less than .05) matches that of the study's previous corresponding analysis.

Table 15. Intent to Treat (ITT) Analyses.

	Intent to Treat Result <i>N</i> = 24	Matches Significance of Corresponding Analyses
<b>Hypothesis</b>		
1a: Meaning Made (ISLES)	$F(2, 46) = 3.89, p < .05$	X
1b: Meaning Made (GMRI)	$F(2, 46) = 4.53, p < .05$	X
2: Continuing Bonds	$F(2, 46) = 4.53, p = .085$	X
3: Depressive Sx	$F(2, 46) = 2.51, p = .093$	X
4a: Negative Grief Sx (CG)	$F(2, 18) = 2.84, p = .085$	
Negative Grief Sx (Non-CG)	$F(2, 26) = 1.09, p = .351$	X
4b: Depressive Sx (CG)	$F(2, 18) = 2.50, p = .110$	
Depressive Sx (Non-CG)	$F(2, 26) = 1.26, p = .300$	X
5a: Social Support	$F(2, 46) = 0.13, p = .875$	X
5b: Personal Growth	$F(2, 46) = 26.95, p < .001$	X
<b>Exploratory Analyses</b>		
Creative Self-Efficacy	$F(2, 46) = 3.30, p < .05$	

*Note:* ISLES = Integration of Stressful Life Experiences Scale; GMRI = Grief and Meaning Inventory; CG = Complicated Grief at Baseline Cohort; Non-CG = Non-Complicated Grief at Baseline Cohort.

The majority of ITT analyses matched previous analyses in significance levels. Significant improvements were found across time points in meaning made from the loss, as measured by both ISLES and total GMRI scores, and personal growth. Insignificant findings, such as change in Continuing Bonds and depressive symptoms, were similarly insignificant in previous analysis, and results trended in the same direction as previously reported (e.g, ITT depressive scores trended in the hypothesized negative direction across time points). ITT analysis did reveal a significant increase in creative self-efficacy over time ( $F(2, 46) = 3.30, p < .05$ ), while original analyses of this construct were insignificant.

In regard to hypothesis four, ITT analysis of the full sample compared negative grief and depression scores of the 10 participants (41.7%) who screened positively for complicated grief at baseline to the scores of the 14 participants (58.3%) who screened negatively for complicated grief at baseline. Contrary to prior analyses, those with complicated grief at baseline did not demonstrate significant change in their ISLES scores ( $F(2,18) = 2.84, p = .085$ ), or depressive scores ( $F(2,18) = 2.50, p = .110$ ) across time, though findings trended in similar directions as previous analyses. Those who screened negatively for complicated grief at baseline also did not demonstrate significant change in their ISLES or depressive scores, but this was congruent with earlier findings. There was not a statistically significant two-way interaction between baseline complicated grief and time,  $F(2, 46) = 1.01, p = .092$ , therefore, simple main effects were not run.



Introducing Your Loved One Collage Examples:

Figure 16. “Introducing Your Loved One Collage” Participant Artwork #1.



Participants completed introductory collages during the first session of the group as a way to explore their relationship with their deceased loved one as well as share fond memories with the rest of the group participants. Figure 16 depicts a collage done by a 70-year-old African-American male who, though he had endorsed numerous losses, focused his artwork on the passing of his best friend five years ago. When explaining the above collage to the group, the participant explained that it depicted his favorite past times with his friend, such as fixing old boats together, taking long walks after work, and sharing a beer over a good meal. He further explained to the group that his friend has passed due to a drug overdose and that he is reminded of these memories every day when he takes his daily walk outside. This participant had chosen to primarily use magazine cut outs for his collage, but other participants were more drawn to the stickers provided by the authors as an alternative form of crafting more narrative collages, such as the collage depicted in Figure 17.

Figure 17. "Introducing Your Loved One Collage" Participant Artwork #2.



Figure 18. "Introducing Your Loved One Collage" Participant Artwork #3.



Loss Road Map Examples:

Participants completed the Loss Road Map activity during the second week of group. Participants were invited to explore metaphors related to roads and outdoor journeys, such as road signs to represent points of decision making, and natural disasters to represent the death of their loved one interrupting their life's path. The participants were provided sheets of drawings for each symbol to help them cultivate additional ideas, copy/trace onto their artwork, or cut and paste. The majority of participants chose to cut and paste these drawings, as depicted in Figure 20, but some took additional creative measures to explore what their loss road map meant to them.

Figure 19. "Loss Road Map" Participant Artwork #1



Figure 20. Loss Road Map” Participant Artwork #2.

# Mom C My experience



Meteorite



volcano

---

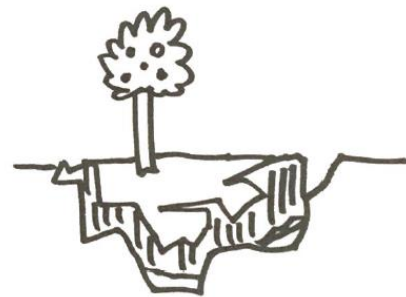
# Audrey (M., experience)



Flooding



Storm



Earthquake

★ CONGRATULATIONS ★ CONGRATULATIONS ★



Figure 21. Loss Road Map” Participant Artwork #3.



Virtual Dream Story Board Examples:

Participants completed the story board activity during the third week of group, and this was their final art activity. Similar to the road map handouts, participants were provided illustrations for each of the 6 themes they had to include in their story board (e.g., compass, a sunrise). This activity also encouraged reflection on goals as participants began to look towards the future at adapting to life after loss, and many participants chose to free hand written goals.

Figure 22. "Virtual Dream Story Board" Participant Artwork #1



Figure 23. "Virtual Dream Story Board" Participant Artwork #2

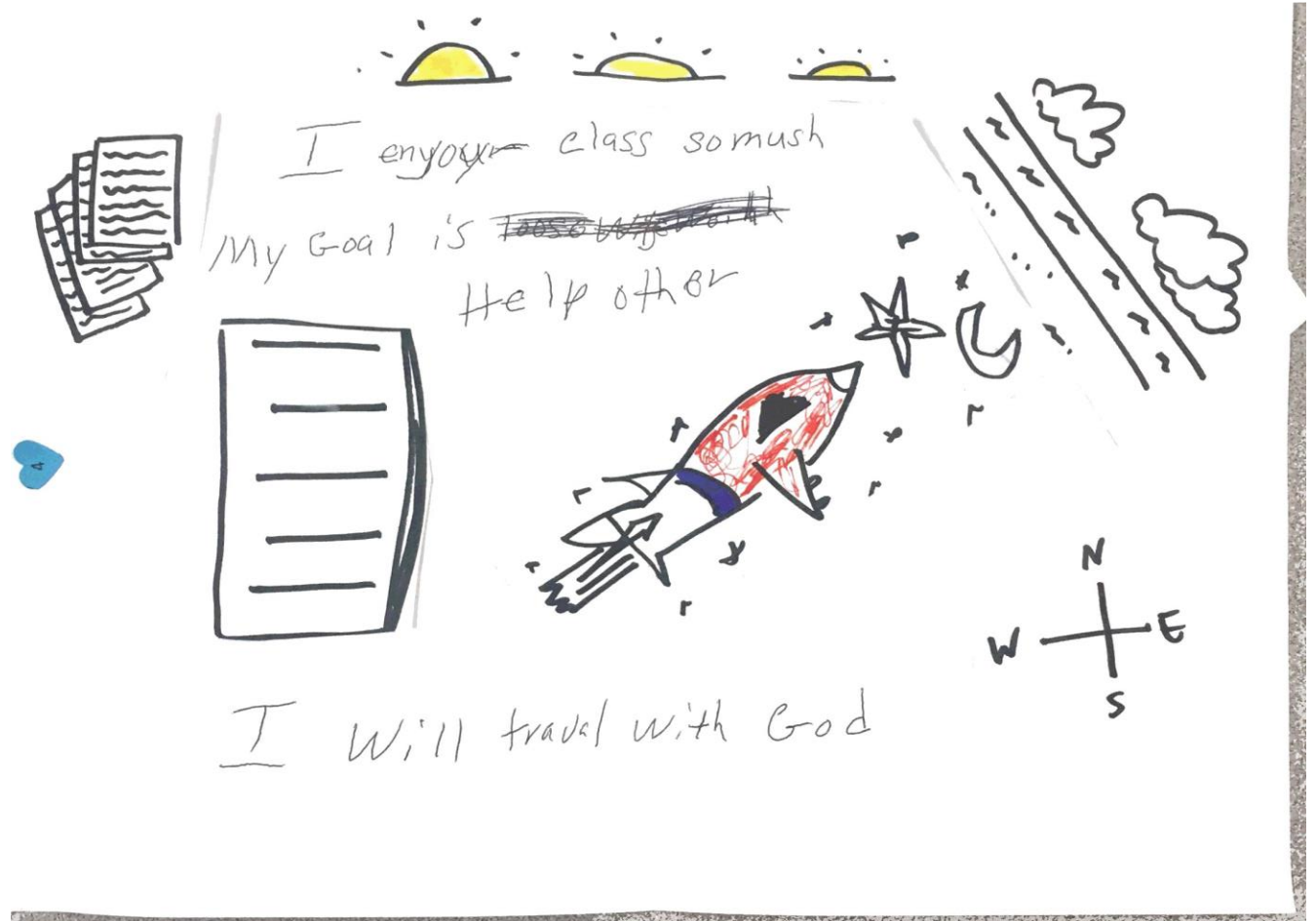
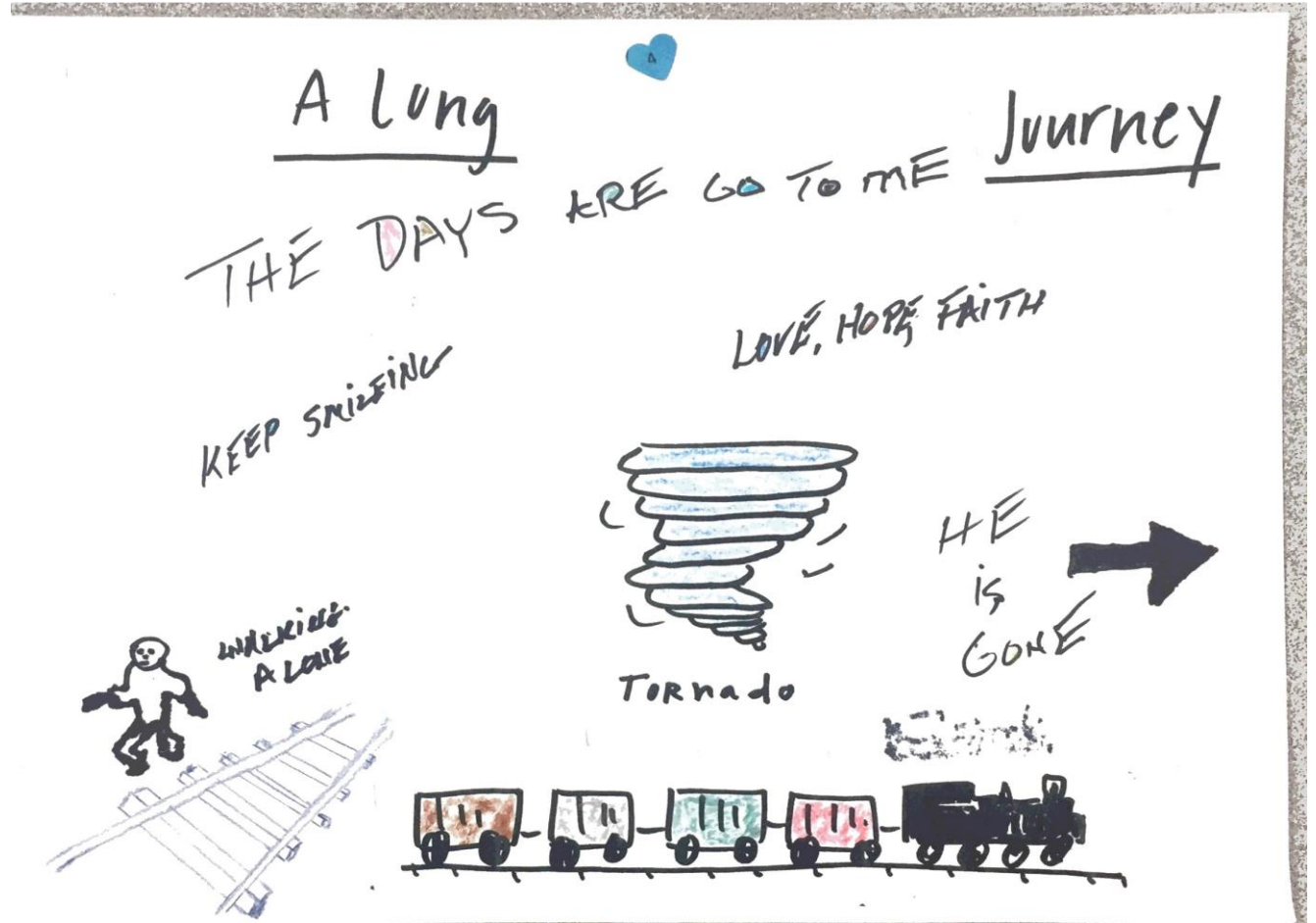




Figure 24. "Virtual Dream Story Board" Participant Artwork #3.



## Discussion

A budding area of research has begun investigating the efficacy of expressive art modalities in grief therapy with positive preliminary results (e.g., Uttley, 2015; Gamino, 2015). In alignment with prevailing grief theory on the importance of cultivating a meaningful narrative about one's loss, many bereavement interventions have incorporated expressive writing activities (e.g., Lichtenthal & Neimeyer, 2012, Stroebe Schut, & Stroebe, 2006). However, expressive writing prompts may be inaccessible to bereaved populations with low rates of literacy such as socioeconomically vulnerable older adults. Adapting traditional grief expressive writing interventions to visual art forms allows for greater treatment accessibility, but a thorough review of the literature found no studies to date that have examined the efficacy of a visual art-based grief intervention on bereavement-specific outcomes within a socioeconomically vulnerable older adult sample. Because this subgroup is one of the most vulnerable to the development of complicated grief (Ghesquiere, Shear, and Naihua, 2013), it is important to develop effective methods for providing culturally-appropriate bereavement support.

The current study used a prospective longitudinal approach to investigate the feasibility of a visual art-based grief support group for older adults residing in four government-subsidized independent living facilities in the community. Participants attended four weekly 90-minute group sessions based on the empirically validated "Meaning in Loss Group" therapy framework (Neimeyer et al., 2016). Four separate, site-specific groups were conducted across the independent living facilities. At the beginning of session one, participants across all sites ( $n = 24$ ) completed a survey packet of questionnaires for baseline measurement of negative grief symptoms, depressive symptoms, perceived social support, meaning made from the loss, personal growth, and continuing bonds with the deceased. At the end of session four, participants

( $n = 19$ ) completed the same survey packet and a program evaluation form created by the authors for the purpose of this study. Participants completed the survey packet again one month following session four to provide follow-up data measurement ( $n = 15$ ). All participants who completed follow up surveys had attended all four group sessions. The current study aimed to investigate the feasibility and efficacy of implementing this intervention. Results and their relationship to current literature are presented in further detail below.

This study provides promising results for the impact of creative art methods within a bereavement intervention context. Participants reported higher markers of healthy adaptation to life after loss, such as meaning making, continuing bonds, and personal growth; while not all findings were statistically significant due to this feasibility study's low  $N$ , all findings trended in the hypothesized direction, and further investigation is warranted to explore expressive arts with a larger sample. Despite the low  $N$ , significant findings include the increase of GMRI scores at follow up (a robust measure of meaning making) and the improvement of ISLES scores for participants with baseline complicated grief. Furthermore, participants reported similar improvement in their negative grief symptoms, such as depression and symptoms of complicated grief. Feasibility and acceptability of this form of intervention was supported by the high rates of enrollment throughout the group and the overwhelmingly positive feedback measured by the program evaluation form. These findings are explained in more detail below as well as a discussion of how they compare with the existing literature.

### **Hypothesis Testing**

Hypothesis 1 proposed that participants would report significantly higher rates of meaning made from the loss across study time points. Participants did endorse significantly higher rates of meaning made from their loss (as measured by total ISLES scores) at completion

of session four, but scores fell back to baseline levels upon one-month follow up. Analyses of total GMRI scores, another measure of meaning made from the loss, found no significant differences over time, though changes in means did trend in the hypothesized direction of higher meaning making at each time point. These findings are encouraging, as this is the preliminary study evaluating the effect of expressive arts on specific measured constructs of adjustment to life after loss. Given the present study's low *N*, positive trends in meaning making point towards the possibility that using visual arts as interventional modalities in grief therapy may assist the bereaved similar to that of traditional talk or narrative therapies (e.g., Neimeyer, 2016). This finding builds upon the few qualitative studies of the subject. For example, in a qualitative study of a group therapy for bereaved parents, Umphrey and Cacciatore (2011) cited the importance of group members expressing the meaning drawn from their loss narratives, as it provided a venue for other group members to help shape each other's perceptions, and thereby meanings made, of their losses. However, the authors provided no specific examples or measures of meaning integration, limiting conclusions regarding the extent to which participants constructed meanings of their loss through group participation. Though the implications of the present study are optimistic, researchers have not yet examined the processes by which meanings related to loss are constructed, co-constructed, or adapted within a grief support group (Rice, 2014). Future clinical research would benefit from administering validated measures of meaning making when evaluating the efficacy of group therapies with the bereaved to improve our understanding of meaning making in this clinical context.

Hypothesis 2 proposed that participants would report higher rates of adaptive continuing bonds with the deceased after completing the study support group. No significant difference was found in continuing bonds over time, though responses trended slightly in the hypothesized

positive direction at each time point. Contemporary techniques of grief therapy frequently emphasize enhancement of continuing bonds through a myriad of methods such as legacy projects, life imprints, and imaginal conversations (Neimeyer, 2012), and theoretical writings have argued that it is helpful to engage conjugally bereaved older adults with the felt presence of their late spouse (Klass, Silverman, & Nickman, 2014). However, there is a paucity of studies that evaluate the impact of these techniques with evidence-based outcome measurement, making it difficult to compare these results with the extant clinical literature. Some germinal research suggests the efficacy of bond-enhancing procedures in mitigating symptoms of complicated grief (Shear, Frank, Houch, & Reynolds, 2005), but just how these interventions ultimately increase or decrease engagement with the deceased remains to be investigated. Recent research has raised the possibility that individual difference variables such as quality of the relationship (Carr, 2018) and attachment orientation may affect participants' responsiveness to bond-enhancing intervention. For example, one study of 195 young adults who were bereaved by violent causes found that level of attachment-related anxiety and avoidance moderated the adaptiveness of continuing bonds on complicated grief symptoms (Currier, Irish, Neimeyer & Foster, 2015). These results suggest that bereaved individuals may receive the greatest benefit from interventions that align the level of emphasis on continuing bonds with participants' attachment style, adopting an "aptitude by treatment interactions" approach (Beutler, Harwood, Kimpara, Verdirame, & Blau, 2011). Future studies based on larger samples should include measurement of adaptive continuing bonds with the deceased when testing the efficacy of bereavement interventions, and controlled research that explores whether the current therapeutic practices of revisiting memories or tokens of the relationship is attenuated by individual difference variables such as attachment style or closeness in the relationship with the decedent.

