

A CONTENT ANALYSIS OF THE TREATMENT NARRATIVES
OF PATIENTS WITH COMPLICATED GRIEF

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Submitted to the graduate faculty of
the School of Education in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy

University of Pittsburgh

2006

UNIVERSITY OF PITTSBURGH
SCHOOL OF EDUCATION

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This dissertation explores the verbal content of revisiting exercises told by patients diagnosed with Complicated Grief during a therapy session. A revisiting exercise is a complete narrative account of a primary loss, from the time that the patient discovered or heard of the loss until the funeral and aftermath. Twenty-two patients receiving treatment for Complicated Grief each provided his or her last revisiting exercise from treatment. Narratives were analyzed via qualitative content analysis. Pearson Product Moment Correlations and Spearman's Correlation Coefficient for Ranked Data were also used to examine the relationship between narrative content and patient's grief, depression, and trauma symptoms.

Results revealed four major thematic categories within the narratives: Emotions, Cognitions, Social Support, and Focus on Death. Overall emotional content tended to be negative, with an emphasis on angry and sad feelings. While patients spoke longer about unsupportive social networks, most patients reported a mix of supportive and unsupportive friends and family. Important cognitive categories included self-evaluations, blame, and asking why the loss occurred. Finally, for most patients, the appearance of the corpse became fixated in their minds and they had trouble getting past their dual aversion and fascination with this image.

Correlations between themes and symptoms scores did not occur in the expected direction and were not consistently significant. Correlations were useful, however, in generating hypotheses for further qualitative analyses. For example, the present study indicated that the integration of narrative themes should be explored in future research.

The study indicated that patients wove positive and negative themes together but primarily focused on themes that troubled them, such as unsupportive family and the corpse's appearance. Although patients were told to tell the story of the death, for most, additional themes such as the support or lack of support from others were integral to the stories. Exploring a subsample of patients revealed how and where in the narratives patients described particular themes. In addition, the subsample exploration revealed that anger was the unifying theme in the narratives, particularly in narratives from early treatment sessions.

Implications for Complicated Grief research and treatment are presented, as well as implications for grief narrative research.

Foreword

How amazing that the two most significant achievements of my life should occur so close to one another. The birth of my firstborn child or and the “birth” of my dissertation demanded the utmost of my physical, mental, and emotional abilities. Each also resulted in a joy and excitement that those who have not experienced one or the other could ever truly understand. I believe that I benefited from the pairing of the two. My evolving into a mother matured me in ways that served to heighten my work on this project. I hope that my completion of the Ph.D. will serve to better my daughter’s life as it opens new doors for us as a family.

As much as I pride myself on being self-reliant, I must acknowledge those whose help I couldn’t have done without. To my God, who taught me much about life and myself throughout this process, I offer thanks for His graciousness at enabling and allowing me to achieve this goal, which has been a desire of mine for a very long time. I thank my husband, Joshua, who is the most supportive and encouraging spouse that I could imagine. To say, “Thank you for your emotional support” does not do justice to how I have benefited from your love during these five years of marriage. I thank my parents for always believing that I was the best at everything that I attempted, for setting me on the right track spiritually, emotionally, and mentally, and for dropping the hint, many years ago, that the academic life is the one for me! Thanks also to my coding partner, Maria Wrzosek, for her enthusiastic commitment to this project.

Thanks to each member of my dissertation committee. Dr. Nancy Elman, I am so thankful to have had you as an academic advisor! You have mentored me in so many ways, and I am so thankful for the many opportunities that you have presented to me over the years. I greatly valued our talks as academic colleagues with a mutual interest in adulthood and aging. Dr. Katherine Shear, thank you for encouraging me (and allowing me!) to use data from your study. Thank you for your continual support, as well as the encouragement to move beyond what I considered to be my limitations. I would never have imagined that I'd be presenting complicated statistical analyses to a group of data analysts or describing my coding scheme to a world-renowned researcher, yet I have grown so much from these opportunities. Dr. Maureen Porter, thank you for challenging me to grow in my understanding and use of qualitative research. I will never forget the encouragement that you gave regarding balancing motherhood and professional life; your comments were so valuable to me. Dr. Louis Pingel, thank you for your sane and well-reasoned advice. Your clear-headedness was such a help to me at so many points.