Hypothesis 3 proposed that participants would report decreased rates of depressive symptoms across study time points. This hypothesis was not fully supported, as no significant difference was found in depressive symptoms over time, though responses trended in the hypothesized negative direction across each time point. The number of participants who screened positively for major depression did decrease over time with six at baseline, five at session four, and only two at one month follow up. All participants who screened positively for depression at session four and follow up were among those who screened positively at baseline. While the differences in these numbers were not statistically significant, when recognizing the limited duration and power of this study it is reasonable to suspect that a larger sample size would power a future study to potentially find significant decreases in depressive symptoms over time.

Hypothesis 4 proposed that participants who screened positively for complicated grief at baseline would experience greater alleviation of their negative grief symptoms than their subthreshold counterparts. This hypothesis was partially supported. Those who screened positively for complicated grief at baseline reported significantly improved grief symptoms and meaning made from the loss between baseline and session four, unlike their counterparts. However, this improvement returned towards baseline levels at one-month follow up. Although participants with baseline complicated grief had significantly higher depressive symptoms at baseline, by session four their symptom burden had decreased to similar levels of their subthreshold counterparts. While this improvement held at one month follow up, depressive symptoms in the complicated grief cohort did trend back towards baseline.

These findings are congruent with the existing literature on the effectiveness of bereavement interventions. Meta-analytic reviews have suggested that, on the whole, bereavement treatment recipients experience significant improvement in grief-related distress

immediately following intervention (above and beyond the effect of time), but therapeutic outcomes often fail to reliably differ from baseline levels at follow up (e.g., Currier, Neimeyer, & Berman, 2008). Grief therapies are substantially more effective in alleviating negative symptoms when the bereaved are currently experiencing clinically significant distress, a benchmark most frequently measured by cut-off scores of complicated grief indices.

Hypothesis 5 proposed that participants would report higher rates of perceived social support for their loss across study time points. This hypothesis was not supported with statistically significant results, though scores trended slightly in the hypothesized positive direction. This pattern may reflect the immediate social benefit of the intervention's group format. Participants may have experienced feelings of support and connectedness with their therapy group members, but perhaps experienced little change in their support systems outside of therapy. This is consistent with Mallinckrodt's (1989) suggestion that for members of theme-oriented treatment groups who have experienced the same life stressors (e.g., bereavement group therapies), mutually-exchanged support within the group may be more valued than the same type of support from individuals outside the group. This potential explanation is notable when examining group session content. In an effort to preemptively attenuate the possibility of participants' perceived loss of support following study completion, the authors focused the fourth and final group session on Mobilizing Support Systems (in accordance with the original framework of Neimeyer's *Meaning in Loss Group*; 2016). Our findings suggest that this module did not evidence significant change in this outcome, and future studies of group bereavement interventions may further inform our understanding of perceived social support in grief by longitudinally examining the rate of follow-through on accessing social support for grief outside of primary intervention.

Our finding provides valuable dimension to the relevant empirical research. The interaction of perceived social support for one's loss in a group therapy context has thus far not yielded a clear picture. For example, when implementing a targeted group therapy for complicatedly-bereaved adults, Ogrodniczuk and colleagues found that perceived social support did not significantly improve until six months after group participation (2003). Other studies suggest that perceived social support is a significant predictor of improved grief outcomes within a group therapy setting, but that perceived social support itself does not significantly change with group attendance (e.g., Brown, Brown, House & Smith, 2008). Very few bereavement studies have investigated group processes that might influence participants' perception of social support, such as group cohesion, universality, altruism, and group pressure to change (Umphrey & Cacciatore, 2011). Of those that have, one preliminary study of a grief support group attended by a complicatedly-bereaved adult sample found that group cohesion was associated with lower group dropout rates, increased hope for the future, and higher self-esteem (Piper, Ogrodniczuk, Joyce, Weideman, & Rosie, 2007). Further investigation is needed to elucidate the influence of social support within and outside of group participation, particularly within the older adult population, who suffers from less bereavement-related social support than younger cohorts. Specifically, our understanding of these heterogeneous findings may be improved by closer examination of whether group-provided support for the loss begets more effect on grief outcomes than that of individual therapy, as first hypothesized by Ogrodniczuk and colleagues (2009).

Some socially supportive processes may have more impact on group outcomes among individuals who share similar traits, such as older adult age or types of loss. For example, a literature review of conjugally bereaved older adult widows reported predominant themes of



loneliness, disrupted routines, and changes in independence, identity, and social context (Naef, Ward, Mahrer-Imhof, & Grande, 2013), and research has found that many older adults face limited social support, restricted transportation, feelings of isolation, and reluctance to express their grief (Breen & O'Connor, 2011). The isolative flavor of these themes is perhaps reflective of the older adult population's significantly lower endorsements of social support than their younger counterparts (e.g., Segrin, 2003), and addressment of these themes may be particularly well-suited for a group therapy format (Ghesquiere, Shear, and Naihua, 2013). The interplay of group dynamics, perceived social support, and meaning-making is a blossoming and largely unexplored path of bereavement research. Future implementation of mixed-methods, qualitative, and quantitative approaches in this area would improve our ability to provide efficacious therapies for bereaved subgroups with high risk of complicated grief due to their limited organic social support, such as socioeconomically vulnerable older adults.

In addition to proposing increased social support across time points, Hypothesis 5 also anticipated that participants with a perception of being socially supported in their grief would endorse higher rates of personal growth. This prediction was not supported with statistically significant findings, but responses trended in the hypothesized direction: those who reported higher perceived social support for their loss were more likely to report higher personal growth. This result offers cautiously optimistic implications when evaluated in the context of the relevant literature. Positive associations between social support and personal growth are encouraging in their congruence with findings of larger, more robust studies of traditional grief group therapies. For example, perceived social support for the loss has been so often linked with personal growth that researchers have crafted a theoretical "pathway of social support" to describe healthy adaptation to life after loss through the bidirectional relationship of social

support and personal growth (Hogan & Schmidt, 2002). Analyses of this proposed pathway have only been conducted with cross-sectional data and should be interpreted with marginal scope, but the present study's longitudinal implications for further research are encouraging when considering its small sample size.

Lastly, hypothesis 5 anticipated that participants with a perception of being more socially supported in their grief would endorse lower rates of negative grief and depressive symptoms. These hypotheses were not supported with statistically significant findings. Though unexpected, this result is a valuable contribution to the extant literature. In contrast to the bevy of research on social support's positive correlations with other markers of adaptive adjustment to life after loss (e.g., Klass, Silverman, & Nickman, 2014), social support has shown less consistent associations with negative bereavement outcomes (e.g., Murphy, Chung, & Johnson, 2002). On the one hand, higher perceived social support has been associated with less depressive symptoms in a widowed sample (Stroebe, Zech, Stroebe, & Abakoumkin, 2005) as well as with large, varied samples of bereaved adults (Vanderwerker & Prigerson, 2003; Hogan, Greenfield, & Schmidt, 2001). However, in a study of homicidally bereaved African-Americans, Burke, Neimeyer, and McDevitt-Murphy (2010) found that although larger numbers of perceived social support figures were associated with lower complicated grief and depression severity, anticipation of negative or insensitive social interaction with some social supporters was associated with greater symptom severity. This confluence was further examined in a meta-analysis of both cross-sectional and longitudinal studies on the influence of social support as a buffer against a difficult and protracted response to loss. Stroebe, Zech, Stroebe, and Abakoumkin (2005) determined that social support did not positively influence recovery speed or the overall grief trajectory of the bereaved and argued that it should not be viewed as a definitive factor for those exhibiting a

normative reaction to grief. Finally, in a qualitative study of individuals who lost a loved one due to a traffic accident, thematic content analysis of participant interviews revealed that one of the primary barriers to making meaning of loss involved social environments that were perceived as misunderstanding or minimizing of the loss (Breen & O'Connor, 2009). Thus, the extant literature lends support to the notion that the extent to which social support alleviates negative bereavement outcomes may be contingent upon the context of one's greater social environment.

This conceptualization of social support is more textured than the one-dimensional perception of support captured by the ISS questionnaire used in the present study. Despite the utility of this assessment tool, the ISS concentrates on social support at an individual level with items ranking the availability of particular forms of grief support. However, there is broad acknowledgment that wider environmental components guide our perception of social support (Neimeyer, Klass, & Dennis, 2014). The ISS's limited scope may help to explain the present study's findings that social support for the loss did not impact levels of negative grief or depressive symptoms. Researchers have recently published a psychometrically validated assessment tool called the Social Meaning in Life Events Scale (SMILES) that measures the degree to which a mourner successfully makes meaning of loss in a social context (Bellet, Holland, & Neimeyer, 2018). In its two-factor measurement of social validation and invalidation, this tool has demonstrated incremental validity in predicting adverse bereavement outcomes over and above general social support measured by the ISS (Bellet, Holland, & Neimeyer, 2018). Future studies on bereavement group therapies may benefit from the inclusion of the SMILES for a more robust and nuanced measure of social interaction in bereavement with hope that it may better contextualize the impact of group participation on one's social environment. The

increasing evidence of social interaction on grief-related processes broadens the scope for meaning-oriented research and therapy as investigators pursue the implications of support across the domains of family, community, and culture.

### **Exploratory Results**

Beyond specific hypothesis testing, this pilot study aimed to better characterize bereaved, underserved older adults based on demographic and loss characteristics, as well as examining the feasibility of conducting a longitudinal intervention with the sample population. As reviewed in the following section, particular attention was given to the examination of creative self-efficacy as a potential covariate of outcome measures and whether demographics, characteristics of the loss, or baseline symptomology influenced participant rate of enrollment.

The influence of creative self-efficacy was explored as it related to time and symptomology. No significant differences were found in our sample across time points on a self-report measure of creative self-efficacy. Further, there were no significant associations between creative self-efficacy and meaning made of the loss, continuing bonds with the deceased, personal growth, and perceived social support at baseline or post intervention. Creative self-efficacy was also unassociated with rates of engagement. The implications of this are surprising: participants with no perceived inclination towards the creative arts were just as likely to attend group sessions and cultivate markers of adaptive adjustment to life after loss as their counterparts who endorsed a proud creative background at baseline. A thorough review of the literature revealed no existing expressive art intervention studies to date that have specifically measured the creative self-efficacy of its participants, an oversight that has been noted by researchers in the field (McFadden & Basting, 2010). Studies of older adults support the notion that the manipulation of art materials and production of one's own art project facilitates a sense of

mastery and restores self-efficacy (Basting, 2006). However, unexplored avenues of research include tests of whether this preliminary finding is consistent across intervention forms and sample populations.

Additional exploratory analyses were conducted to investigate possible influencers of attrition and rates of enrollment. Higher adherence rates were found in participants who had experienced an expected (rather than sudden) death of a loved one, whose loved one was of older age at the time of death, and who reported fewer additional losses. These characteristics are indicative of a less complicated adaptation to life after loss, as these variables' counterparts (unexpectedness of the loss, younger decedent age, and cumulative losses, respectively) have been associated with elevated symptoms of complicated grief (e.g., Dillen et al., 2009). Research has identified complicated grief as a diagnosis with unique symptomology unattributable to other psychological diagnoses (Prigerson et al., 2008). At the same time, individuals with complicated grief often demonstrate stress-responsive patterns similar to those with post-traumatic stress disorder; avoidance is a hallmark perpetrator for symptoms of both conditions (Dillen et al., 2009). It is possible that participants with a higher tendency to avoid reminders of their loved one's death experienced higher rates of attrition, though analyses revealed no correlations between complicated grief symptoms or distress severity and group attendance.

Additional exploratory analyses reviewed the results of the program evaluation questionnaire. Responses indicate that participants endorsed an overall enjoyment of the group, as evidenced by their highly positive ratings across all items. Many participants also chose to elaborate on their feedback with free form written responses. In regard to the study's feasibility, findings demonstrate that retaining bereaved older adults in a weekly four session support group

is possible. Participants generally were willing to engage in the art activities at each session, despite the sample's low reports of creative self-efficacy at baseline and follow up.

### **Study Limitations, Strengths and Future Directions**

**Sample Characteristics.** As this was an exploratory pilot study, the final sample  $n$  of 15 (those who attended all four sessions and the one-month follow up) was too small to have enough power to run certain statistics. If the sample had been larger, regression analyses would have been performed; for example, linear regression analyses could be used to examine whether demographic (e.g., gender, ethnicity) and other complicated grief risk variables (e.g., type of loss, relationship to the deceased) predict treatment outcomes. Furthermore, the sample consisted of predominantly single, divorced, or widowed African American females. As a result, our sample characteristics potentially underrepresent certain groups within the older adult population and results may have limited transferability.

The decisions about sample size and inclusion of all forms of bereavement were intentionally made to ensure that we would have enough data given the pilot nature of the study; one strength of the study is that we maintained a rate of compliance congruent with existent bereavement intervention literature (e.g., Schut et al., 2001) at all four study sites. Additionally, beginning these investigations with older adults of lower socioeconomic status appeared to be the best place to start given that they are among the highest risk groups for negative psychological and physical health outcomes following bereavement (e.g., Ghesquiere, Shear, and Naihua, 2013). These decisions, however, potentially limited our ability to generalize from the sample more broadly to older adults and other at-risk groups. Specifically, we found nonsignificant results that conflict with the current literature, such as no relationship between time since the loss and negative grief symptoms (Currier et al., 2008). This potentially indicates

that we did not have the power necessary to detect important differences; while we could have closer examined potential descriptive variable correlates of grief symptoms, the intent of our study was to look at the broader impact of the study groups on symptoms over time.

Relatedly, the authors had originally intended to run multiple iterations of the study group across sites. This proved infeasible, as there were less available/eligible/interested participants than anticipated. In the interest of adhering to the goal of building social support in the site communities, the authors decided to run one iteration of slightly larger groups than planned, rather than splitting participants into two small cohorts. As a result, the study sample is smaller than original power analyses pointed towards, and there was an unequal *N* for each site group. However, this lopsided site representation does appear similar to that of the total resident populations at each building as indicated by the most recent reports available; the study sample appears to accurately reflect residential proportions.

The additional drawback of being limited to one group iteration across sites was the loss of a waitlist control group. This transformed the design approach to that of a single-arm study. Given the lack of a concurrent or waitlist comparator arm, the observed longitudinal effects of the intervention should be interpreted with caution. The single-arm study design was unable to control for the effects of potential covariates of outcome measures, and as such cannot provide conclusive evidence that participants' symptom improvement is attributable to the expressive art intervention. Potential covariates of outcome measures that were not captured by this design include: (1) the effect of general social support received from participating in a group therapy, and (2) the normative alleviation of grief symptoms over time. On the other hand, participants reported unchanged perceptions of social support for their loss over time, and the study sample's uniquely elevated time since loss (described and discussed in greater detail below) suggests that

the moderating effect of a four-week delay may have been minimal, if not negligible, on outcome measurement. These limitations of the single-arm approach remain, however, along with the important consideration that the current study was unable to compare outcomes to that of a traditional talk-therapy grief support group, or “treatment as usual” (TAU) control group. As such, future studies of expressive art bereavement interventions should incorporate TAU control groups to further enhance our understanding of the mechanisms of change within grief intervention.

An interesting characteristic of the study sample is the averaged time since loss. The current study’s participants reported a longer average time since loss than typical presentations in the bereavement literature. In a thorough meta-analytic review of the bereavement intervention literature, Currier and colleagues (2008) found that adult participants across 60 published studies averaged 14 months ( $SD = 16.3$  months) since the time of their loss. Bereavement studies with older adult samples have reported an average time since loss.

**Measures.** One unavoidable weakness of the study design is that all of the measures are based on self-report information. The exclusive reliance on self-report measures is potentially problematic because chances of bias and distortion on the part of the participant are increased (e.g., social desirability). However, this type of measurement was suitable to the study aims.

Since one of the aims of the study was to examine the feasibility of engaging community residents in participatory research of a potentially sensitive nature, measures were carefully considered and conservatively chosen. The selection of assessments was based on consideration for the reported psychometric properties, costs of data collection in terms of participant/researcher time, low literacy levels in the sample population, and feasibility of completion. Therefore, assessment questions were limited to those that have demonstrated



clinical value and could contribute directly to the objectives of the study. The study incorporated evidence-based accommodations to facilitate measurement completion, such as using large print serif typeface for written materials, offering verbal reading of measure items and providing color coded response option keys for individuals endorsing reading difficulties (National Institute on Aging). However, the measures for this study are obtrusive and participants were aware of, and possibly influenced by, the fact that they were participating in an investigation. Reactivity to measures is a particular challenge in community-based participatory research settings, where participants can often be wary of self-disclosure to an academic unit. We attempted to limit reactivity in several ways. Each participant was privately provided a randomized study ID number that they wrote on the last page of their survey packets to ensure their study IDs could not be easily seen by group peers and so no names or other identifying information were connected to their written responses.

**Procedural Issues.** Technological challenges arose during the course of the study that are unique to this particular participant population. For example, the majority of participants have government-funded phone plans with limited monthly minutes; this commonly leads to call screening and a reliance on voicemail messaging so as to not waste cellular minutes. While savvy in its frugal functionality, this prevalent communication limitation created delays in study recruitment and screening. In addition, many participants requested reminder phone calls from the author one day before each session to prompt their attendance, to which the author happily obliged. Future researchers may benefit from recognizing that requesting weekly reminders through voice mail is developmentally and contextually normative for this older population of limited means.

Another procedural challenge arose in scheduling the weekly support groups. When working with this population, date of the month is an important methodological consideration with potentially dramatic effects on attrition. Many individuals in this population receive social security and/or disability benefits as their sole form of income, which are provided once monthly. If a program or study is scheduled for the day or day after everyone receives their checks that month, it will experience a disproportionately high number of no shows. Indigent older adults are often reliant on family or friends for transportation and will typically schedule their carpools to the grocery store or supercenter on these days. Thus, familiarity with the SS Disability payment schedule (openly accessible online) is imperative when conducting participatory research in this area.