Finally, I thank the 22 patients whose words made this study possible. I wish much happiness to you, despite your pain, and I hope that others can benefit from your experiences.

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1.0 INTRODUCTION

Grief is the reaction to the loss of a loved one, and it includes emotional, behavioral, and cognitive components (Stroebe, Hansson, Stroebe, & Schut, 2001). Some individuals grieve only briefly and mildly, while the grief of others is lengthy and intense. Grief is a natural response to death and it is unreasonable to expect it to entirely dissipate, particularly when a close loved one passes away.

For a minority of individuals, however, intense grief is prolonged. Such individuals have trouble resuming life even years after the loved one's death. Rather than being able to engage in daily activities, equipped with comforting memories of the deceased, they are persistently troubled by painful grief symptoms, such as recurrent intrusive images of the dying person. While individuals vary somewhat with regard to how quickly they resume everyday life, theorists have long recognized the existence of pathological grief (Bowlby, 1961; Freud, 1957; Stroebe, Schut, & Finkenauer, 2001). Current research utilizes the term, Complicated Grief, to describe grief that is debilitating and lingering. Complicated Grief includes traumatic stress reactions such as feelings of numbness and detachment, as well as separation distress symptoms such as yearning and searching for the deceased (Prigerson et al., 1999).

One treatment, Complicated Grief Treatment (CGT), specifically targeted Complicated Grief (CG). Traditionally, theorists and researchers associated grief with depression and often assumed that treating a bereaved individual's depression would also address the grief. Yet the low effectiveness of supportive depression psychotherapy and antidepressants for the treatment of grief (Marmar, Horowitz, Weiss, Wilner, & Kaltreider, 1988; Reynolds, Miller, et al., 1999; Shuchter & Zisook, 1986; Windholz, Marmar, & Horowitz, 1985), despite their effectiveness in targeting depression, convinced many researchers that a grief-specific treatment would be necessary to help persons with CG. CGT specifically targeted Complicated Grief but acknowledged that this syndrome shares symptoms with both Major Depressive Disorder (MDD) and Post-Traumatic Stress Disorder (PTSD). Thus, CGT integrated depression and PTSD treatments and tailored this blended treatment toward individuals with CG. Research outcomes showed CGT to be more effective than interpersonal psychotherapy in the treatment of CG (Shear, Frank, Houck, & Reynolds, 2005).

CGT utilized a technique, called a revisiting exercise, in which patients told the story of the primary loss that occurred. I examined these revisiting exercises in the present study. While narrative exploration occurs in grief research (Maercker, Bonanno, Znoj, & Horowitz, 1998), no study explored the clinical narratives of patients with Complicated Grief. The rationale for analyzing narrative accounts is typically two-fold. First, narratives arguably provide more in-depth and rich information about psychological symptoms than self-report measures (Ericsson & Simon, 1984), since individuals are given greater opportunity to speak at length about thoughts and feelings without necessarily being constrained to specific questions. Second, the process of an individual reporting his or her emotional grief

experiences is often viewed as being therapeutic (Shucter & Zisook, 1993). Thus, narratives may be used to understand recovery from loss (Maercker et al., 1998). In the present study, I explored the stories of the losses of bereaved individuals with Complicated Grief, as described in their revisiting exercises as part of Complicated Grief Treatment.

1.1 Statement of the Problem

This study addressed the question, “What is the content of the revisiting exercises?” Since no research specifically explored the content of Complicated Grief narratives, very little is known about such death narratives.

To explore relevant literature, one must turn to studies on related issues such as natural grief narratives and Post-Traumatic Stress Disorder. Such research typically focuses on quantitative instead of qualitative methods of inquiry. Researchers tally means of narratives themes and compare such themes to physical and mental health. One disadvantage of relying on descriptive statistics in narrative exploration, instead of also utilizing qualitative methods, is that specific themes either are not explored or they are not explored in detail. A description of the types of themes evident in Complicated Grief narratives could aid CG research by adding further insight into this condition. While some qualitative work on grief narratives does exist, most wholly qualitative grief studies focus on specific subgroups of participants who are not particularly comparable to the present group of patients with Complicated Grief.

Grief research overall neglects clinical samples of grieving patients (Wortman & Silver, 2001). Yet, this is precisely the group most likely to evidence the most severe symptoms. An exploration of narratives from a clinical population could aid grief narrative

research by describing a methodology specifically designed for research in this population. Many narrative researchers apply the same methodologies across bereaved and non-bereaved samples, whether or not the coding strategies are relevant to the group at hand. The codes in the present study arose primarily from the CG narratives themselves and the analyses integrate quantitative and qualitative elements specifically for the purpose of addressing this clinical population.

Maercker, Bonanno, Znoj, and Horowitz (1998) coded interviews of conjugally bereaved individuals. They found positive emotional themes to be significantly and inversely related to grief scores six months post-loss. However, Pennebaker, Mayne, and Francis (1997), studying bereaved gay male caregivers, did not find positive emotions to be clearly related to grief scores. In other studies, Pennebaker's group found that non-bereaved individuals utilizing more positive emotions in narratives tended to have better physical and mental health outcomes (Pennebaker & Seagal, 1999). Results are clearly inconclusive regarding whether positive emotional use is beneficial for all groups of bereaved individuals. It is unknown how the content of the CG revisiting exercises would relate to grief symptoms. Thus, a secondary goal of the study was to explore how narrative content related to patient symptoms.

1.2 Significance of the Study

Grief is a universal human experience; thus, the study of grief is perennially relevant. For the subset of individuals with Complicated Grief, bereavement is particularly debilitating. Researchers are just beginning to describe this syndrome and understand its mechanisms, in the hopes for a future inclusion in the Diagnostic and Statistical Manual of Mental Disorders

(current version: DSM-IV-TR; American Psychiatric Association, 2000). In the present study, I explored the connection between the content of the revisiting exercises and patient symptoms. I expected positive emotional expression to be associated with better mental health outcomes, based on the most recent studies in grief research.

Prior to the present study, I conducted a pilot study on a small subset of CG revisiting exercises. In these exploratory analyses, certain characteristic thoughts and feelings of CG patients frequently occurred. In the narratives, patients reported feeling emotions such as guilt, anger, fear, sadness, love, and pride. The pilot study aided the development of a coding plan for Complicated Grief revisiting exercises as well as suggesting the types of themes likely to be present in such narratives. While results in the pilot study suggested the relevance of certain themes, the present study more fully explored the thoughts and feelings of persons with CG, as voiced in the exercises. Future narrative research may be aided by a study that explores specific themes in addition to overall “positive” and “negative” themes and does so by utilizing a hybrid methodology of qualitative and quantitative methods. By utilizing a qualitative coding methodology, I endeavored to explore themes to a greater extent than typically occurs in grief narrative studies.

Besides the pilot study, the present study is the first known study that explores the clinical narratives of patients with Complicated Grief. Results may inform Complicated Grief research by specifying the issues and topics present in narratives of the deaths that occurred, as described in a treatment setting.

2.0 REVIEW OF THE LITERATURE

Grief research is a field with a long history. The journey from conceptualizing grief as the equivalent of depression to considering it as a natural reaction that, for some, can become a debilitating disorder with specific, identifiable symptoms has been ongoing for roughly 100 years. The following section will briefly describe this journey, beginning with the theorists and researchers who began to make distinctions between normal grief and abnormal grief reactions. Subsequent sections will discuss connections between grief and trauma research, the three interrelated disorders of Major Depression, Complicated Grief, and PTSD, and the respective treatments for these disorders. This chapter will conclude with a discussion of grief narrative research, focusing on content analysis and discerning meaning in a loss.