From the standpoint of decreasing risk of experimenter expectancies, it would have been ideal if the researcher did not have direct contact with participants. However, having a separate researcher posed its own set of problems: additional training, compliance testing, monitoring, and payment for services would have been taxing on unavailable resources. In addition, the researcher had an existing relationship with staff and residents of the study sites through involvement with the Richmond Health and Wellness Program (RHWP) and the RHWP Wellness Clinics that had diligently worked to foster respectful, bidirectional trust within the community of each study site. This existing relationship allowed for a level of baseline rapport when approaching residents for recruitment to the study. Members of the sampled community have well-founded suspicions and unease of participating in medical or mental health research that has led to infrequent participation in research. One unfortunate consequence of this is the sample population's underrepresentation in the bereavement literature. The existing relationship between the researcher and study participants is a hallmark of community-based participatory

research (CBPR), a research paradigm that encapsulates the present study with its integration of academic and community partners. CBPR has been framed as an orientation to research that focuses on relationships between research partners and goals of societal transformation (Minkler & Wallerstein, 2003) that must equitably involve community members, organizational representatives and researchers to effort implementation and change (Israel et al., 2001). In sum, within the paradigm of CBPR, there are study and participatory benefits in the researcher's involvement with the administration of the study sessions.

### **Future Directions.**

*Large-Scale Study.* This study is unique in its focus on evaluating the feasibility of a grief therapy group for an often clinically inaccessible subset of socioeconomically vulnerable older adults residing independently in the community. Our findings present benchmark data on the efficacy of a longitudinal visual-art based grief support group. Since this study was largely exploratory in nature, the employed design could not address all of the questions involving the burgeoning use of creative arts in bereavement intervention. This study represents a first step in what should be a long line of research in this area. In general, more quantitative research is needed to better understand the therapeutic outcomes of expressive art modalities with a bereaved population. Such research will help inform subsequent evidence-based intervention efforts. Towards this end, this pilot study may serve as a platform for a larger project.

Based on what was learned by running this study, there are several logistical changes that should be made to the methods of a larger-scale project. The next phase of research would benefit from longer recruitment periods. A larger  $N$  would allow for the following: additional subgroup populations to be examined, order effects to be controlled for in the applicable analyses, and determination of any differences associated with procedural variation (e.g.,

research assistant administration of measures, days of week conducting on-site groups, and scheduling effects on attrition). Data analyses should include prediction (i.e., regression analyses), including influence of demographic and loss characteristic variables. Larger-scale projects would benefit from the use of pre-existing visual art modules specific to a grief therapy context, such as the current study's treatment manual, in order to examine the effectiveness of these modules across populations and treatment settings. Once a standard therapy methodology is practiced at several institutions on a large scale, a meta-analysis can be performed to further establish the efficacy and value of expressive arts therapy in the treatment of bereavement and grief.

*Other Studies.* From results of this pilot study, there are indications of areas that need additional exploration apart from a larger-scale study. Future studies may benefit from targeting participants who have experienced a specific type of loss, such as losing a loved one to homicide or suicide, or who have experienced the death of a particular relation, such as groups for bereaved spouses or siblings. Further, as the present study data focused on older adults of lower socioeconomic status, a high-risk group for cumulative traumatic loss, it will be important in future research to look at the efficacy of visual-art based therapies with other particularly high-risk groups, such as those who have lost someone to a threatening or stigmatizing circumstance (e.g., the death of a child or of a loved one to suicide or overdose). Group therapies that are specialized to particular forms of loss and can facilitate meaning-making through helping members narrate the story of their loved one's dying in a safe and containing therapeutic context (Rynearson & Salloum, 2011).

Our results indicate that there are several measurement issues that should be further investigated. Overall, grief symptom assessments are developed to inquire about the effects of

one significant loss. Many study participants endorsed negative grief symptoms attributable to multiple losses. The development of grief symptom assessment that allows for the measurement of cumulative loss would initiate more investigations of grief effects; this would be of particular use in future studies with the older adult population due to the prevalence of having experienced multiple significant losses. To this end, the uniquely layered grief experiences of the elderly may present an opportunity to devise a screening instrument with enhanced discriminative power in this age group, perhaps in similar developmental aptitude as the Geriatric Depression Scale (Yesavage, 1983).

Other considerations for future studies regarding measurement include the encouragement of mixed methods designs. The present study offers important contribution to the expressive art literature with its use of quantitative outcome measurement, but the addition of qualitative analyses would strengthen and further contextualize these findings. For example, similar to this study's intervention, most expressive art group therapies allocate time in session for participants to voluntarily share their artwork with their peers. This component is often quite moving as participants describe the meanings and stories behind their work that otherwise would have been veiled. Studies of similar context would benefit from audio recording or scribing group sessions for subsequent qualitative analysis of these descriptions. Indeed, Gillies, Neimeyer and Milman (2014) have developed a 30-category Meaning in Loss Codebook to guide process-outcome studies of meaning made in grief therapy. In a study of the multimodal Complicated Grief Group Therapy (CGGT) for survivors of suicide, Supiano, Haynes, and Ponds (2017) used the Meaning in Loss Codebook on video data of the group to evaluate participant meaning reconstruction. Replication of this approach, paired with quantitative symptomology

measures, is just one of the many options for evidence-based, mixed-methods investigation of expressive arts in bereavement intervention.

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Appendix B: Dominion Place Recruitment Flyer



# Grief Support Group

Participate in a research study on grief support by attending a free, 4-week grief support group here at Dominion Place!

*Snacks and drinks will be provided. Participants will receive a \$5 gift card.*

**When:**  
**Fridays, 11:00 am—12:30 pm**  
May 25<sup>th</sup>, June 1<sup>st</sup>, June 8<sup>th</sup>, & June 15<sup>th</sup>

If you are interested in participating or have questions, talk to Rachel Weiskittle at 804-506-3213 or at the Wellness Clinic on Thursdays.

Sandra E. Gamling, PhD, LCP – Principal Investigator  
Department of Psychology  
Virginia Commonwealth University



Grief Support Group  
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# **Common Questions about Grief Support Groups**

## **What is a Grief Support Group?**

A Grief Support Group is a group of people who meet to learn about grief and support one other in their loss.

## **What happens at a Grief Support Group?**

The person who organized the group (called a facilitator) asks how everyone is doing and introduces a topic or activity about grief. Group members can choose to talk about their thoughts, memories, and feelings about their loss.

## **Why do people go to Grief Support Groups?**

Different people go for different reasons. Some people want to learn tips about how to cope with their loss. Others want to have a safe space to talk about their loved one, or want to be with people who have experienced similar losses.

## **What if I want to go but don't want to talk?**

That is okay! Group members do not have to talk if they don't want to. A lot of people feel that way and just like to listen.

## **What if people talk or gossip about what I said during group?**

Everything said during a Grief Support Group is **private** and confidential. This is **very important** so that everyone feels safe and supported during group. **What is said during group does not leave group.**

## **How do I find out about local Grief Support Groups I could go to?**

There are multiple ways! You can contact the Richmond Health and Wellness Program about their upcoming Grief Support Groups offered here, or contact the Richmond Bon Secours Bereavement Services at 804-433-4710. You can also talk to your doctor, nurse, chaplain, or the Wellness Clinic for other local resources.

**Appendix D: Half Sheet Recruitment Flyer**

**Grief Support Group**

Participate in a study on grief by attending a free, 4-week grief support group here at Dominion Place! *Snacks and drinks will be provided.*

When: Thursdays 1:00 pm—2:30 pm  
Dates To Be Determined

**Call 804-506-3213 or talk to Rachel Weiskittle  
on Thursdays to see if you are eligible to participate!**

**Grief Support Group**

Participate in a study on grief by attending a free, 4-week grief support group here at Dominion Place! *Snacks and drinks will be provided.*

When: Thursdays 1:00 pm—2:30 pm  
Dates To Be Determined

**Call 804-506-3213 or talk to Rachel Weiskittle  
on Thursdays to see if you are eligible to participate!**

## Appendix E: Verbal Screening Script

Research staff will utilize the following semi-structured screening script when approaching potential participants in the community rooms or when responding to potential participants who approach research staff.

*“Good (morning/afternoon), I’m (insert name), a research assistant at VCU. I would like to ask you a few questions about yourself to see if you might qualify for a research study. Participation is voluntary and nothing bad will happen to you if you refuse or stop answering questions. You may find answering the questions to be uncomfortable and can stop at any time. Before I tell you more about the study, may I ask you a few questions to see if you are eligible?”*

**(If no, please thank the person for their time).**

**If yes,**

*“Okay, thank you.*

*How old are you? [ $\geq 55$  = eligible]*

*Do you currently live at this residence? [Yes = eligible]*

*Have you experienced the death of someone close to you?” [Yes = eligible]*

**(If ineligible, please thank the person for their time and provide local grief resources if they are ineligible due to age or current residence).**

**If eligible, administer the Mini-Cog [Score  $\geq 3$  = eligible]**

**(If ineligible, please thank the person for their time and provide local grief resources).**

**If eligible,**

*“We are conducting a study that aims to provide social and coping resources to help people adapt to loss. The information we learn from people in this study may help us design better programs for other individuals who have experienced the death of someone close to them.*

*Participants will attend four weekly grief support groups in a private room on the first floor of this residence. There are no costs for participating in this study other than the time you will spend in the groups and filling out questionnaires. You will receive a \$5.00 gift certificate following your completion of a follow-up survey four weeks after the final session of the support group.*

*Any data we collect from you via surveys is for research purposes only. Surveys will be identified by ID numbers, not names, and stored in a locked research area. However, if, as part of this research, we learn about real or suspected child or elder abuse, the law says that we have to let*



*people in authority know so they can protect the person(s) at risk. Additionally, if something we learn through this research indicates that you may intend to harm yourself or others, we are obligated to report that to the appropriate authorities.*

*Would this be something you would be interested in participating in?"*

**(If no, please thank the person for their time and provide them with local grief resources).**

**If yes,**

*"Great! Our next step is to review and sign a consent form that will provide further details about this study. Then you will complete a brief survey packet that takes around 10 minutes to complete. Let's move to this more private room over here and get started."*

## Appendix F: Demographics Questionnaire

### Demographic Questionnaire

Listed below are demographic questions.  
Please provide a response for every question.

---

1. **What is Your Age?** \_\_\_\_\_

2. **What is your Gender?** *Male*                      *Female*

3. **Which of the following best describe your ethnicity?**

*White/Caucasian*                      *Black/African American*                      *Hispanic*                      *Asian*

*Native Hawaiian or Other Pacific Islander*                      *Other:* \_\_\_\_\_

4. **What is your Marital Status? (Please Circle One)**

*Single*                      *Married*                      *Separated*                      *Divorced*                      *Widowed*

*Long-Term Relationship (not married)*                      *Living Together (not married)*

5. **How many years of education have you completed?** \_\_\_\_\_

6. **Which of the following best describes your religious faith? (Please Circle One)**

*Protestant Christian*                      *Catholic*                      *Muslim*                      *Hindu*                      *Buddhist*                      *Jewish*

*Spiritual but Not Religious*                      *Not Spiritual or Religious*

*Other:* \_\_\_\_\_



## Appendix H: The Patient Health Questionnaire (PHQ-2)

Over the past TWO WEEKS, how often have you been bothered by any of the following problems?

	<b>Not at all</b>	<b>Several Days</b>	<b>More than Half the Days</b>	<b>Nearly Every Day</b>
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Scoring: Sum scores of each question. Scores greater than 6 indicate depressive symptoms.

## Appendix I: The Integration of Stressful Life Experiences Scale (ISLES)

Please indicate the extent to which you agree or disagree with the following statements with regard to your recent loss.

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
1. Since this loss, the world seems like a confusing and scary place	1	2	3	4	5
2. I have made sense of this loss	1	2	3	4	5
3. If or when I talk about this loss, I believe people see me differently	1	2	3	4	5
4. I have difficulty integrating this loss into my understanding about the world	1	2	3	4	5
5. Since this loss, I feel like I'm in a crisis of faith	1	2	3	4	5
6. This loss is incomprehensible to me	1	2	3	4	5
7. My previous goals and hopes for the future don't make sense anymore since this loss	1	2	3	4	5
8. I am perplexed by what happened	1	2	3	4	5
9. Since this loss happened, I don't know where to go next in my life	1	2	3	4	5
10. I would have an easier time talking about my life if I left this loss out	1	2	3	4	5
11. My beliefs and values are less clear since this loss	1	2	3	4	5
12. I don't understand myself anymore since this loss	1	2	3	4	5
13. Since this loss, I have a harder time feeling like I'm part of something larger than myself	1	2	3	4	5
14. This loss has made me feel less purposeful	1	2	3	4	5
15. I haven't been able to put the pieces of my life back together since this loss	1	2	3	4	5
16. After this loss, life seems more random	1	2	3	4	5

**Scoring of The Integration of Stressful Life Experiences Scale (ISLES):**

The ISLES can be scored by summing items together after reverse-coding item 2. A total score of the ISLES or two separate subscale scores (for Comprehensibility or Footing in the World) may be derived. All items are scored so that higher scores indicate more adaptive meaning made of a stressful life event.

<b>Factor</b>	<b>Items</b>
Comprehensibility	2, 4, 6, 8, 10
Footing in the World	1, 3, 5, 7, 9, 11, 12, 13, 14, 15, 16

Though clear cutoffs for the ISLES have yet to be established, unpublished data indicate that a total ISLES score of 52 or below can correctly classify bereaved young adults as having elevated complicated grief symptoms with 90% sensitivity and 74% specificity (Holland, 2017).

## Appendix J: Grief and Meaning Reconstruction Inventory (GMRI)

The following statements refer to thoughts, beliefs, feelings, and meanings some bereaved people experience following their loss. Please circle the number that rates the degree to which each of these experiences has been true for you in the past week, on a scale from 1 to 5.

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
1. The time I spent with my loved one was a blessing	1	2	3	4	5
2. I do not see any good that has come from this loss	1	2	3	4	5
3. Since this loss, I'm more self-reflective	1	2	3	4	5
4. I value family more	1	2	3	4	5
5. I will see my loved one again	1	2	3	4	5
6. Since this loss, I find myself more alone and isolated	1	2	3	4	5
7. I've been able to make sense of this loss	1	2	3	4	5
8. Since this loss, I'm a stronger person	1	2	3	4	5
9. I can't understand this loss	1	2	3	4	5
10. I was prepared for my loved one to die	1	2	3	4	5
11. My loved one was a good person; he/she lived a good life	1	2	3	4	5
12. I value and appreciate life more	1	2	3	4	5
13. Since this loss, I've changed my lifestyle for the better	1	2	3	4	5
14. Memories of my loved one bring me a sense of peace and solace	1	2	3	4	5
15. This death brought my loved one peace	1	2	3	4	5
16. I've lost my innocence	1	2	3	4	5
17. This death ended my loved one's suffering	1	2	3	4	5
18. I miss my loved one	1	2	3	4	5
19. Since this loss, I make more effort to help others	1	2	3	4	5
20. I feel empty and lost	1	2	3	4	5

21. I cherish the memories of my loved one	1	2	3	4	5
22. Since this loss, I value friendship and social support more	1	2	3	4	5
23. My loved one was prepared to die	1	2	3	4	5
24. Whenever I can, I seize the day. I live life to the fullest	1	2	3	4	5
25. Since this loss, I'm a more responsible person	1	2	3	4	5
26. I believe my loved one is in a better place	1	2	3	4	5
27. I feel pain from regrets I have in regard to this loss	1	2	3	4	5
28. I've come to understand that life is short and it gives us no guarantees	1	2	3	4	5
29. Since this loss, I've pursued new avenues of knowledge and learning	1	2	3	4	5

**Scoring the Grief and Meaning Reconstruction Inventory (GMRI):**

GMRI items factor into the five following subscales: Continuing bonds, personal growth, sense of peace, emptiness and meaninglessness, and valuing life. The total score on the GMRI represents the sum of all items, with Factor 4 items reverse scored so that higher values on all factors represent better adjustment.

Factor	Items
1. Continuing Bonds	1, 5, 11, 14, 18, 21, 26
2. Personal Growth	3, 8, 13, 19, 22, 25, 29
3. Sense of Peace	7, 10, 15, 17, 23
4. Emptiness and Meaningless*	2, 6, 9, 16, 20, 27
5. Valuing Life	4, 12, 24, 28

\*These items are reverse scored.



## Appendix K: Inventory of Social Support (ISS)

Read each item carefully. Using the scale shown below, please select the number that best describes the way you have been feeling during the **PAST TWO WEEKS** including today. Please select the number that best describes YOU and put that number in the blank provided.

- 1 = Does not describe me at all
- 2 = Does not quite describe me
- 3 = Describes me fairly well
- 4 = Describes me well
- 5 = Describes me very well

- \_\_\_ 1. People take the time to listen to how I feel.
- \_\_\_ 2. I can express my feelings about my grief openly and honestly.
- \_\_\_ 3. It helps me to talk with someone who is nonjudgmental about how I grieve.
- \_\_\_ 4. There is at least one person I can talk to about my grief.
- \_\_\_ 5. I can get help for my grieving when I need it.

Scoring: The ISS is scored by adding the response values for each item and dividing this value by the number of items in the scale.

### Appendix L: Creative Achievement Questionnaire (CAQ)

The following questions ask about your experience with visual arts, which include drawing, painting, sculpture, collages, scrapbooking, and other art forms. Please mark the extent to which you agree or disagree with each statement.

	<b>Strongly Agree</b>	<b>Agree</b>	<b>Neither agree nor disagree</b>	<b>Disagree</b>	<b>Strongly disagree</b>
1. I have no training or recognized talent in visual arts	1	2	3	4	5
2. I have taken lessons in the visual arts	1	2	3	4	5
3. People have commented on my talent in the visual arts	1	2	3	4	5
4. I have won a prize or prizes at a juried art show.	1	2	3	4	5
5. I have had a showing of my work in a gallery.	1	2	3	4	5
6. I have sold a piece of my work.	1	2	3	4	5
7. My work has been critiqued in local publications.	1	2	3	4	5
8. My work has been critiqued in national publications	1	2	3	4	5

Scoring: The Creative Achievement Questionnaire is scored by adding the response values for each item and dividing this value by the number of items in the scale.

### Appendix M: Kaufman Domains of Creativity Scale (K-DOCS)

Compared to people of approximately your age and life experience, how creative would you rate yourself for each of the following acts? For acts that you have not specifically done, estimate your creative potential based on your performance on similar tasks.

	<b>Much Less Creative</b>	<b>Less Creative</b>	<b>Neither More or Less Creative</b>	<b>More Creative</b>	<b>Much More Creative</b>
1. Sketching a person or object	1	2	3	4	5
2. Doodling/Drawing random or geometric designs	1	2	3	4	5
3. Making a scrapbook page out of my photographs	1	2	3	4	5
4. Taking a well-composed photograph using an interesting angle or approach	1	2	3	4	5
5. Making a sculpture or piece of pottery	1	2	3	4	5
6. Appreciating a beautiful painting	1	2	3	4	5
7. Coming up with my own interpretation of a classic work of art	1	2	3	4	5
8. Enjoying an art museum	1	2	3	4	5

Scoring: The Kaufman Domains of Creativity Scale is scored by adding the response values for each item and dividing this value by the number of items in the scale.