2.1 History of Abnormal Grief Research

Early researchers sought to distinguish between normal and abnormal grief, and they utilized various terms to describe these differences. Perhaps the earliest modern theorist to focus on grief was Sigmund Freud. In his discussion of mourning and melancholia (Freud, 1957), Freud distinguished between normal grief (mourning) and depression (melancholia). He viewed mourning as a natural process that transpires after the loss of a healthy relationship and melancholia as a pathological outcome. This outcome may arise following the loss of an attachment characterized by ambivalence. Ambivalence is characterized by both desiring

and rejecting a loved one. Melancholia, according to Freud, could also arise from negative life circumstances that trigger ambivalence, such as neglect.

Lindemann (1944) observed and treated 101 bereaved individuals who sought psychological help after the famous Coconut Grove fire claimed nearly 500 lives at a nightclub in Boston, Massachusetts. In his 1944 book, Lindemann also discussed his experience in interviewing and treating psychiatric and non-psychiatric samples of bereaved individuals. Lindemann noted certain similarities in the bereaved individuals' experiences of grief. Many evidenced somatic symptoms, preoccupation with the deceased loved ones, guilt and anger, and an inability to resume normal daily functioning. Lindemann considered these symptoms to be indicative of a pathological grief disorder, which he called acute grief. Lindemann was also the first to label anticipatory grief, in which individuals experience psychological distress under the threat of death, despite the death not yet occurring.

In subsequent decades, researchers used numerous terms to describe grief reactions. Delayed grief referred to a reaction that is more fully experienced at a later time instead of immediately following the loss (Bonanno & Kaltman, 1999). Chronic grief described grief symptoms that were persistently troubling and intense (Parkes, 1965) or "excessive in duration" (Worden, 1982, p. 59). John Bowlby (1980) also described chronic grief as being rooted in separation anxiety. Just as healthy children respond with despair when separated from their mothers, a similar despair may happen to adults when a separation is caused by death. Bowlby also described how chronically grieved individuals either blamed third parties such as hospitals and relatives or never engaged in any criticism toward the deceased. Bowlby designated factors that he considered to be predictive of chronic grief, such as a sudden loss, quarrelsome relationships with relatives, and a troubled childhood.

Some theorists became enamored of stage theories. Abnormal grief, then, was conceptualized as grief that becomes stuck in one of the stages. For instance, Zisook and DeVaul (1985) listed the hypothetical stages as being 1) shock, disbelief, and denial; 2) somatic complaints, experience of negative emotions, and social withdrawal; and 3) recovery. Abnormal grief would involve being stuck in either the first or second stage of grief. Zisook and DeVaul indicated that, without intervention, an individual with abnormal grief would remain stuck.

Grief research no longer gives precedence to stage theories and now focuses on other topics such as the link between grief and trauma. Although Lindemann did not fully explore the links between traumatic events and grief in his work with the Coconut Grove fire survivors, subsequent researchers noticed the connection between grief and trauma. The following section explores the research linking trauma and grief.

2.2 Trauma and Grief

Mardi Horowitz wrote an early influential book linking traumatic stressors and grief, entitled *Stress Response Syndromes* (1976). He stated that traumatic stressors include traumatic events such as the Coconut Grove fire or other tragedies but also may include the death of a close loved one. Horowitz et al. (1997) began to develop criteria for what they termed, complicated grief. “Complicated” is a DSM (American Psychiatric Association, 1994) term for bereavement that is complicated by depression (Prigerson, Frank et al., 1995). Horowitz et al.’s proposed criteria for Complicated Grief are presented in Table 1. These criteria are based on structured diagnostic interviews with 70 conjugally bereaved individuals. Horowitz et al. have not conducted further empirical research regarding these proposed criteria.

Prigerson et al. (1999) also conducted research on Complicated Grief. Table 2 presents their criteria for this disorder that they termed, Traumatic Grief, in order to highlight its separation trauma symptoms and its similarities to PTSD stress responses. Prigerson et al. formulated their criteria via a three-step process. First, they held a consensus conference in which a panel of experts discussed the differences between normal and abnormal grief and developed an initial set of CG criteria. Secondly, they empirically tested the proposed criteria by analyzing data from Zisook and Shuchter's San Diego Widowhood study (1987). Three hundred and eight widows and widowers participated in the full study, which consisted of interviews at seven weeks after the loss and then again at seven months. The mean age of the subjects was 61 and 70% were female. Based on results from the empirical study, the third step involved refining the CG criteria, which involved omitting poorly performing items to improve internal consistency. Prigerson et al. found that endorsing three of four separation distress symptoms (Criterion A) and four of eight traumatic distress symptoms (Criterion B) provided a sensitive and specific diagnosis of CG. Combining criteria A and B, as would occur in clinical practice, resulted in the highest sensitivity.

The two research groups, Horowitz et al. and Prigerson et al., developed remarkably similar criteria for CG. The criteria from both groups inform current diagnostic guidelines of CG. For both groups, Criterion A is the death of a significant other. CG symptoms identified by both groups include: intrusive thoughts regarding the lost relationship, severe emotional pangs, yearning for the deceased, and feelings of emptiness and loneliness. Differences include the specified duration since the loss and the inclusion of physiological

Table 1.

Proposed signs and symptoms for Complicated Grief (Horowitz et al., 1997, p. 909)

Criterion A

Bereavement (loss of a spouse, other relative, or intimate partner) at least fourteen months ago (12 months is avoided because of possible intense turbulence from an anniversary reaction).

Criterion B

In the last month, any three of the following seven symptoms with a severity that interferes with daily functioning:

Intrusive Symptoms

1. Unbidden memories or intrusive fantasies related to the lost relationship.
2. Strong spells or pangs of severe emotion related to the lost relationship.
3. Distressingly strong yearning or wishes that the deceased were there.

Signs of Avoidance and Failure to Adapt

4. Feelings of being far too much alone or personally empty.
 5. Excessively staying away from people, places, or activities that remind the subject of the deceased.
 6. Unusual levels of sleep interference.
 7. Loss of interest in work, social, caretaking, or recreational activities to a maladaptive degree.
-

Table 2.

Consensus criteria for Traumatic Grief (Prigerson et al.,1999, p. 71)

Criterion A

1. Person has experienced the death of a significant other
2. Response involves 3 of the 4 symptoms below experienced at least sometimes:
 - (a) Intrusive thoughts about the deceased
 - (b) Yearning for the deceased
 - (c) Searching for the deceased
 - (d) Loneliness as result of the death

Criterion B

In response to the death, 4 of the 8 following symptoms are experienced as mostly true:

1. Purposelessness or feelings of futility about the future
2. Subjective sense of numbness, detachment, or absence of emotional responsiveness
3. Difficulty acknowledging the death (e.g. disbelief)
4. Feeling that life is empty or meaningless
5. Feeling that part of oneself has died
6. Shattered world view (e.g. lost sense of security, trust, control)
7. Assumes symptoms or harmful behaviors of, or related to, the deceased person
8. Excessive irritability, bitterness, or anger related to the death

Criterion C

Duration of disturbance is at least two months.

Criterion D

The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning.

symptoms. Horowitz et al. stated that at least fourteen months since the loss must elapse prior to diagnosis while Prigerson et al. simply stated that symptoms must be experienced for at least two months. Horowitz et al included sleep disturbances in their Criterion B while Prigerson et al. concluded that including sleep disturbances as a symptom would cause CG to overlap too much with Major Depression.

2.3 The Nature of Complicated Grief

To summarize the combined work of Prigerson et al. (1999) and Horowitz et al. (1997), Complicated Grief is a condition that is precipitated by the loss of a close loved one and general symptoms include intrusive thoughts about the deceased, painful emotions, yearning for the deceased, avoidance of reminders of the loss, and impaired daily functioning (Chen et al., 1999). The disturbance must cause significant functional impairment in order for CG to be diagnosed.