## Appendix N: Program Evaluation Questionnaire

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
1. Overall, I benefited from being in this group	1	2	3	4	5
2. I enjoyed my participation in this group	1	2	3	4	5
3. This group provided a safe place to talk about my grief with others	1	2	3	4	5
4. I feel more comfortable talking about my loss than before this group	1	2	3	4	5
5. I feel less alone in my grief than before this program	1	2	3	4	5
6. I feel more confident in my ability to cope with my grief than before this group	1	2	3	4	5

The following three questions ask about the collage made in the first week of this program, called the “Introducing Your Loved One Collage,” where you pasted pictures and words that reminded you of your loved one.

7. The collage I made in the first week of this group helped me reflect on my relationship with my loved one	1	2	3	4	5
8. The collage I made in the first week of this group helped me make sense of my loss	1	2	3	4	5
9. The collage I made in the first week of this group helped me explore my goals for the future	1	2	3	4	5

The next three questions ask about the art activity made in the second week of this program, called the “Loss Road Map,” where you drew a road map that represented your grief journey.

10. The Loss Road Map activity helped me reflect on my relationship with my loved one	1	2	3	4	5
11. The Loss Road Map activity helped me make sense of my loss	1	2	3	4	5
12. The Loss Road Map activity helped me explore my goals for the future	1	2	3	4	5

The next three questions ask about the art activity made in the third week of this program, called the “Virtual Dream Story Board,” where you drew a picture that incorporated six

13. The Virtual Dream Story Board activity helped me reflect on my relationship with my loved one	1	2	3	4	5
14. The Virtual Dream Story Board activity helped me make sense of my loss	1	2	3	4	5
15. The Virtual Dream Story Board activity helped me explore my goals for the future	1	2	3	4	5

**Program Evaluation Questionnaire Continued**

16. Which art activity did you find most helpful in processing your grief?

- Introducing the Loved One Collage
- Loss Road Map
- Virtual Dream Story Board
- All of the art activities helped me process my grief equally
- None of the art activities helped me process my grief

17. Please use the space below to provide feedback about what you most benefitted from as well as components of the group that you found less helpful or did not enjoy.

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Thank you for participating in this group and for completing these questionnaires!  
We appreciate your time.

**Appendix A: Visual Art Bereavement Group Guidebook**

**Visual Art Bereavement Group Guidebook**

## TABLE OF CONTENTS

### **Part I: Introduction and Background**

How to Use This Guidebook.....	4
Terminology of Bereavement.....	5
Theoretical Frameworks of Grief.....	6
Intervening with the Bereaved.....	9
Expressive Arts and Grief.....	15
Development of the Manual.....	19

### **Part II: Facilitation Guidelines**

General Facilitator Guidelines.....	23
Techniques of Facilitating Group Discussion.....	25
Time Management Tips.....	26
Troubleshooting Difficult Situations.....	27

### **Part III: Intervention Modules**

Module and Session Structure.....	30
Module 1: Introduction and Reopening the Story.....	33
Module 2: Processing the Event Story of the Loss.....	37
Module 3: Exploring Sources of Meaning.....	41
Module 4: Consolidation, Mobilization, and Termination.....	50

### **Part IV: References**

References.....	53
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## **Part I: Introduction and Background**



## **HOW TO USE THIS GUIDEBOOK**

This guidebook has been developed to assist those who encounter bereaved individuals in the course of their outreach work. The information and methods offered in this guidebook have been written to be of use to licensed mental health practitioners, paraprofessionals, and outreach workers. Components of this guidebook may also be useful for teachers, health care providers, or caregivers seeking to provide support to those who have experienced a significant loss. Whenever a person is encountered who is experiencing severe reactions or complicating conditions for which the worker feels unqualified to address, consultation with an appropriate mental health professional and an appropriate referral for more formal services should be made.

The guidebook provides a brief historical overview of expressive art interventions with the bereaved and introduces a pilot program informed by these findings. The included program manual is designed as a four-week group intervention for individuals who have recently experienced a significant loss. During each module, participants are introduced to a structured art activity that explores themes of loss. Participants complete the activity in session with materials provided by the facilitator. Participants are then given the opportunity to share their artwork with the group if desired and a discussion of the emergent themes is guided by the facilitator.

Detailed information and empirically-informed rationales about the content, structure and development of this guidebook is located in the Introduction and Background section.

This guidebook is divided into four parts:

- 1) Introduction and Background  
A brief overview of bereavement terminology, theory, and intervention development.
- 2) Facilitation Guidelines  
General instructions and suggestions for leading group discussions and activities about grief.
- 3) Intervention Modules  
A manualized facilitator's guidebook for a 4-week bereavement group intervention utilizing visual art activities to facilitate adaptation to loss.
- 4) Resources and References  
Provides all references cited in the guidebook as well as a list of grief websites, organizations, and other bereavement resources.

## **AN OVERVIEW OF GRIEF AND BEREAVEMENT**

### **Terminology**

The terms grief, bereavement, and mourning have been used interchangeably in early psychological literature. As bereavement research has expanded, consensus definitions of these terms have been specified.

#### ***Bereavement***

Stroebe, Hansson, Schut, and Stroebe (2008) define *bereavement* as the “objective situation of having lost someone significant through death.” A person of significance can refer to any personal loss experienced across the lifespan.

#### ***Grief***

*Grief* is defined as the emotional reaction which accompanies the state of bereavement. This reaction is generally considered to include “diverse psychological...and physical manifestations,” including loneliness, anger, despair, yearning, withdrawal, and hallucinatory re-experiencing of the lost figure (Stroebe, et al., 2008).

#### ***Mourning***

*Mourning*, although often used colloquially as a synonym for grief, is identified as the actions and manner in which one expresses their grief and incorporates the loss into their life, often taking the form of religious beliefs and social customs (Granek, 2010). Another way to describe *mourning* is as the way grief is displayed to the public.

### **Negative Health Impacts of Bereavement**

Coping with the death of a loved one is often challenging and can affect bereaved individuals across multifaceted domains. Along with heightened emotions and longing for the deceased, bereaved individuals may experience symptoms of depression, anxiety, and cognitive disorganization (Utz et al., 2002).

Those bereaved may also endorse physical manifestations of their distress, such as increased fatigue, greater propensity for developing illness, and overall poorer physical health outcomes than their non-bereaved counterparts (Prigerson et al., 2001; Murphy et al., 1999). These symptoms are collectively identified as the negative symptoms of grief and can catalyze a myriad of functional complications, including decreased academic performance (Servaty-Seib & Hamilton, 2006), job productivity, and quality of life (Neimeyer et al., 2008).

## **THEORETICAL FRAMEWORKS OF GRIEF**

### **Stage and Task Models of Grief**

Early grief theories either Freud's (1917) analytic interpretation of grieving or Bowlby's (1980) attachment model. Both theories argued that adjusting to the death of a loved one required "grief work," that required the completion of difficult stages. Examples of predicted stages included a confrontation about the loss followed by a period of intense distress or depression.

Subsequent grief theories deemphasized the pathology of grief but maintained the stage-model heuristic. The most recognizable and influential is that of Kubler-Ross (1969). Originally developed to describe how a dying individual relates to his or her own impending death, Kubler-Ross' model was readily applied by clinicians to describe the grief processing of the bereaved. The model was also favorably received by non-clinicians and soon assimilated into the mainstream cultural cannon (Holland, & Neimeyer, 2010; Maciejewski et al., 2007). According to Kubler-Ross, individuals go through five stages of grief: denial, anger, bargaining, depression, and acceptance. Kubler-Ross' model is in accordance with psychodynamic theories delineating grief into an initial period of distress worked through until the individual is returns to the level of their pre-loss functioning.

Worden (1982, 1991) introduced a model of bereavement similar in construct to that of Kubler-Ross but introduced a alternative design, termed as a "task" model. The difference between tasks and stages, Worden argued, is that individuals can complete tasks in any order. Based on anecdotal evidence and clinical experience, Worden hypothesized that to process their grief, bereaved individuals must: 1) accept the reality of the loss, 2) experience the pain of grief, 3) adjust to an environment that does not contain the lost loved-one, and 4) emotionally relocate the deceased and move on with life. He further stated that the grieving process is complete when the bereaved can "think of the deceased without pain" and "reinvest his or her emotions back into life and in the living" (Worden, 1991). Influence of psychodynamic theory within the task model appears in its assumptions that the bereaved must experience significant emotional distress during the grieving process and that deatthesis is considered the completion of the linear grief journey. However, Worden's model was progressive in its conceptualization of grief as a variable process. By allowing the tasks of grief to be experienced in any order, the model was one of the first to accept the influence of individual differences on bereavement responses.

### **The Multiple Trajectories of Grief**

A burgeoning of bereavement research over recent decades has dramatically contextualized our understanding of loss. Many assumptions of psychodynamic and stage models have been challenged or dismantled. This is demonstrated perhaps most prominently in the bereavement field's paradigm shift away from models of ubiquitous bereavement stages. Longitudinal research has demonstrated that most individuals do not go through predictable stages when grieving (e.g., Holland, & Neimeyer, 2010). Most bereavement researchers believe the idea of a fixed sequence of stages to be not particularly useful (Wortman, & Boerner, 2007).

As the bereavement literature has expanded, a more nuanced conceptualization of grief has emerged. A large body of empirical evidence indicates multiple distinct trajectories of grief (e.g., Bonanno, 2004). Some people demonstrate considerable resilience when faced with loss, others experience significant but temporary impairment, and approximately 10—15% find themselves “stuck” in a persistent state of intense, complicated grief (Bonanno, 2004; Prigerson et al., 2009).

Characteristics of the bereaved and of their loss can impact grief trajectories. For example, relationship to the deceased and expectedness of the loss have been found to be particularly influential on the intensity of grief reactions (Holland & Neimeyer, 2011; Currier, Holland, & Neimeyer, 2006). As such, contemporary models of grief emphasize that the ways people adapt to loss vary as a function of individual differences. Grief is viewed as an idiosyncratic process in that reactions to the loss of a loved one span a wide range of cognitive and emotional states (Wortman, & Boerner, 2007). Leaders in the field suggest that reactions to loss can be as varied as the bereaved individuals themselves (Currier et al., 2008).

Theorists and researchers currently embrace a range of empirically-validated frameworks that account for the variegated trajectories of bereavement experiences, but two theories have emerged as the most demonstrable in empirical promise.

### **The Dual Process Model of Bereavement**

The Dual Process Model of Bereavement posits that grieving a loved one entails oscillating between orientation to the loss (i.e., continuing bonds with the deceased by expressing emotion related to the death and reconnecting with the memory of the loved one) and restoration of contact with a changed world (i.e., re-engaging relationships and experimenting with new life roles; Stroebe & Schut, 1999).

One aim in the development of this model was to portray the daily coping process of the bereaved. The model presents two styles of coping that facilitate adjustment to the death of a loved one: loss-oriented coping and restoration-oriented coping.

Loss-oriented coping focuses on the processing of the loss experience. Examples of loss-oriented coping include the expression of emotion related to the death and reconnecting with the memory of the loved one through dialogue or pictures.

Restoration-oriented coping focuses on daily practical needs following the loss, such as problem-solving challenges resulting from the death, re-engaging relationships, pursuing enjoyable activities and experimenting with new life roles.

Bereaved individuals experience a natural oscillation between these two coping styles in varying patterns of confrontation and avoidance of their loss. The openness to this oscillation and ability to engage in both coping styles is important to optimal adjustment to one’s loss. The Dual Process Model thus conceptualizes grief as the state of coming to terms with the loss (loss-oriented coping) and participation in future-oriented experiences (restoration-oriented coping; Stroebe & Schut, 1999).

## **The Meaning Reconstruction Model**

The Meaning Reconstruction Model views grief as the process of reaffirming or reforming a world of meaning that has been challenged by loss (Neimeyer, 2001).

This model approaches grief from a cognitive constructivist perspective, which posits that people create and maintain a system of beliefs in order to anticipate and respond to their surroundings. One's system of beliefs can be challenged by events if the meaning an individual ascribes to them is incongruent with the overarching system. Events' ascribed meaning must be either assimilated into the existing belief system or the system must be accommodated to make congruent meaning of the event (Neimeyer & Sands, 2011). Accordingly, the Meaning Reconstruction model characterizes grief as the process of making meaning of one's loss and reconstructing one's belief system to accommodate this meaning (Neimeyer, 2006).

## **The Complimentary Nature of These Bereavement Models**

The Dual Process Model of Bereavement and the Meaning Reconstruction Model share core assumptions about grief and complement each other in application. Both models view grief as a life-long process of formulating meaning into life after the loss and renegotiating ties with the deceased (Lister et al., 2008). The Meaning Reconstruction Model proposes that the search for meaning is the bereaved individual's quest following loss, and the Dual Process Model's oscillation between loss-focused and restoration-focused coping help to explain how the meaning is created (Stroebe & Schut, 2001). Both models aim to address not only the formulation of meaning ascribed to the death experience but also the assimilation of this meaning to future-oriented goals and developing identity of the bereaved.

## INTERVENING WITH THE BEREAVED

### **Early Bereavement Interventions**

Most early prevalent bereavement interventions were based on the theories of Freud (1917) and Bowlby (1980), which viewed bereavement as a ubiquitous, linear process of suffering that required “grief work” to sever emotional connection with the deceased and return the bereaved to their pre-loss, baseline functioning. Interventions informed by these models aimed to assist the bereaved through his or her grief work. This work included the expression of intense distress and confrontations about the loss and was expected across loss situations. It was believed that experiencing positive emotions during the early stages of grieving was inappropriate or evidence of denial (e.g. Deutsch, 1937). Long-term goals of treatment included the gradual alleviation of negative grief symptoms. The extent to which the bereaved endorsed negative grief symptoms served as a measure of treatment efficacy.

The existent literature offers some important considerations on the relationship between negative grief symptoms and the evaluation of treatment efficacy. First, studies indicate that the absence of negative grief symptoms is not necessarily a marker of successful adaptation to the death. Common trajectories of grief include delayed or inhibited grief, by which individuals either do not immediately or ever endorse traditional negative grief symptoms (Bonanno et al., 2004). There is also strong evidence against the idea that those who do not exhibit grief following a loss are insecurely attached and emotionally distant (Bonanno et al., 2002). Thus, the endorsement or expression of negative grief symptoms is not directly indicative of grief intensity or one’s adaptation to loss as early interventions assumed.

Second, the negative aspects of bereavement are no longer considered to be the only formulation of grief (Doka, 2010). As leading models of bereavement demonstrate, a large body empirical evidence supports the conceptualization of grief as a complex system of experiences that can include both negative and positive attributes. Positive outcomes of bereavement include, but are not limited to: personal growth, meaning making, benefit finding, and greater self-worth (Park & Folkman, 1997; Tedeschi, & Calhoun, 2004; Shapiro, 2007; Hogan & DeSaints, 1996). The exclusive measurement of negative outcomes following loss fails to assess the full spectrum of possible bereavement experiences. The limitations in this unipolar measurement of symptoms is especially relevant when attempting to evaluate the effects of bereavement interventions,

Although the negative aspects of bereavement are no longer considered to be the only formulation of grief, they are still viewed as integral and commonly endorsed components of bereavement (Doka, 2010). These negative grief reactions generally cause distress or impairment to the bereaved. The reactions may be exhibited affectively, emotionally, behaviorally, physiologically, cognitively, or socially (Worden, 2002). Negative grief symptoms are measured in the literature by endorsement of depressive symptoms, anxiety, poor social/relational functioning, cognitive disorganization, and physical health attributes (Shapiro, 2007). Quantitative measures of normative levels of negative grief symptoms are numerous, among them including the Core Bereavement Items (CBI; Burnett et al., 1997), and the Hogan Grief Reaction Checklist (HGRC, Hogan et al., 2001). Quantitative measures of complicated grief symptoms include the Inventory of Complicated Grief (ICG; Prigerson et al., 1995), and the

Texas Revised Inventory of Grief (TRIG; Faschingbauer, 1981). The aforementioned measures of negative grief symptoms have the strongest presence in bereavement literature because they demonstrate strong psychometric properties across a number of bereaved populations.

## **Bereavement Interventions Today**

In contrast to early bereavement intervention's focus on negative symptoms, today's empirically-informed interventions address both the negative and positive outcomes of loss. Interventions are predominantly informed by two aforementioned bereavement theories, the Dual Process Model of Bereavement and the Meaning Reconstruction Model. These theories encourage a strength-based approach to bereavement with emphasis on growth and cognitive understanding of the impacts of the loss (Neimeyer et al. 2010).

As bereavement theory evolved toward an increasing appreciation for the variety of ways individuals react to loss, interventions for the bereaved similarly evolved in scope to include a range of treatment modalities (Neimeyer et al., 2012). Many practices have made alterations to traditional grief psychotherapy in order to avoid a "one-size fits all" approach to treatment (Thompson et al., 2011; Mancini & Bonanno, 2006; Miles-Mason, 2005). Providers offer a variety of treatment modalities to address the diverse needs of the bereaved community. Common interventions include grief support groups, group therapies specific to type of loss experienced (e.g., type of relationship to the deceased, cause of death), weekend retreats, and individual psychotherapies informed by cognitive behavioral intervention techniques (Neimeyer, 2016). Interventions vary in length of time. Some bereavement manuals are written for 10-12 weekly sessions, others offer sessions across a month. Research indicates that even brief exposure to theoretically-based interventions significantly improves grief outcomes. For example, participants of a weekend workshop based in the Meaning Reconstruction Model reported a reduction in grief-related suffering, enhancement of meaning made, and reports of personal growth (Neimeyer & Young-Eisendrath, 2015).

Despite the variety in treatment methodologies, nearly all empirically-based practices endorse the same therapeutic aims. Interventions provide avenues for bereaved individuals to explore particular domains that indicate successful adjustment to a loss, as evidenced by studies of the Dual Process Model of Bereavement and the Meaning Reconstruction Model. These domains include: continued bonds with the deceased, personalized meaning behind the loss, cognitive understanding of the impacts behind the loss, and a reconstruction of purpose in a life without the loved one (Currier et al., 2008; Neimeyer et al. 2010). The domains most consistently and reliably measured are *continuing bonds*, *meaning making*, and *personal growth* (Neimeyer et al. 2010). The subsequent section describes these three domains and the ways they are commonly measured.

### **1) *Continuing Bonds***

Continuing bonds is a term that reflects the "ongoing attachment to the deceased" (Field, Gal-Oz, & Bonanno, 2003). Continuing bonds with the deceased can be experienced emotionally, through missing, yearning and feeling strongly connected to the loved one (Silverman, Nickman, & Worden, 1992), and cognitively, by thinking of and remembering the deceased person (Bonanno, Mihalecz, & LeJeune, 1999).