Both Horowitz's and Prigerson's groups emphasized that the type of loss experienced need not be violent in order for Complicated Grief to occur. The fact that a loved one has died is a sufficient stressor, and this finding is commensurate with Horowitz's (1976) work on traumatic stressors. One individual may lose a loved one to a suicide and might then develop Complicated Grief, while another individual may lose a loved one to cancer and also develop Complicated Grief symptoms.

Other grief and trauma researchers generally subscribe to the notion that a variety of losses, not just violent and horrific ones, may precipitate grief and trauma. However, there is disagreement as to whether an additional disorder besides PTSD is warranted as a future entry into the DSM, although there is a reasonable likelihood that CG will be included in

DSM-V (The Associated Press, 2005). Those who support the formation of a distinct disorder emphasize that PTSD does not include specific grief symptoms (Prigerson et al., 1996). Thus, equating Complicated Grief with PTSD might result in missing important, distinct criteria, which would be especially problematic when treating CG. Others, however, feel that a new category is unnecessary and that Complicated Grief can fit within the framework of PTSD (Stroebe, Schut, & Finkenauer, 2001). In order to explore these issues, the following section will describe two disorders that are similar to CG: PTSD and Major Depressive Disorder. While current research indicates that these syndromes are distinct from one another, they share similarities.

2.4 Post-Traumatic Stress Disorder

PTSD is a relatively new disorder in the DSM, being first introduced in 1980. PTSD can be diagnosed if a) an individual experienced, witnessed, or confronted an event that involved actual or threatened death or serious injury and b) the individual responded in intense fear, helplessness, or horror. Examples of such stressor events include military combat, natural disasters, terrorism, serious accidents, and rape.

People with PTSD persistently re-experience the event through intrusive and distressing recollections, nightmares, hallucinations or feelings that the event is occurring again, and they experience intense psychological and physical distress. In addition to experiencing a stressor event and re-experiencing the event, a third criterion of PTSD includes avoiding stimuli associated with the trauma. Avoided stimuli may include thoughts and feelings associated with the trauma, activities, people, and places. The person may

report feeling detached. A fourth criterion includes increased arousal, anger, hypervigilance, exaggerated startle response, and difficulty concentrating.

Various treatments are used to address PTSD, such as cognitive-behavioral therapy, pharmacotherapy, and eye movement desensitization and reprocessing (Foa & Meadows, 1997). The treatment most relevant to the proposed study is cognitive-behavioral therapy, since Complicated Grief Treatment incorporates a series of techniques used in cognitive behavioral therapy for PTSD, namely, exposure therapy. Exposure therapies include systematic desensitization, imaginal exposure, and *in vivo* exposure. Systematic desensitization, originated by Wolpe (1958), paired relaxation with systematic and imaginal exposure to feared stimuli, arranged in a hierarchy. This specific technique is no longer used, but other exposure techniques are still widely used in therapy. *In vivo* exposure involves repeated confrontations with feared stimuli. These encounters are not imaginal and involve patients going out and actively confronting certain feared situations and objects. Finally, imaginal exposure is a prominent component of PTSD treatment. Prolonged imaginal exposure, as utilized by PTSD researcher Foa and colleagues, involves patients imagining the traumatic event as vividly as possible and describing the scenario as though it is happening in the present (Foa, Rothbaum, Riggs, & Murdock, 1991). This is done over a lengthy period, typically 60 minutes per session. CGT utilized both imaginal and *in vivo* exposure, although it tailored these techniques to specifically address CG. A description of the modifications used to create CGT is included in section 2.6.

Numerous studies validated the effectiveness of exposure therapies. In a study of 26 veterans with combat-related PTSD, participants were randomized to receive either a standard treatment of psychosocial and pharmacological therapy or an augmented treatment

of psychosocial, pharmacological, and imaginal exposure therapy (Cooper & Clum, 1989). Those who received imaginal exposure treatment showed a greater reduction of symptoms than those receiving the standard treatment. Imaginal exposure was particularly effective for reducing nightmares, with 96% of patients evidencing nightmare reductions when being treated with imaginal exposure, compared to 15% of veterans receiving the standard treatment.