Continuing bonds can behaviorally entail talking to the loved one, maintaining his or her belongings post-loss, feeling the presence of the loved one, and passing on the deceased's habits or virtues to others (Attig, 2000). Importantly, accepting the reality of the death and communicating the narrative of the loved one's life arc are also manifestations of adaptive continuing bonds with the decedent (Field, Eval Gal-Oz, & Bonanno, 2003).

Continuing bonds with the deceased facilitates grief resolution by helping the bereaved to preserve a sense of identity and meaningful connection with the past (Bowlby, 1980; Field, 2008). When the bereaved are successful in finding meaning, evidence indicates that they fare better than their counterparts who struggle to make sense of the experience. Specifically, studies have reported that finding meaning is related to higher subjective well-being (Uren & Wastell, 2002) and more positive immune system functioning (Bower et al. 2003).

Continuing bonds is most often measured in quantitative bereavement research with the Continuing Bonds Scale (CBS; Waskowic & Chartier, 2003). In qualitative research, continuing bonds is commonly measured by the presence and frequency of the endorsements of the aforementioned characteristics.

## 2) *Meaning Making*

Meaning making, according to Thompson and Janigian (1988), is the "ability to develop new goals and purpose, or to construct a sense of self that incorporates the significance of an experience." Drawing from this definition, Neimeyer and colleagues (Currier, Holland, Coleman, & Neimeyer, 2007; Gillies & Neimeyer, 2006; Neimeyer, 2001) propose that meaning making following loss is a cyclical course in which the pain of bereavement (i.e., negative grief symptoms) prompts efforts to find meaning in the challenging event of the loss, with new meanings forming and integrating into a system of beliefs. In sum, meaning making during bereavement refers specifically to the reconciliation or reconfiguration of pre-existing meanings with the death of a loved one.

When the bereaved are successful in finding meaning, evidence indicates that they fare better than their counterparts who struggle to make sense of the experience. Studies report that finding meaning is related to higher subjective well-being (Stein et al. 1997) and more positive immune system functioning (Bower et al. 2003). Research provides empirical support for the processes proposed by the field's leading bereavement theories and suggests that bereaved people struggling to adjust to their loss could benefit from interventions driven around these two domains. As such, most empirically-informed grief therapies aim to provide avenues for patients to explore continued bonds with the deceased, the personalized meaning behind their loss, and a reconstruction of purpose in a life without their loved one (Currier et al., 2008).

Meaning making can be manifested in the following documentable ways: sharing views that relate to the philosophical aspects of death and dying such as fairness (Nedeau, 2001), questioning, examining and changing global meaning (Park,



Edmondson, Fenster, and Blank, 2008); discussing topics of religious connotations (Nedeau, 2001); expression of lessons learned, new insights gained, or changes in self or family since the death (Nedeau, 2001); expression of strengthened familiar relations following the loss (Davis, 2001).

Qualitative investigation of meaning making during bereavement often prompts participants to describe their loss experience in their own words and codes responses on the presence of the aforementioned documentable manifestations. For example, Lichtenthal and colleagues (2010) assessed meaning making processes in parents who had lost a child with open-ended written prompts (e.g., have there been any ways in which you have been able to make sense of the loss of your child?). Similarly, Wheeler (2001) observed a “crisis in meaning” among bereaved parents in a qualitative study that revealed themes of parents’ struggle to make sense of why the loss occurred, wondering what could have been done to prevent the loss, preserving the significance of their child’s life, and positive gains related to the loss. Quantitative measurement of meaning making during bereavement is most often assessed by directly asking participants to estimate how much they have been able to “make sense of” a loss on a Likert scale (Coleman & Neimeyer, 2010).

For a singular but comprehensive measure of grief symptomology, the Hogan Grief Reaction Checklist (HGRC, Hogan et al., 2005) provides a multidimensional report on both negative and positive aspects of bereavement experiences, such as personal growth, anger, and cognitive disorganization, among others. Since the HGRC’s development, it has been identified as one of the most widely employed instruments for measuring grief reactions and personal growth after a loss (Feigelman, Jordan, & Gorman, 2009). Additionally, the HGRC has been found to be compatible with the meaning reconstruction model of grief, allowing for consistency in grief conceptualization, symptom tracking, and treatment aims (Neimeyer & Sands, 2011).

### **3) *Personal Growth***

Separate from continuing bonds and meaning making, studies have highlighted many other positive developments that may occur after a loss (Bonanno & Kaltman, 2001; Calhoun and Tedeschi, 1989; Davis, Ho, Chu, & Yiu, 2008). These positive changes have been grouped together and labeled variously as personal growth, posttraumatic growth, or stress-related growth, (Helgeson, Reynolds, & Tomich, 2006; Park & Folkman, 1997; Tedeschi, & Calhoun, 2004). There are many examples of positive outcomes from bereavement. For example, bereavement can lead to a more fulfilling understanding of the external world. Frankl (1963) emphasized that suffering can facilitate the discovery of purpose in one’s life. Traumatic life events may lead to successful coping, learning lessons, and a fuller appreciation for life (Janoff-Bulman, 1992). Newly recognizing that life is finite can lead individuals to believe their actions matter more (Nerken, 1993).

Bereavement can also result in deeper and more meaningful social relationships. Bereaved individuals often report an increase in compassion for themselves and others, as well as a greater sense of self-worth (Hogan & DeSantis, 1996).

Experiencing a great loss can also result in resiliency, which is described as the ability to “maintain relatively stable, healthy levels of psychological and physical functioning” when confronted with loss and trauma (Bonnano, 2004). In a meta-analysis of the published research on personal growth in adults, Helgeson, Reynolds, and Tomich (2006) examined correlates of personal growth. They found that objective severity of the stressor, subjective perceptions of stress associated with the event, and greater intrusive and avoidant thoughts about the stressor were positively related to personal growth. In addition, personal growth was positively related to higher levels of positive affect, optimism, religiosity, and the coping strategies of positive reappraisal, acceptance, and denial. Personal growth has also been linked to improved physical health outcomes, such as decreased risk for heart attacks (Affleck, Tennen, Croog, & Levine, 1987) and lower AIDS-related mortality (Bower, Kemeny, Taylor, & Fahey, 1998).

One of the most methodologically sound ways this general construct of personal growth has been operationalized is through the personal growth subscale on the Hogan Grief Reaction Checklist (HGRC; Hogan, Greenfield, & Schmidt, 2001). The Personal Growth scale is made up of 12 items and measures spiritual and existential awareness. This includes “a sense of becoming more forgiving, caring, compassionate, hopeful, and tolerant of self and others” (Hogan, Greenfield, & Schmidt, 2001).

### **The Effectiveness of Bereavement Interventions**

Bereavement interventions are evaluated for effectiveness by measuring the extent to which treatment recipients endorse changes in negative grief symptoms and in domains indicative of successful adjustment to a loss are, which most frequently include continuing bonds, meaning making, and personal growth.

The degree to which any intervention significantly alleviates negative symptoms within the range of normative grief reactions (as opposed to complicated grief) has been contended in the literature (e.g., Granek, 2010; Stroebe et al., 2000). A meta-analysis of bereavement interventions found that most treatment recipients experience only minimal improvement of negative grief symptoms (Currier et al., 2008). In contrast, recipients with indications of complicated grief reported significantly greater benefit and alleviation of functional impairment following treatment (Currier et al., 2008).

Reviews of specific modalities of bereavement interventions report similar findings. For example, the Pennebaker paradigm is an expressive writing intervention pervasive in clinical practice addressing grief. A meta-analysis indicated that the paradigm in its traditional form is not sufficient for improving negative grief outcomes and should not be implemented as a stand-alone intervention for the alleviation of distress (Frattaroli, 2006). There is also substantial evidence that negative grief symptoms improve over time for the majority of those bereaved without the assistance of therapeutic intervention (Bonanno et al., 2002). It remains unclear whether participation in grief therapy impacts negative grief symptoms above and beyond the effects of time for individuals below the criteria threshold for complicated grief.

Bereavement interventions demonstrate greater effects on domains that reflect growth, resilience, and adaptation to loss. Much of bereavement therapy aims to facilitate the strength-based approaches to grief, focusing on positive outcomes and cognitive understanding of the impacts of the loss (Neimeyer et al. 2010). Meaning making post-loss has been found to predict the positive outcomes for bereaved individuals across numerous studies (Neimeyer, 2015). It is also notable that meaning-making is a difficult process for the bereaved and is rarely successful even in those who intentionally search for meaning following a loss (Neimeyer, Burke, Mackay, & van Dyke Stringer, 2010), which lends particular significance to the documented facilitation of meaning made in bereaved participants. Collectively, bereavement interventions are sometimes considered a preventative approach that buffer possible manifestations of impaired functioning, rather than the traditional aims of psychotherapy for direct alleviation of targeted symptoms (Currier et al., 2008).

## **EXPRESSIVE ARTS AND GRIEF**

### **What Are Expressive Arts?**

Expressive art modalities are defined as the use of dance, drama, drawing, music, painting, photography, sculpture, and writing within the context of psychotherapy, counseling, rehabilitation, or medicine (Malchiodi, 2008). Expressive art therapies are sometimes referred to as integrative or creative art therapies when purposively used in combination with treatment (Estrella, 2005).

### **Expressive Arts and Grief Theory**

Theoretical support for the frequent integration of expressive arts and bereavement within a therapeutic setting is evident in the fields' overlapping theory and treatment goals.

Art therapists' orientation towards externalizing processes and facilitating insight meld naturally with meaning-focused therapeutic practice (Neimeyer, 2012). The leading theories of both grief and of the expressive arts (i.e., the expressive therapies continuum; Kagin & Lusebrink, 1978) argue that creating meaning is the leading mechanism of change. Research also suggests that the spontaneous creation of art, poetry and performance assists to memorialize the relationship with the deceased and facilitate continuing bonds (Potash & Ho, 2014).

Theoretical models of art therapy posit that creativity is both a restorative and assertive act (Levine, 1992). These two tenets are at the core of the Dual Process Model's suggestions for healthy adaptation to bereavement. Similarly, Malchiodi (2003) argues that therapeutic art making serves four purposes: confronting mortality, meaning making, crisis resolution, and authentic emotional expression. These purposes reflect the assimilation and accommodation processes of the Dual Process Model and further emphasize the shared theoretical foundations of expressive arts and bereavement.

### **Expressive Arts and Bereavement Interventions**

Many manualized bereavement interventions incorporate expressive art techniques, such as Shear and colleagues' treatment for complicated grief and Neimeyer's Meaning in Loss Group (2001; Shear, Frank, Houck, & Reynolds, 2005; Neimeyer, 2016). Neimeyer and Thompson recently published a clinical manual with over 50 expressive art modules that facilitate adaptation to loss (2014). The authors encourage practicing grief therapists to adopt these expressive art modalities to augment their existing clinical bereavement practice (Neimeyer & Thompson, 2014). Likewise, incorporating expressive arts into grief therapy has been hailed as a way for clinicians to take their "game" to the next level (Gamino, 2015).

Not only has the incorporation of expressive arts within traditional bereavement interventions become increasingly documented, but it is also common for those seeking grief therapy to receive care from a certified art therapist. Over 80% of trained art therapists report working with bereaved individuals, and bereavement/grief is reported as one of the top 10 specialties of practicing art therapists (American Art Therapy Association, 2007). Peer-reviewed art therapy

journals frequently publish educational editorial materials on grief theory in an effort to empirically inform art therapists' existing practices (i.e., Lister, Pushkar, & Connolly, 2008). Thus, bereaved individuals seeking therapeutic assistance for adjusting to their losses are likely to encounter exposure to expressive art modalities within a therapeutic context.

### **The Effectiveness of Bereavement Interventions Using Expressive Arts**

Remarkably, despite the prevalence of implementing expressive art techniques with the bereaved, only recently have studies begun to investigate its efficacy or effectiveness.

In their 2014 literature review, Torres and colleagues examined some of the existing literature. The authors found preliminary evidence to support the incorporation of music therapy techniques effectiveness in expressing emotions, feeling connected to the deceased, and finding comfort (Torres, Neimeyer, & Neff, 2014). In another review, a meta-analysis of 27 studies with bereaved children and adolescents, researchers found music therapy to be the “most promising venue” for grief intervention when compared to talk therapy, psycho-education, play therapy, and trauma-focused school-based psychotherapy (Rosner, Kruse, & Hagl, 2010). This review did not address visual art modalities or art therapy, despite existing literature.

In 2015, the NIH conducted a meta-analysis of art therapy interventions in which some of the included studies had a bereaved sample (Uttley). Findings suggested evidence for significant effectiveness of expressive art modalities with the bereaved population, but heterogeneity of the included studies limited the findings' generalizability. Notably, visual art modalities were found to be one of the most commonly employed methods of expressive art treatments alongside expressive writing and music therapy (Uttley, 2015).

Some literature reviews to date have parceled expressive arts into treatment-specific modalities. Expressive writing has garnered particular attention in the field, perhaps contributable to the increased acceptance of “narrative therapy” as an intervention in line with the constructivist meaning making model of bereavement (e.g., Neimeyer, 2001). Results from these investigations raise concerns and abed the importance of investigating visual art modalities with the bereaved. For example, the Pennebaker paradigm, an expressive writing intervention, is pervasive in clinical practice addressing grief. However, investigatory research yielded results indicating that the paradigm in its traditional form is not sufficient for improving negative grief outcomes (e.g., Frattaroli, 2006) and is therefore not recommended as a stand-alone intervention for those with complex grief reactions. In fact, there is some theoretical support indicating that the use of the paradigm has potential to cause harm for highly distressed bereaved individuals (Honos-Webb et al., 2000). Though visual art modalities are most commonly implemented as an adjunct to traditional psychotherapy for grief, these findings raise concerns for the possibility of ineffectiveness of visual arts in alleviating distress of grieving individuals, and hint at the risk that subjective clinical interpretation of visual art effectiveness may not translate to objective measures.

## **Visual Art Modalities in Bereavement Interventions**

Though the expressive arts in general have been suggested by many clinicians as useful tools to facilitate adaptation to loss, use of the visual arts has particularly burgeoned within the field in recent years.

The American Art Therapy Association defines visual art as “drawing, painting, sculpture, and other art forms” (AATA; 2016). A review of cross-disciplinary publications assisted in clarifying methods consistently included in the vague “other art forms” category. Activities described as visual art included the following: printmaking, crafts (e.g., collage, scrapbooking), graffiti, photography, and ceramics (Efland, 2002).

Visual arts such as drawing, painting, photography, and multimodal forms have been commonplace in grief therapy (e.g., Neimehyer & Thompson, 2014). The creation of mandalas, scrapbooks, and thematic collages are among the most frequently implemented expressive art techniques with the bereaved. For example, photography and the curation of a photographic narrative of the deceased loved one is one of the modules in Shear and colleague’s manual for complicated grief (2005).

Visual arts’ frequent use in the field is congruent with available historical context. Mourning and grief in funeral rituals often employ visual art to express loss, love, and remembrance across cultures (Malchiodi, 1998; McKissock, 1992). Visual memorials are often created for remembrance, documentation, and healing for family and community of the decedent (Frankenstein & Brady, 1995).

## **The Effectiveness of Visual Arts within Bereavement Interventions**

Important work in the area of using visual art modalities with grief therapy has been completed, but the designs of the majority of the available studies do not provide sufficient evaluation of this treatment modality and a great deal of work remains.

A recent literature review of visual art therapies within bereavement interventions revealed that this therapeutic method may aid the acquisition of positive skills that facilitate the adaptation to bereavement (i.e., sense-making, benefit findings, preservation of the loved one’s legacy) but there is little evidence to support a significant impact on negative grief symptoms (Weiskittle & Gramling, 2017). These findings are congruent with the existent literature. As previously reviewed, the degree to which any intervention significantly alleviates negative symptoms within the range of normative grief reactions (as opposed to complicated grief) has been repeatedly contended (e.g., Granek, 2010; Stroebe et al., 2000).

Treatment recipients overwhelmingly endorse a positive subjective impact of the treatments incorporating visual art modalities. Across several studies (e.g., McIntyre, 1990; Lu, 2007) participants rated their well-being as significantly improved. Though this finding is ineffectually captured with measurement of objective changes, it warrants further attention and perhaps speaks to the efficacy of visual art techniques witnessed by clinicians across disciplines. The use of positive or growth-oriented measures (e.g., personal growth, posttraumatic growth, benefit-

finding, self-efficacy) could be an avenue of future research that provides insight into participants' experiences and whether they translate to objective outcomes. Given the frequent clinical application of visual art modalities for those bereaved, it is imperative that more investigative work be done to evaluate this method of treatment.

## **INTERVENTION MODULE DEVELOPMENT**

### **Purpose**

Research on expressive art interventions for bereavement has burgeoned in recent years. Studies have supported their effectiveness in facilitating participants' adjustment to loss (e.g., Rosner, Kruse, & Hagl, 2010; Uttley, 2015; Gamino, 2015) and have revealed the frequency with which they are clinically implemented (American Art Therapy Association, 2007; Neimeyer & Thompson, 2014).

Despite visual art modalities serving as one of the most commonly employed methods of expressive art treatments (Uttley, 2015), studies of expressive arts and bereavement have disproportionately focused on music therapy and expressive writing (Torres, Neimeyer, & Neff, 2014). This gap may be due to the greater availability of manuals on music therapies and established writing paradigms within the bereavement field (e.g., Lichtenthal & Neimeyer, 2012). Another possible contributing factor may be art therapists' reported distaste for the spreading "clinification syndrome" of art therapy, a term used to describe the perception of increased favoritism of empirically-driven treatment approaches at the detriment of art therapists' uniquely layered artistic expertise (Spooner, 2016). The recent spike in research on visual arts and bereavement may be indicative of increasing cross-disciplinary interest in these methods.

Publications have highlighted particular visual art activities that empirically demonstrate their facilitation in loss adjustment (e.g., Neimeyer & Thompson, 2014; Neimeyer, 2016), but these activities are most often presented as stand-alone tools for clinicians to incorporate into their traditional clinical practice. No manuals to date have synthesized these individual visual art techniques into a longitudinal bereavement intervention.

This guidebook aims to address this gap. The included manual provides evidence-based instructions for a 4-session group intervention in which participants complete visual art modules designed to facilitate adjustment to a loss. The subsequent sections detail the ways in which the development of this intervention was guided by empirical bereavement literature.

### **Theoretical Framework**

This intervention was designed in accordance with the theoretical frameworks of the Dual Process Model of Bereavement and the Meaning Reconstruction Model. As such, this intervention approaches grief as a lifelong process of meaning reconstruction about to the loss and assimilating these meanings into one's system of beliefs. Treatment goals accordingly include: maintenance and cultivation of continued bonds with the deceased, personalization of the meanings behind loss, enhanced cognitive understanding of the impacts behind the loss, and reconstruction of purpose without the loved one (Currier et al., 2008; Neimeyer et al. 2010).