Foa et al. (1991) randomly assigned female assault victims to various treatment conditions, including prolonged exposure (which included in vivo and imaginal exposure) and supportive counseling. All participants had been diagnosed with PTSD. Prolonged exposure proved to be the most successful treatment given, with 55% of women in this condition no longer meeting criteria for PTSD, compared to 45% of women receiving supportive counseling. This study illustrates that while supportive psychotherapy is beneficial for trauma patients, this treatment consistently is outperformed in this population by exposure therapy.

While symptoms of CG and PTSD overlap, an important distinction between the two disorders is that CG includes separation distress, such as yearning and searching for the deceased. The loss associated with CG may be conceptualized as a separation trauma, in which patients are both drawn to memories of the deceased individual as well as fearful of reminders of the death. Such duality is not present in PTSD.

2.5 Major Depressive Disorder

Major Depressive Disorder is characterized by a persistent depressed mood. According to DSM-IV-TR (American Psychiatric Association, 2000), an individual meets criteria for

MDD if, in addition to having depressed mood and lost interest in activities significantly impairing one's life, he or she experiences at least four of the following symptoms within a two week depressed period: overwhelming sadness, anhedonia, appetite or weight changes, sleep disturbances, agitated or slowed motor activity, fatigue, guilt, decrease in self-esteem, poor concentration, and abnormal thoughts of death or suicide. DSM-IV-TR specifies that these symptoms cannot be due to normal bereavement for MDD to be diagnosed.

While Major Depression and CG both are characterized by negative feelings and mood impairment, few specific symptoms actually overlap. Furthermore, a number of CG symptoms are completely unrelated to Major Depression: numbness, pangs of severe emotion related to the loss, disbelief, and yearning for the deceased.

In a study of Complicated Grief and depression in elderly bereaved spouses, 23 out of 82 conjugally bereaved adults met criteria for Major Depression (Prigerson, Frank, et al., 1995). The authors conducted a principal-components factor analysis on the subjects' baseline data. Two factors emerged: Factor 1 accounted for 26.2% of the variance and included symptoms such as insomnia, suicidal ideation, depressed mood, and psychomotor retardation, while Factor 2 accounted for 20% of the variance and included symptoms such as preoccupation with the deceased, crying, searching for the deceased, disbelief about the death, and being stunned by the death. Factor 1 was conceptualized as a Bereavement-related depression factor, while Factor 2 was conceptualized as a Complicated Grief factor. These findings support the belief that CG comprises a syndrome distinct from MDD.

Similarly, in their formation of diagnostic criteria for Complicated Grief, Horowitz et al. (1997) found that CG symptoms did not significantly overlap with symptoms of MDD

among 70 conjugally bereaved adults. The authors concluded that a separate diagnosis of Complicated Grief would be warranted for many of the patients.

MDD can be treated in a number of ways. Pharmacotherapy treatments are commonly shown to be efficacious and anti-depressants are widely prescribed (Reynolds, Frank, et al., 1999). Psychotherapy treatments are also efficacious. Specifically, cognitive-behavioral and interpersonal psychotherapy are well-studied and validated depression treatments. Interpersonal psychotherapy (IPT) is specifically designed to address depression and includes a focus on grief reactions (Miller et al., 1994). Complicated Grief Treatment is based on IPT, augmented with trauma-targeted techniques. A basic premise of IPT is that depression occurs within a social context. The overarching goals of IPT are to reduce depressive symptoms and to improve the quality of the patient's interpersonal functioning.