## **Drawing from Neimeyer and Colleagues' Meaning in Loss Group**

The thematic structure of this intervention is based on Neimeyer and colleagues' Meaning in Loss Group (MLG; Neimeyer et al., 2016). Neimeyer has encouraged creative adaptation of the MLG's basic structure, and various trials of this group model for the bereaved are currently under development (2016). For example, one trial of this group makes use of enhanced exposure and behavioral activation procedures, and another trial gives greater attention to culturally specific means of continuing bonds with the deceased (Neimeyer, 2016). The present intervention aimed to adapt MLG by applying visual art modules to its thematic arch.

The MLG is a multimodal therapy spanning 12 90-minute sessions (Neimeyer et al., 2016). MLG sessions are divided by evidenced-based grief processing themes in the following order: 1) Introduction, 2) Reopening the Story, 3) Processing the Event Story of the Loss, 4) Exploring Sources of Meaning 1, 5) Accessing the Back Story of Relationship, 6) Exploring Sources of Meaning 2, 7) Consolidation, 8) Termination (Neimeyer et al., 2016).

The modules of each session reinforce these themes. Modules promote (a) processing the "event story" of the loss and its implications for the survivor's life, and (b) accessing and affirmation of the "back story" of the relationship with the deceased to enhance continuity and security in the mourner's self-narrative (Neimeyer & Thompson, 2014). Modules are multimodal and incorporate group discussion, psychoeducation, and expressive arts such as journaling. For example, after *introducing the deceased* (Hedtke, 2012), early sessions of the MLG feature a *loss timeline* for depicting significant life transitions (Dunton, 2012), and *restorative retelling procedures* guide participants in processing and integrating meaning of their loss (Neimeyer 2012, Saindon et al., 2014). Similarly, later sessions facilitate reconstruction of the attachment bond with the loved one in modules devoted to *imaginal letter writing* to and from the deceased (Neimeyer, 2012), and the exploration of their *life imprint* on the vocation, lifestyle, and values of the group members (Neimeyer, 2010). Closing sessions use *symbolic virtual dream stories* (Neimeyer, Torres, & Smith, 2011) and *group rituals* (Doka, 2012) to validate the work done and project into a hopeful future.

The present intervention consolidates the thematic arch of MLG's session structures to an intervention of 4 weeks. Each session addresses the major themes of MLG. This intervention adjusts the original MLG modules to visual art modalities designed to promote the same themes. The following section details the background and supporting evidence for each visual art activity incorporated into the intervention.

### **Visual Art Activities**

#### **Introducing the Loved One Collage**

In early sessions of Neimeyer and colleagues' MLG, participants were *Reopening the Story* about their loss through *Introducing the Loved One* to members with dialogue. Participants were asked to introduce the group to the deceased, reviewing the character of the relationship during life and validating the loved one's special qualities. Group members were also invited to share meaningful objects related to the deceased. The

present intervention adjusted this module by asking participants to attend to these prompts through the creation of a collage about their loved one. Participants glue magazine cut outs and other drawings to colored paper that represent their relationship with their loved one. Participants are then given the opportunity to share their collages with the group.

Collage is a well-documented method of grief processing that promotes an effective, non-judgmental avenue for emotional insight, mindfulness, and meaning reconstruction (Strouse, 2014). Collages serve as visual representations of important grief experiences, such as efforts to reaffirm or reconstruct a system of beliefs that has been challenged by loss (Sands, Jordan, & Neimeyer, 2012) and offers a creative process that facilitates the exploration of self-identity (Strouse, 2013). In this way, participants receive the same prompts as the original MLG *Reopening the Story* session, but explore its themes in a safe space of reflection and engagement.

### **Loss Road Map**

The original MLG format uses the *Loss Time Line* module to help participants *Process the Event Story of the Loss*. Group members completed this module by plotting their life trajectory on paper, including significant points of transition and loss, noting emotional response to each and symbolizing or naming different life ‘chapters’ (Neimeyer, 2016). The present intervention adjusted this module to emphasize creative processing with metaphor. Participants complete a visual art module in which they draw a “road map” of their loss experience (Davies, 2014). Participants are encouraged to implement metaphor into their road maps; for example, using the size of the road to indicate the strength of the relationship with the deceased, or construction signs during times of adjustment. Visual metaphors have been documented as enhancements to traditional forms of self-narrative exploration (Davies, 2014). A page of visual aids associated with roads and maps is offered to participants to generate creativity; the pictures can also be cut out and pasted onto the participants’ road maps.

### **Virtual Dream Story Board**

MLG provides the *Virtual Dream Story* module for participants to engage in the *Consolidation* of the meanings they construct about their loss (Neimeyer, 2016). This exercise entails writing a symbolic story about loss to place the death in perspective and consider its implications for the future. Facilitators guide the exercise by suggesting that writers include, in whatever way they choose, an assigned list of six elements, two of which typically refer to the setting of the narrative (e.g., a mountain trail, a tragic loss), two of which are figures with “voice” or intention (e.g., a crying child, a talking animal), and two of which represent potentially symbolic objects or events (e.g., an empty house, a rusted chest; Neimeyer & Young-Eisendrath, 2014). For example, participants might be invited to write a virtual dream story that contains the following elements: 1) a violent storm, 2) a long journey, 3) yourself, 4) an opened letter, 5) a compass, 6) a sunrise. Such stories nearly always reflect important themes in how the authors have dealt with their loss, even if the literal plot of the story differs greatly from their own (Neimeyer & Young-Eisendrath, 2014).

The present intervention adjusts this module by replacing its expressive writing modality with one of visual art. Participants are provided 6 elements, taken from the same published list of dream story prompts, but rather than write a metaphorical story about loss that includes these 6 words, participants will draw a metaphorical picture about loss that includes visual depictions of these words. Participants are provided visual aids of each element to stimulate ideas or to cut out and paste onto their story board.

### **Additional Session Components**

Sessions make use of a recurrent structure featuring dyadic interaction among members, followed by whole group processing to promote high levels of empathy and engagement, as well as homework of both a reflective and action-oriented character. Periodic psychoeducation about theories of grief (e.g., the Dual Process Model) and sources of meaning (e.g., creative and spiritual) are used to scaffold assignments to confront avoidance, extend the loved one's legacy, and rebuild a life of purpose and meaning.

## **Part II: Facilitation Guidelines**

## **GENERAL FACILITATOR GUIDELINES**

### **Your Role as the Facilitator**

It is important to present yourself as a researcher rather than a friend. You will need to let participants know that you are part of a team that is conducting research for a community needs assessment. This formality communicates to participants that their participation is important and contributes to the community.

### **Balancing Rapport and Professionalism**

Part of your role is to achieve a balance between building rapport with participants and conveying an appropriate level of professionalism. Your role during focus groups is not that of a good conversationalist or a friend who provides feedback, but a professional. If you are too casual, participants may not see you as someone who is prepared to take what they have to say seriously. However, if you are too formal, participants may feel intimidated by you and may not be as willing to reveal information. Strive to achieve a balance between being formal and casual during your focus groups.

### **Recognizing and Appreciating Participants for their Time and Contributions**

This is one of the most important things you can do to help create rapport. Remember to thank participants for their time and participation. Let them know that the information they have shared is valuable for this project.

### **Listen Carefully to Participants**

Active listening allows you to probe effectively and at appropriate points during the focus group. Active listening involves not only hearing what someone is saying, but also noticing body posture and facial gestures (i.e., any changes in nonverbal behavior) that might provide cues as to the appropriate or necessary ways to engage participants.

### **Show Participants You Are Listening**

Show participants that you are listening to what they are saying. Signs that you are paying attention may include leaning forward slightly, looking directly at participants while they are speaking, or nodding at appropriate times. Such behaviors not only indicate that you, as the facilitator, are more engaged, but also help maintain the engagement of the participants, themselves. Looking away, yawning, or frequently checking your watch will most likely make participants feel that you are not listening.

### **The Importance of Neutrality During the Interview**

While showing participants that you are actively listening and interested in what they are sharing, you will also want to remain as neutral or impartial as possible, even if you have a strong opinion about something. Use phrases such as “Thank you. That is helpful.” Comments such as “I can’t believe it!” or “You really think that?!” are not appropriate remarks for a facilitator to make, because they infer your opinion and impose judgment on the participant, which will shut down discussion.

### **Gathering Honest Information**

You want to gather information during focus groups that is as honest as possible. If participants sense that you have an opinion, they may want to change their responses so that they will seem more socially desirable, rather than reflect what they truly believe or feel about a topic.

### **Silence Encourages Elaboration**

Allowing silence at times encourages elaboration by participants because it gives them a chance to think about what they want to say. More often than not, participants will fill the silence with more information. However, it is important to strike a balance between keeping the conversation moving (so that you use your time well) and allowing participants adequate time to share and process what has been shared.

## **TECHNIQUES ON FACILITATING GROUP DISCUSSION**

*Probes and clarifying questions are an important part of interviewing and have two main purposes: to help clarify what a participant has said and to help participants feel comfortable enough to share more if they want to.*

### **Basic Techniques to Encourage Elaboration**

- *Repeat the question* – repetition gives more time to think.
- *Pause for the answer* – a thoughtful nod or expectant look can convey that you want a fuller answer.
- *Repeat the reply* – hearing it again sometimes stimulates conversation
- *Ask when, what, where, which, and how questions* – they provoke more detailed information
- *Use neutral comments* – “Anything else?”
- *Toss it out to the group* – “Who else would like to give their perspective on what was just said?”

### **Examples of Probes**

Some good examples of probes used to help clarify what a participant has said include:

“Please tell me (more) about that...”

“Could you explain what you mean by...”

“Can you tell me something else about...”

An example of a probe that you would not want to use is:

“So you’re telling me that ..... Right?”

### **Probing in Not Finishing Their Thoughts**

Again, you want to show participants that you are there to listen to what they have to say. Interrupting participants may influence how they answer and if they answer the questions you ask. If a participant strays off course, encourage them to finish their thought. After they have finished their thought, it is appropriate to bring them back to the question you asked to make sure that they have answered it completely.

### **Seeing Things From Their Perspective**

Using probes for clarification helps you to gather good information while avoiding the assumption that you understand the meaning of a key word, phrase, or perspective of the interview respondent. Probes such as the ones above help you see things from the perspective of the person being interviewed.

### **Avoid Making Assumptions**

The opinions of participants should not be assumed by the interviewer. To help ensure that you are not assuming, make small steps in your questioning with simple questions, not big leaps. This way you will get more detail and elaboration from participants and will keep you from making assumptions about what they have shared.

### **Avoid Asking Leading Questions**

An example of a leading question is “Don’t you think...” This presents to the participants that you have an opinion, not that you are there as an unbiased listener. This type of questioning may lead participants to answer questions according to what you expect to hear, rather than how they really feel. Participants may also want you to look at them in a favorable way, matching your opinions rather than sharing what they truly believe or have experienced.

## **TIME MANAGEMENT TIPS**

### **Managing Time During Sessions**

Individuals love to talk about their experiences and may have a tendency to go on and on about them. Here is where your skills as a facilitator you are put to the test. As the interviewer, your job is to structure the interview in such a way that you elicit a complete response to questions, probing insightfully so that you get the level of detail you need in order to the issues adequately.

### **Basic Conversation Management Skills**

- Setting the frame
- Looking for natural pauses and openings
- Polite Interruption
- Summarizing
- Checking-in on how much time is left

### **Keep the Interview Moving**

It is also your job to politely move the interview forward when what the respondent is sharing is less useful given your research questions. Sometimes, it is possible to do this by listening for a segue – something that the respondent talks about that is relevant to another question or set of questions. Other times, you may want to acknowledge that your time together is waning and there are some other aspects of their work and experience that you want to be sure you have time to learn about and explore, and, for this reason, you are going to move on.

### **Check With the Group**

At least once during the interview, ask the group how they are doing with time. Use your perceptive abilities to sense if there is a feeling of strain on the part of the respondents to participate in the interview. If he or she has had another commitment come up since you scheduled the interview with him or her, there may be a feeling of being rushed. It is polite to check in, and it also allows you to move to the most critical questions in case that you must end the interview early. It is also important to periodically remind the group of the time that is left in the focus-group period.

### **Efficient Use of the Interview Guide**

A well-developed interview guide will have built-in prompts that remind you, as the interviewer, to do a time check periodically to make sure that the interview is progressing appropriately. Another strategy is to listen for relevant information to questions that you have not yet asked so that you can skip these later. If you do run out of time before you have covered all the questions in the interview guide, be sure to use your remaining time asking and exploring only the most important questions remaining. The more familiar you are with the interview guide, the easier it will be for you to prioritize particular questions and to recognize when the respondent has already provided relevant information (indeed, adequately answered) questions you have not yet asked. This will ensure that your questions do not feel redundant to the respondent and that the interview, overall, flows smoothly and efficiently.

### **Not Rushing the Interview Respondent**

Overall, you want to achieve a balance between collecting necessary information and gathering important data that have not been anticipated. Sometimes it can be difficult to tell the difference until you ask clarifying questions or probes. Again, you want to make sure that you interrupt the interview respondent as little as possible and not rush them with their answers while keeping them on course with the interviewing guide.

## **TROUBLESHOOTING DIFFICULT SITUATIONS**

### **What do I do if someone is dominating the conversation?**

Focus groups, ideally, allow researchers to collect the opinions and ideas of a variety of people. If someone is doing a lot of the talking, however, this may prevent others from contributing their thoughts, and limits the usefulness of the focus group. It is important to notice when this is happening and do what you can to try to make sure that other people have the opportunity to say things, even if they seem reluctant at first or insist that what is being said by others reflects what they would have said. It is important to have people say things in their own words as much as possible. If someone is dominating the conversation, you might want to respectfully acknowledge their contribution, and thank them, saying something like, "I really appreciate your comments." Then make direct eye contact with other people and ask something like, "I'm very interested in hearing how other people are feeling about this issue" or "It's very interesting to get a variety of perspectives, and I would like to hear from other people as well."

### **What do I do if no one responds to a question?**

In this kind of situation, it is helpful to try to understand why people aren't responding.

#### ***Did you ask a question that was difficult for the participants to understand?***

If you think this might be the case, you might try asking the question in a different way. The more familiar you are with the research objectives of a particular focus group, the more successful you will be in rephrasing or rewording a question in an appropriate way that ensures that salient issues are explored and the research integrity of the group discussion is maintained.

#### ***Do you think you might have asked a politically sensitive question (i.e., something that people are afraid to answer honestly because it might make other people angry)?***

If you think this might be the problem, you might move to a different question or topic that is less sensitive, and try coming back to the topic later, or use probes, during a different line of questioning, that might get at aspects of the sensitive topic but more subtly.

Here, again, it might be helpful simply to rephrase the question or ask a slightly different question. Either approach may make it possible to pose a less controversial question to the group.

#### ***Are people tired of talking about the topic and/or do they have no more to say about a topic?***

In this case, it may be important to simply state, "Is there anything else that you would like to share? [pause] If not, we can move on to our next question." This communicates to participants that this is their opportunity to contribute any additional thoughts and allows you to move on to the next topic more naturally and politely. If you, as the facilitator, think you haven't gotten all of the information you want on that topic, rather than trying to force things, just be aware that there may be an opportunity to elicit salient information in probing that occurs with respect to other questions. In other words, there may be important linkages and connections to explore throughout the focus group that emerge through subsequent discussion.

#### ***Are people feeling uncomfortable about talking?***

This typically occurs at the beginning of a focus group and is less likely to occur when focus groups start with an icebreaker or the facilitator is able to set a comfortable tone and put people at ease in the beginning. If, however, this continues to be an issue during the focus group, you may need to back up and do a little work to make people feel more comfortable. Talk about easier topics, things that you think participants may be more familiar with or



comfortable talking about, or, perhaps, things that you know are particularly interesting to them. This may help the participants begin to feel more comfortable talking in a group setting. If no one responds to a question, and you aren't sure exactly what the problem is, it's okay sometimes to just wait it out. Be quiet for a moment and allow people time to think. Often, someone will speak up, either to answer the question or to ask a question that allows you to have a better understanding of the silence.

**What do I do if the group begins to talk about topics that are not relevant to the research?**

Sometimes the conversation will start to stray away from the topics of the focus group. When this happens, you might take advantage of a pause and say, "Thank you for that interesting idea. Perhaps we can discuss it in a separate session. For the purposes of exploring further the specific topics that are the focus of this discussion, with your consent, I would like to move on to another item." Another strategy is to orient the group to the time you have remaining for your discussion. You do not want the duration of the focus group to extend beyond the amount of time you communicated to participants. You may want to mention this when discussion strays from the intended focus, and then refocus the discussion accordingly or use this as an opportunity to indicate that you want to be sure that you hear from others.

**What do I do if people are having side conversations (i.e., conversations among themselves)?**

If people are having conversations among themselves, it can disrupt the focus group by making the other participants feel uncomfortable, making it hard for people to hear what others are saying, and making it hard for the facilitator to focus on what is being said. One of the best ways to handle this situation is to address it before the focus group begins, when you tell the participants about focus group ground rules. Stress that it is *very* important not to have side conversations because it interferes with individual's full participation in the group discussion and also possess challenges for recording the discussion. If side conversations do occur during a focus group, do not stop the conversation abruptly. You might respectfully remind people of the ground rules and ask that people finish their conversations and rejoin the larger group discussion taking place. This kind of disruption may also signal that it is time to take a break, and you may want to suggest no more than a five minute break (so that people can use the restroom – make sure people know where to go – or to stretch). It will be important to make sure people know at one time the focus group will continue and be proactive about bringing people back together so that the focus group can re-convene.

**What do I do if I ask a question and the interview respondent says that they do not feel comfortable answering it?**

An interview respondent may not feel comfortable answering a question from the interview guide. Or, it may be an issue of permission from a spouse to discuss the topic. This must be honored according to research ethics and informed consent, a respondent may elect to not answer any question at any time. At the beginning of the interview make it clear that they may decline to answer a question(s) or choose to stop the interview at any time. If this happens, say "thank you" and that you acknowledge and appreciate their honesty. Then, ask them if it would be okay to move on to the next question in the interviewing guide.

## **Part III: Intervention Modules**

## **MODULE AND SESSION STRUCTURE**

The modules are formatted for easy reference and use. Each of the modules contains:

- Module number and title
- Goals of the module
- Suggested format for the module
- Materials/handouts needed
- Detailed description of information to be review and activities to be completed

### **Time Frames**

The time frames in the sections are suggestions for planning. Once a session starts the individual and the facilitator can develop their own pace for going through the materials and activities in each module.

### **Keys to Conducting the Modules**

There are a variety of ways facilitators may want to conduct the individual modules. Factors such as the particular characteristics of the group may influence how the facilitator conducts each module or session. Individual facilitators also have various strengths and preferences for how they can best lead groups. The following keys suggest various types of methods facilitators may use at different times in the modules. They are guideposts to help plan and conduct the modules. The keys, like the suggested time frames in the modules, are a starting point for the module. The facilitator is thus guided, and also free to use and modify the methods, outlined in the modules, as needed.

#### ***Guided Discussion***

Some of the material to be covered in the modules is best accomplished through “Guided Discussion.” This is a form of Socratic discussion in which the facilitator focuses on a specific issues and invites an open discussion of this with the participants. Guided discussions are preferable to didactic education whenever possible. Guided discussion is essential in working with problems like guilt or anger or other maladaptive beliefs so that the facilitator does not appear to be “arguing” with a participant and so that the facilitator elicits the participant’s struggle. Nevertheless, it is also important that the facilitators guide these discussions with the questions they ask and thereby shape the discussion.

#### ***Psychoeducation***

Some sections of the module have portions where the facilitator provides specific information. This is information that would be futile to ask the participants about. Examples of psychoeducation are explaining what the intervention will be or describing the models of grief used in this treatment. Another example is providing specific instructions for a technique or activity.

### ***Visual Art Activity***

This intervention includes a structured visual art activity each session. These activities comprise the core of the intervention and we strongly suggest using them as described in the guidebook. Each session focuses on one of the core components of the Meaning Making Model of bereavement and each session’s visual art activity facilitates the processing of the session’s specific theme. These activities have been supported by research and the methods in the interventions have been documented to be effective. The following table provides an overview of the intervention’s module themes and corresponding visual art activities.

<b>Session</b>	<b>Theme</b>	<b>Visual Art Technique</b>	<b>Summary description</b>
1	Introduction, Reopening the Story	Introducing the Loved One Collage	Introductions, reminders regarding confidentiality, and group norm setting. Create collage from available magazine cut-outs that describes who the deceased was to the participant, their special qualities, and where the participant is right now in their grief. Optional sharing of collages.
2	Processing the Event-Story of the Loss	Loss Road Map	On paper, plot life trajectory, including significant points of transition and loss, noting emotional response to each and symbolizing or naming different life points. Share with partner, who then reports to the group. Plan one concrete step to take in the next week in a hopeful or healing direction.
3	Exploring Sources of Meaning	Virtual Dream Story Board	Introduce and discuss the Dual Process Model of Coping and the Meaning Making Model of Grief as potential guides for interpreting and, thus, making meaning of the loss experience. Introduce and lead participants through the Virtual Dream Story. This exercise entails drawing a symbolic story about loss to place the death in perspective and consider its implications for future.
4	Consolidation, Mobilizing Systems, Termination	--	Recap the group members’ experiences. Revisit therapeutic goal and discuss the future. Discuss mobilizing systems and provide participants with list of local grief resources. Provide systems with “Strategies for Coping with Grief” for future use. Participants fill out survey packet. Process end of group and future goals.

### ***Personal Goals***

Identifying and working on personal goals is a core component of the intervention. To work with goals, the facilitator asks the participants what they would like to be doing with their life if grief was not holding them back. The idea is to identify personal dreams and long-term goals. This procedure does not target treatment goals, but rather life goals. In this way, the intervention aims to not only facilitate participants' loss-oriented coping but also their restoration-oriented coping (Stroebe & Schut, 1999). It is important to bring participants' goals out and to encourage them to begin moving towards these goals while also dealing with their loss.

In some instances, participants may have difficulty identifying their own goals. When this happens, the facilitator can probe by asking questions. Some examples include:

- “Did you have any dreams a long time ago that got put on hold because your life was taking a different direction?”
- “Is there anything you planned to do with the person who died that you never got to do or that you wish you could have done more of?”
- “Is there anything that you decided not to do because you couldn't do it with the person who died?”

If these questions are answered affirmatively, the facilitator can help participants explore how practical it would be to revisit them now. If they are no longer goals or if they are not practical, they will still provide the facilitator with information and hints about what goals might be, as well as providing examples to other group members who may be having a difficult time identifying their own goals.

Throughout the intervention, participants share the steps they are taking towards achieving their goals. Together they consider practical and psychological barriers, and the facilitator can guide discussion towards support and practical advice.

**SESSION 1: INTRODUCTION AND REOPENING THE STORY (90 min.)**

**GOALS:** During this module the therapist and participants:

1. Establish introductions, reminders regarding confidentiality, and group norm settings
2. Review instructions and examples of the Introducing the Loved One Collage
3. Independently complete individual Introducing the Loved One Collage
4. Group discussion of completed visual art activity process and outcome
5. Set one concrete step to take in the next week in a hopeful or healing direction

**SESSION 1 FORMAT:**

	<b>SKILLS/INFORMATION</b>	<b>METHOD(S)</b>	<b>TIME</b>
<b>1</b>	<b>Introduction and Orientation to Intervention</b> Overview and goals of the intervention, establishing confidentiality and group norms	Discussion, brief review of some materials	15 min.
<b>2</b>	<b>Explanation of Session 1 Art Activity</b>	Brief description of activity, example review	5 min.
<b>3</b>	<b>Structured Visual Art Activity: Introducing the Loved One Collage</b>	Completed independently by group members with optional engagement with facilitator or peers	45 min.
<b>4</b>	<b>Group Discussion of Art Activity</b> Supportive counseling and relevant grief psychoeducation provided by facilitator	Discussion and processing of activity; optional sharing of Collages	15 min.
<b>5</b>	<b>Wrap-Up</b>	Summarize session themes and plan one concrete coping goal for week	10 min.

**MATERIALS:**

- Printed consent forms (at least 1 per participant)
- Variously sized paper and/or poster board (approximately 1 per participant)
- Magazines (approximately 3 per participant)
- Scissors (approximately 1 per participant)
- Glue Sticks (approximately 1 per participant)
- Optional: music-playing device for use during structured art activity

**SESSION 1 FACILITATION DIRECTIONS AND INFORMATION:**

1. Introduction and Orientation To Intervention
2. Explanation of Session 1 Art Activity
3. Structured Visual Art Activity: Introducing the Loved One Collage
4. Group Discussion of Art Activity
5. Wrap-Up

## **INTRODUCTION AND ORIENTATION TO INTERVENTION (15 MIN.)**

**Welcome the participants.** Hello to everyone, welcome and thank you for agreeing to be a part of our group today. My name is [FACILITATOR NAME] and this is my colleague [COFACILITATOR NAME]. We are all here today to learn more about your experiences with grief and the ways that engaging in art may express those experiences. We will be guiding your through the group, but our primary job is to help you to feel comfortable opening up and sharing your experiences with regard to your loss. Please feel free to use the restrooms or take a break at any time during group, which can be located at [LOCATION].

**Review Consent.** You will find in front of you a form explaining the process that we are about to go through. This information is identical to what you provided when you were screened for eligibility to participate in the group. Please take a moment to read over the document carefully. Important things to note are:

1. We will be discussing topics of an emotional and personal nature. We hope that you feel comfortable sharing your experiences openly, but we also urge to only share what you feel comfortable sharing.
2. Participation is completely voluntary. If you do not wish to participate in the focus group, you are free to leave at any time with no penalty to your SONA credit.
3. If you have read and understood the consent document, you may keep the copy for yourself if you choose.

**Review Group Guidelines.** Before we begin, let me mention a few things about how we usually conduct these groups.

1. I will be the facilitator for the group. My role is to facilitate group discussion, provide brief educational materials on grief, and assist with activities as needed. It's my job to see that everyone who wants to has a chance to voice their thoughts, as well as to keep us moving along. At times it might seem as though I am cutting you off, and this is not meant to be rude but rather to make sure that we have time to hear from everyone who wants to share. That being said, we encourage you to weigh in on what others have said. Also keep in mind that you can take extra time after the group is finished to talk more with each other if you wish. We want to thank each of you for being here, so please know that we value your participation.
2. It's really important that everyone hear this: **THERE ARE NO RIGHT OR WRONG WAYS TO GRIEVE!** Each person's experiences and opinions are valid. If you feel that you wish to weigh in on what someone else has said, but do not want to interrupt them, feel free to *raise your hand*. It may feel a little bit like a classroom, but it will help me to know when someone has a comment that they feel is relevant.
3. It's also important that everyone hears this: **THE ART WE COMPLETE IN GROUP IS NOT ABOUT SKILL.** It is about expressing yourself and your grief through an artistic means. No artistic experience is necessary to get meaning out of the activities we will be completing, and none of the prompts require a high level of artistry to complete.
4. Sometimes participants bring up sensitive issues during these discussions, and we want to be sure that everyone agrees before we begin the group that anything of a personal nature that is mentioned in this room will **NOT** be repeated to others outside of this discussion group. Can I see a nod from everyone showing me that you to protect each others

privacy? (If anyone is not willing to give their consent to confidentiality, they may be excused from the group.)

5. Let me mention before we start, that we plan to be finished with our group by [STATE END TIME].
6. In case anyone needs to use the restroom, they are located at [STATE LOCATION]. One last thing, we ask that everyone turn their cell phones off or to silent mode so that we can begin our group. Thanks.

**Introductions Amongst Group Members.** Some of us may have already met each other, but let's start with a little introduction anyway. Let's go around the room and say your first name, who you lost, and how long ago.

### **EXPLANATION OF SESSION 1 ART ACTIVITY (5 MIN.)**

**Providing instructions and examples of art activity.** Participants are invited to “reopen the story” about their loss by creating a visual collage about their loved one and grief experience. Participants are encouraged to create this collage as a means of introducing the group to the deceased, reviewing the character of the relationship during life and validating the loved one's special qualities. Group members are also invited to include meaningful objects related to the deceased in their collage, such as pictures of their favorite hobbies, foods, or activities they were do together. A completed or example collage is shown to participants to give them additional context for what their collage might look like.

### **STRUCTURED VISUAL ART ACTIVITY: INTRODUCING THE LOVED ONE COLLAGE (45 MIN.)**

Participants complete visual art activity independently with optional assistance from the facilitator. Participants are given a 10 and 5 minute warning as module timing is drawing to a close. Soft, relaxing music can be played per the facilitator's discretion. Group members may choose to occasionally engage each other during this time, but typically complete the activities on their own. The facilitator can opt to walk around the room and showcase availability for answering questions or guidance. The facilitator may also wish to quietly engage in drawing or coloring a mandala or other art activity. The facilitator can oscillate between these actions as appropriate.

### **GROUP DISCUSSION OF ART ACTIVITY (15 MIN.)**

**Facilitating group discussion of art activity.** Alright, lets gently wrap up our final thoughts and designs and bring ourselves back to the group. What was that experience like for everyone? [ANSWER QUESTIONS AND RESPOND TO COMMENTS AS TIME ALLOWS]. Now we will have the opportunity to share the work we created today. Sharing is voluntary and not mandatory; people can also share further thoughts and reflections on what this activity brought up from them. Who would like to go first? Great. Who else would like to share?

### **WRAP-UP (10 MIN.)**

**Summarize Session Themes.** Thank you again to everyone who shared their stories and introduced their loved one to us today through their collages. All of us have experienced our grief in unique and individual ways, and there were also some themes that emerged during our group discussion. Some of these themes included [NOTED THEMES] (similar emotional reactions to loss, types of loss, relationship to the



deceased, etc). Another theme is that all of you chose to come here today to participate and explore your grief, and we appreciate the bravery it takes to engage in these activities and discussions. Are there any questions or comments before we end? [ANSWER QUESTIONS AND RESPOND TO COMMENTS AS TIME ALLOWS]. Thank you all for coming today and we look forward to seeing you at our next session!

**SESSION 2: PROCESSING THE EVENT-STORY OF THE LOSS (90 min.)**

**GOALS:** During this module the therapist and participants:

1. Review past week and previous session’s coping goals
2. Review instructions and examples of the Loss Time Line
3. Complete grief-focused visual art activity (Loss Time Line)
4. Group sharing and discussion of completed visual art activity process and outcome
5. Set one concrete step to take in the next week in a hopeful or healing direction

**SESSION 2 FORMAT:**

	<b>SKILLS/INFORMATION</b>	<b>METHOD(S)</b>	<b>TIME</b>
<b>1</b>	<b>Review Past Week</b>	Discussion, review of previous session’s coping goals	10 min.
<b>2</b>	<b>Explanation of Session 2 Art Activity</b>	Brief description of activity, example review	5 min.
<b>3</b>	<b>Structured Visual Art Activity: Loss Road Map</b>	Completed independently by group members with optional engagement with facilitator or peers	40 min.
<b>4</b>	<b>Paired Sharing of Art Activity</b>	Group split in dyads and share their work with partner	10 min.
<b>4</b>	<b>Group Discussion of Art Activity</b> Supportive counseling and relevant grief psychoeducation provided by facilitator	Partners share each other’s work to group, discussion and processing of activity	20 min.
<b>5</b>	<b>Wrap-Up</b>	Summarize session themes and plan one concrete coping goal for week	5 min.

**MATERIALS:**

- Various sized paper and/or poster board (approximately 1 per participant)
- Magazines (approximately 3 per participant)
- Scissors (approximately 1 per participant)
- Glue Sticks (approximately 1 per participant)
- *Loss Road Map Metaphor Icon Packet* (pages 37-38; 1 per participant)
- Optional: music-playing device for use during structured art activity

**SESSION 2 FACILITATION DIRECTIONS AND INFORMATION:**

1. Review Past Week
2. Explanation of Session 2 Art Activity
3. Structured Visual Art Activity: Loss Time Line
4. Paired Sharing of Loss Time Line
5. Group Discussion of Art Activity
6. Wrap-Up

### **REVIEW PAST WEEK (10 MIN.)**

**Welcome the participants.** Welcome back, everyone! How was everyone's week? Are there any questions from the prior session?

### **EXPLANATION OF SESSION 2 ART ACTIVITY (5 MIN.)**

The original MLG format uses the *Loss Time Line* module to help participants *Process the Event Story of* Participants will complete a visual art module in which they draw a "road map" of their loss experience (Davies, 2014). Participants are encouraged to implement metaphor into their road maps; for example, using the size of the road to indicate the strength of the relationship with the deceased, or construction signs during times of adjustment. Visual metaphors have been documented as enhancements to traditional forms of self-narrative exploration.

[PROVIDE PARTICIPANTS WITH THE *LOSS ROAD MAP METAPHOR ICON PACKET* AND EXAMPLES OF COMPLETED COLLAGES]

### **STRUCTURED VISUAL ART ACTIVITY: LOSS ROAD MAP (40 MIN.)**

Participants complete visual art activity independently with optional assistance from the facilitator. Participants are given a 10 and 5 minute warning as module timing is drawing to a close. Soft, relaxing music can be played per the facilitator's discretion. The facilitator can opt to walk around the room and showcase availability for answering questions or guidance. The facilitator may also wish to quietly engage in drawing or coloring a mandala or other art activity. The facilitator can oscillate between these actions as appropriate.

### **PAIRED SHARING OF LOSS TIME LINE (10 MIN.)**

Participants are invited to partner with another group attendee and share their Loss Timeline with each other for ten minutes.

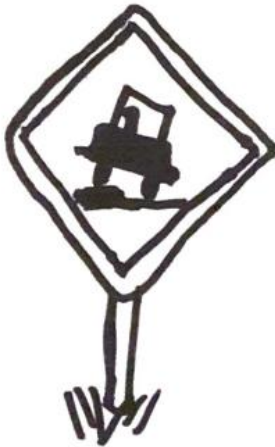
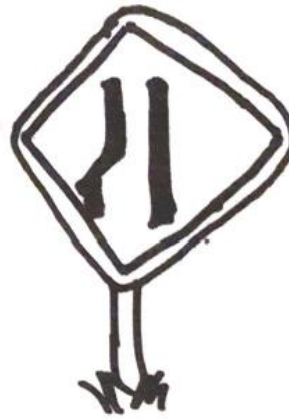
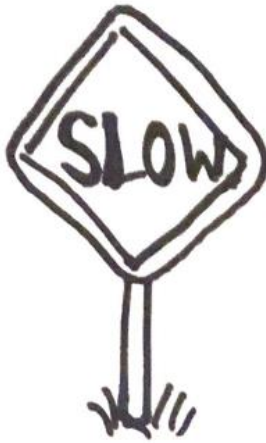
### **GROUP DISCUSSION OF ART ACTIVITY (20 MIN.)**

**Facilitating group discussion of art activity.** Alright, lets gently wrap up our final thoughts and designs and bring ourselves back to the group. What was that experience like for everyone? [ANSWER QUESTIONS AND RESPOND TO COMMENTS AS TIME ALLOWS]. Now we will have the opportunity to share the work we created today. Sharing is voluntary and not mandatory; people can also share further thoughts and reflections on what this activity brought up from them. Who would like to go first? Great. Who else would like to share?

### **WRAP-UP (5 MIN.)**

**Summarize Session Themes.** Thank you again to everyone who shared their stories and introduced their loved one to us today through their collages. All of us have experienced our grief in unique and individual ways, and there were also some themes that emerged during our group discussion. Some of these themes included [NOTED THEMES] (similar emotional reactions to loss, types of loss, relationship to the deceased, etc). Another theme is that all of you chose to come here today to participate and explore your grief, and we appreciate the bravery it takes to engage in these activities and discussions. Are there any questions or comments before we end? [ANSWER QUESTIONS AND RESPOND TO COMMENTS AS TIME ALLOWS]. Thank you all for coming today and we look forward to seeing you at our next session!

LOSS ROAD MAP METAPHOR ICON PACKET



Road  
Signs

# Natural Disasters



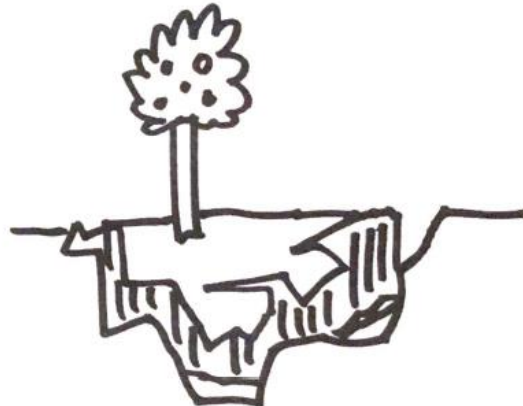
Meteorite



Tornado



Volcano



Earthquake



Flooding



Storm

**SESSION 3: EXPLORING SOURCES OF MEANING (90 min.)**

**GOALS:** During this module the therapist and participants:

1. Review the past week and previous session’s coping goals
2. Review leading theories of grief as guides for making meaning of loss experience
3. Review instructions and examples of the Loss Time Line
4. Independently complete individual Virtual Story Dream Boards
5. Process and discuss completed visual art activity and sources of meaning
6. Set one concrete step to take in the next week in a hopeful or healing direction

**SESSION 3 FORMAT:**

	<b>SKILLS/INFORMATION</b>	<b>METHOD(S)</b>	<b>TIME</b>
<b>1</b>	<b>Review Past Week</b>	Discussion, review of previous session’s coping goals	10 min.
<b>2</b>	<b>Leading Theories of Grief Explained</b> Dual Process Model of Coping, Meaning Making Model of Grief	Psychoeducational discussion	10 min.
<b>3</b>	<b>Explanation of Session 3 Art Activity</b>	Brief description of activity, showing examples, and introduction to materials	5 min.
<b>4</b>	<b>Structured Visual Art Activity: Virtual Story Dream Board</b>	Completed independently by group members with optional engagement with facilitator or peers	45 min.
<b>5</b>	<b>Group Discussion of Art Activity</b> Supportive counseling and relevant grief psychoeducation provided by facilitator	Discussion and processing of activity; optional sharing of Story Board	15 min.
<b>6</b>	<b>Wrap-Up</b>	Summarize session themes and plan one concrete coping goal for week	5 min.

**MATERIALS:**

- Various sized paper and/or poster board (approximately 1 per participant)
- Drawing utensils (e.g., markers, crayons, colored pencils, pens, erasers)
- *Story Board Element Icon Packet* (pages 42-47; 1 per person)
- Optional: music-playing device for use during structured art activity

**SESSION 3 FACILITATION DIRECTIONS AND INFORMATION:**

1. Review Past Week
2. Leading Theories of Grief Explained
3. Explanation of Session 3 Art Activity
4. Structured Visual Art Activity: Virtual Dream Story Board
5. Group Discussion of Art Activity
6. Wrap-Up

## **REVIEW PAST WEEK (10 MIN.)**

**Welcome the participants.** Welcome back, everyone! How was everyone's week? Are there any questions from the prior session?

## **LEADING THEORIES OF GRIEF EXPLAINED (10 MIN.)**

**Introduce Grief Theory.** We are going to begin today's group by doing something a bit different. We are going to learn about two leading theories of grief. You may feel that these ideas resonate with your experience with loss, but you also may find differences in the way you have experienced grief compared to the ideas we will go over. All thoughts and opinions are equally valid and are encouraged!

**The Dual Process Model of Coping.** The Dual Process Model of Bereavement suggests that grieving a loved one is a process of two parts. The first part has to do with orienting oneself with the loss and the second part has to do with restoration with their changed world. Orienting oneself to their loss means engaging in emotions or activities that has to do with the loss or the loved one. This can be expressing emotion related to the death or doing something that reconnects us with the memory of our loved one. On the other hand, examples of restoration includes re-engaging relationships and reintegrating yourself with your surroundings. This sometimes means focusing on daily practical needs following the loss, such as problem-solving challenges resulting from the death, re-engaging relationships, pursuing enjoyable activities and experimenting with new life roles. According to the Dual-Process Model, grief is the process of going back and forth between these two types of activities or mindsets. Everyone experiences the balance or back and forth differently. Often, this process comes across as confrontation and avoidance of the loss. Sometimes we need to focus on our loss, and other times it is more helpful for us to achieve urgent needs if we focus on them instead. The Dual Process Model thus conceptualizes grief as the state of coming to terms with the loss (loss-oriented coping) and participation in future-oriented experiences.

**The Meaning Making Model of Grief.** The Meaning Reconstruction Model views grief as the process of reaffirming or reforming a world of meaning that has been challenged by loss. This model approaches grief from a perspective that people create and maintain beliefs in order to anticipate and respond to their surroundings. One's system of beliefs can be challenged by events if the meaning an individual ascribes to them is incongruent with the overarching system. Events' ascribed meaning must be either assimilated into the existing belief system or the system must be accommodated to make congruent meaning of the event. Accordingly, the Meaning Reconstruction model characterizes grief as the process of making meaning of one's loss and reconstructing one's belief system to accommodate this meaning.

**Synthesizing Both Theories with Meaning.** These theories are complimentary in that they both emphasize the importance of *self-narratives* and *meaning making* as important processes of grief. In many ways, the experiences we share in this group aim to facilitate these processes.

What thoughts do we have on these ideas about grief? [*Group briefly discusses their reactions on these models. Facilitator answers questions as needed*]. Thank you everyone for sharing. We are now going to move into our activity for today.

## **EXPLANATION OF SESSION 3 ART ACTIVITY (5 MIN.)**

Today we're going to work on a project called a Virtual Dream Story Board. MLG provides the *Virtual Dream Story* module for participants to engage in the *Consolidation* of the meanings they construct about their loss. This exercise entails writing a symbolic story about loss to place the death in perspective and consider its implications for the future. Facilitators guide the exercise by suggesting that writers include, in whatever way they choose, an assigned list of six elements, two of which refer to the setting of the

narrative, two of which are figures with “voice” or intention, and two of which represent potentially symbolic objects or events. Our task is to draw a scene that incorporates all six elements. These elements sometimes evoke metaphors about loss. As such, your story boards might reflect important themes in how we have dealt with our loss, even if the literal plot of your story board differs greatly from your loss experience.

The six elements that we are going to create a visual story board with today are: 1) a violent storm, 2) a long journey, 3) yourself, 4) an opened letter 5) a compass, 6) a sunrise.

[SHARE EXAMPLE VIRTUAL DREAM STORY BOARDS WITH PARTICIPANTS AND PROVIDE THEM WITH THE *STORY BOARD ELEMENT ICON PACKET*]

### **STRUCTURED VISUAL ART ACTIVITY: VIRTUAL DREAM STORY BOARD (45 MIN.)**

Participants complete visual art activity independently with optional assistance from the facilitator. Participants are given a 10 and 5 minute warning as module timing is drawing to a close. Soft, relaxing music can be played per the facilitator’s discretion. Group members may choose to occasionally engage each other during this time, but typically complete the activities on their own. The facilitator can opt to walk around the room and showcase availability for answering questions or guidance. The facilitator may also wish to quietly engage in drawing or coloring a mandala or other art activity. The facilitator can oscillate between these actions as appropriate.

### **GROUP DISCUSSIONS OF ART ACTIVITY (15 MIN.)**

**Facilitating group discussion of art activity.** Alright, lets gently wrap up our final thoughts and designs and bring ourselves back to the group. [*Participants wrap up projects and turn their attention to group discussion*]. What was that experience like for everyone? [ANSWER QUESTIONS AND RESPOND TO COMMENTS AS TIME ALLOWS]. Now we will have the opportunity to share the work we created today. Sharing is voluntary and not mandatory; people can also share further thoughts and reflections on what this activity brought up from them. Who would like to go first? Great. Who else would like to share?

### **WRAP-UP (5 MIN.)**

**Summarize Session Themes.** Thank you again to everyone who shared their stories and introduced their loved one to us today through their collages. All of us have experienced our grief in unique and individual ways, and there were also some themes that emerged during our group discussion. Some of these themes included [NOTED THEMES] (similar emotional reactions to loss, types of loss, relationship to the deceased, etc). Another theme is that all of you chose to come here today to participate and explore your grief, and we appreciate the bravery it takes to engage in these activities and discussions.

Are there any questions or comments before we end? [ANSWER QUESTIONS AND RESPOND TO COMMENTS AS TIME ALLOWS]. Thank you all for coming today and we look forward to seeing you at our next session!

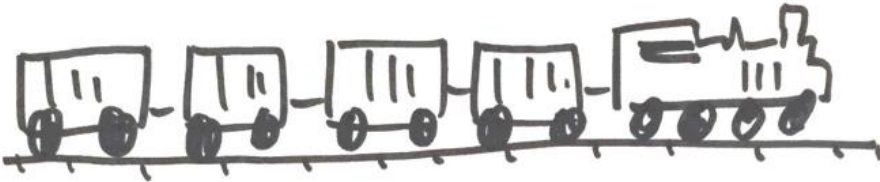


STORY BOARD ELEMENT ICON PACKET

A VIOLENT STORM

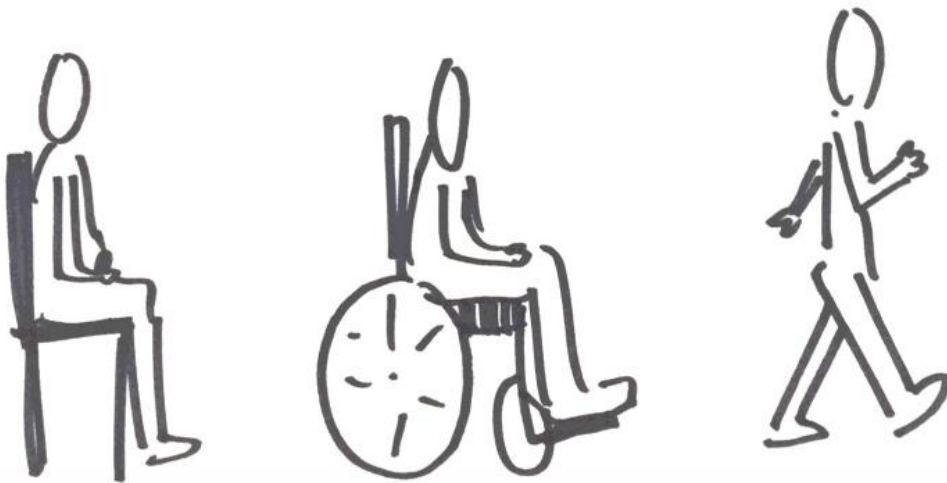
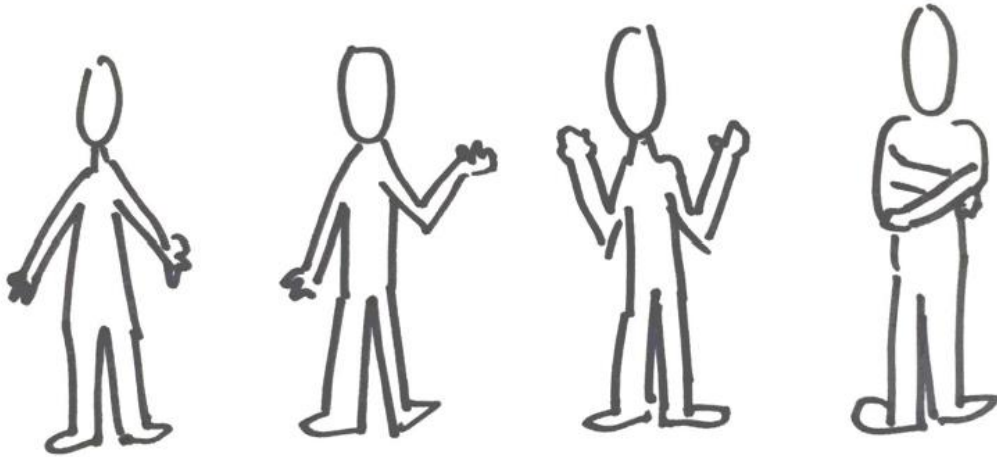
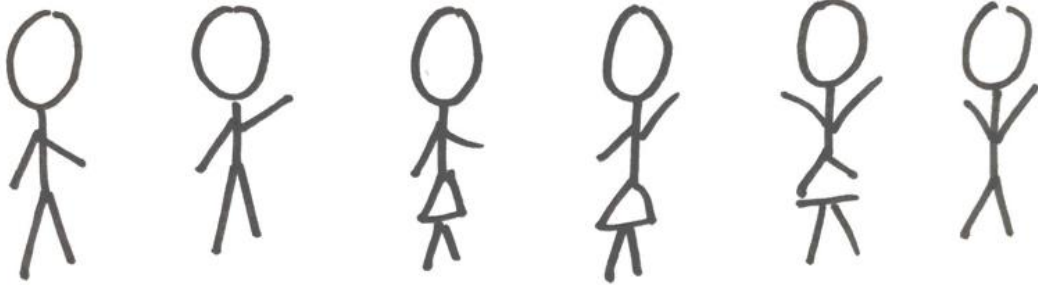


# A Long Journey



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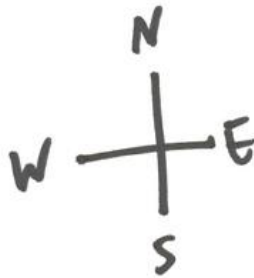
# YOURSELF



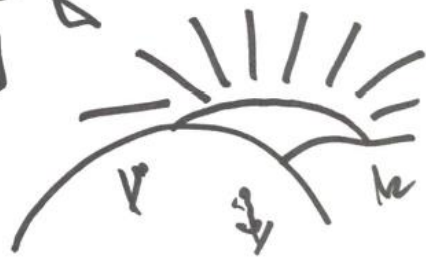
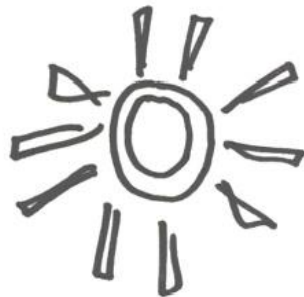
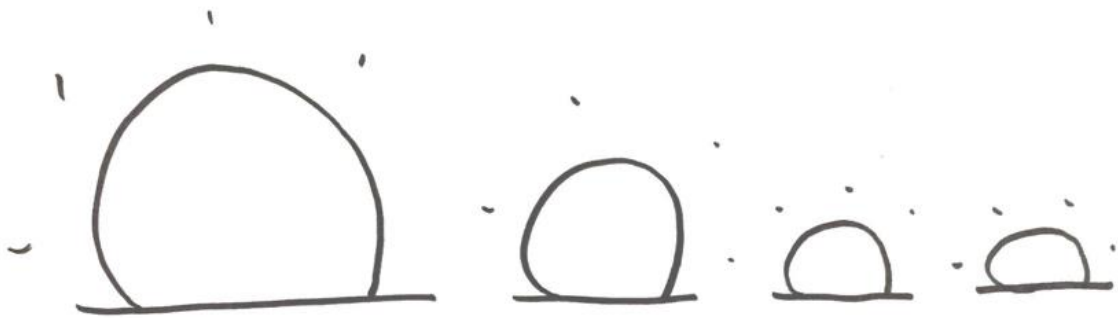
# An Opened Letter



# A COMPASS



# A SUNRISE



## **SESSION 4: CONSOLIDATION, MOBILIZING SYSTEMS, TERMINATION (90 min.)**

**GOALS:** During this module the therapist and participants:

1. Review past week and previous session's coping goals
2. Consolidate participants' experiences via group discussion
3. Revisit therapeutic goals and address barriers/successes to goal achievements
4. Complete survey packet
5. Discuss mobilizing systems and local grief resources available for continued community
6. Process end of group and confirm future plans

### **SESSION 4 FORMAT:**

	<b>SKILLS/INFORMATION</b>	<b>METHOD(S)</b>	<b>TIME</b>
<b>1</b>	<b>Review Past Week</b>	Discussion, review of previous session's coping goals	15 min.
<b>2</b>	<b>Consolidation</b> Recap Group Experiences	Psychoeducational discussion	15 min.
<b>3</b>	<b>Survey Completion</b>	Participants fill out survey packet	15 min.
<b>4</b>	<b>Review Goals and Self-Care</b>	Review steps participants have taken to achieve self-care goals	10 min.
<b>6</b>	<b>Mobilizing Systems</b>	Psychoeducational discussion, provision of local grief resources	15 min.
<b>7</b>	<b>Future Plans</b>	Psychoeducational discussion, provision of psychoeducation handouts	15 min.
<b>8</b>	<b>Wrap-Up</b>	Ending of intervention and sessions	5 min.

### **MATERIALS:**

- Survey packet
- Pencils for survey completion (at least one per participant)
- Blank white paper and writing utensils (at least one per participant)
- Handout: Local Grief Resources (at least one per participant)
- Handout: Strategies for Coping with Grief (at least one per participant)

### **SESSION 4 FACILITATION DIRECTIONS AND INFORMATION:**

1. Review Past Week
2. Consolidation
3. Survey Completion
4. Review Goals and Self-Care
5. Mobilizing Systems
6. Future Plans
7. Wrap-Up

### **REVIEW PAST WEEK (15 MIN.)**

**Welcome the group.** Welcome back, everyone! How was everyone's week? Are there any questions from the prior session?

### **CONSOLIDATION**

We are going to begin today by reviewing some of the things we have learned about loss during our time together in this group. Last week we discussed some of the leading theories of grief and the way a lot of people process loss. One of the major themes in this discussion that has also come up for us in other sessions was meaning making. The meaning to ascribe to our loss really impacts the way we process and cope with the death of someone we love. Sometimes it can be really hard or seemingly impossible to feel that we could make any sort of sense out of a loss. This can be especially difficult if someone died unexpectedly, suddenly, or under troubling circumstances. Not being able to make meaning out of a significant loss can lead us to question other beliefs we hold, such as thinking the world is a just or safe place, or that everything has a purpose. The process of working through what someone's death means to us is a major component of grief and can be very difficult. It also can lead us to learn more about ourselves as we ask challenging questions that get at the heart of our relationships and values. The art activities we completed during our time together can be one way to explore meaning. Sharing our thoughts and feelings about the loss with others we trust can also be a helpful way to process loss. As we participate in our last group together today, take some time to think about the activities and experiences you have found most helpful in reflecting on your loss.

### **SURVEY COMPLETION (15 MIN.)**

**Facilitating survey completion:** Now we are going to take a few minutes to complete a survey packet. This packet asks us questions about what our participation in this group was like for us, as well as some reflections on our loss experience and the meaning we have made from our loss. The packet contains some of the same questionnaires you have completed before. Completing these surveys is estimated to take no longer than 10 to 15 minutes. I will be available to help anyone who has questions or who needs some assistance.

### **REVIEW GOALS AND SELF-CARE (10 MIN.)**

Now I would like everyone to reflect back to the activities or experiences you have had over the past four weeks that were most helpful to you. Whether they were helpful to you by improving your mood, sparking a positive memory of your loved one, or were beneficial to your health, take some time to think about some positive experiences you have had recently. Now I would like you to write down three goals that you have for yourself for the future. These goals can be anything—they can be about your job, your health, your family, anything. These goals will allow us to point towards the future and work towards something positive in our lives.

### **MOBILIZING SYSTEMS (15 MIN.)**

Discussion of additional sources of support that participants can engage in. Review friends, family members, faith communities, and mental health resources in the community that are accessible to participants. Lead discussion in the benefits of social support, especially in times of loss, and have participants each identify three individuals or resources that they would feel comfortable reaching out to if they were having a difficult day.



**WRAP-UP (5 MIN.)**

Thank you again to everyone who shared their stories and introduced their loved one to us today through their collages. All of us have experienced our grief in unique and individual ways, and there were also some themes that emerged throughout our group discussions together. Some of these themes included [NOTED THEMES] (similar emotional reactions to loss, types of loss, relationship to the deceased, etc). Another theme is that all of you chose to come here today to participate and explore your grief, and we appreciate the bravery it takes to engage in these activities and discussions.

Are there any questions or comments before we end? [ANSWER QUESTIONS AND RESPOND TO COMMENTS AS TIME ALLOWS]. Thank you all for coming today!

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