Grief is one of several possible focus areas in IPT. Depression is conceptualized as being rooted in one of four problem areas: unresolved grief, interpersonal role disputes, role transitions, and interpersonal deficits. The general course of IPT involves a) addressing the depressive symptoms, b) identifying and exploring which problem area is most pertinent to the patient, and c) preparing for the disruption of the therapeutic relationship. When treating grief, IPT primarily focuses upon two problem areas, unresolved grief and role disputes. When targeting unresolved grief, the IPT therapist seeks to reconstruct the patient's relationship with the deceased, including guiding the patient toward more realistic appraisals of his or her relationship with the deceased. The patient is also invited to express painful feelings. These emotions are discussed in a less structured way than in cognitive-behavioral treatments, and the patient may or may not actually tell a prolonged story of the death in therapy.

When targeting role transitions, the IPT therapist primarily helps the patient to relinquish the lost role, positively view the new role, and master the new role. For example, for a bereaved widow, the therapist might facilitate grieving over the lost role of wife. Then, the patient would be guided in embracing either new or existing roles and developing self-esteem and mastery in regard to those roles. Grief-focused IPT would also involve managing painful emotions pertaining to the loss.

While IPT is a well-validated treatment for depression (Frank, Kupfer, Wagner, McEachran, & Cornes, 1991), it has been less successful in addressing grief symptoms. Reynolds, Miller et al. (1999) treated 80 conjugally bereaved adults in a randomized, controlled trial, which included antidepressant, interpersonal psychotherapy, and combined pharmacotherapy and psychotherapy treatment conditions. Participants were adults over the age of 50 who had experienced major depressive episodes between six months prior to the loss and 12 months after the loss. The authors reported significant reductions in depressive symptoms, particularly for the combined treatment group. However, grief symptoms showed little improvement. Scores on the Texas Revised Inventory of Grief (Faschingbauer, Zisook, & DeVaul, 1987) declined from 50.1 to 38.4 (maximum score possible being 65) across all treatments. Scores on the Inventory of Complicated Grief (ICG; Prigerson, Maciejewski, et al., 1995) evidenced a similar modest reduction. Given these results, researchers at the University of Pittsburgh sought to develop a treatment that specifically targeted CG symptoms.

In a pilot study of Complicated Grief Treatment (CGT), 21 subjects were treated (Shear et al, 2001). Similar to the Reynolds, Miller et al. sample, the majority of patients were over the age of 50. Results indicated that CGT was more efficacious than IPT alone in

reducing grief symptoms. Scores on the Inventory of Complicated Grief declined, on average, from 38.85 to 18.08 for treatment completers. The maximum possible score on the ICG is 76. In the full Complicated Grief study (Shear, Frank, Houck, & Reynolds, 2005), analyses of 83 women and 12 men who received either Complicated Grief Treatment or Interpersonal Psychotherapy indicated a greater response rate (51%) for CGT versus IPT (28%; $p = .02$)

Based on the above research, CG appears to be distinct from both PTSD and MDD, arguably warranting both an inclusion in the DSM-V as a distinct disorder and a therapy that specifically targets CG's unique symptoms. A description of Complicated Grief Treatment is presented below.

2.6 Complicated Grief Treatment

Complicated Grief Treatment (CGT) draws upon both IPT and PTSD prolonged exposure interventions. CGT is a standardized treatment comprised of sixteen therapy sessions, each of which lasts approximately 90 minutes, and it includes three phases of treatment. The first phase is introductory and requires approximately three therapy sessions. This phase involves gathering information about the patient's experiences related to the loss as well as his or her clinical and relationship histories and it also involves planning the patient's treatment. During this time, the therapist and patient discuss the patient's loss-related thoughts, behaviors, and feelings, the nature of the treatment, and the patient's personal goals for treatment.

The second phase consists of approximately six sessions and focuses on treating the trauma using an imaginal exposure technique and treating separation distress using an

imaginal conversation with the deceased. Behavioral change is also a target in the second phase of treatment, and *in vivo* exposure is utilized to focus the patient on activities of daily life that he or she has avoided since the loss.

The third phase includes the option for therapists to use IPT techniques to discuss the patient's relationship with the deceased. Thus, in this phase, therapists may elect to continue the exposure techniques or augment *in vivo* with IPT. The third phase typically lasts for seven sessions, including the final session in which treatment termination and future planning is discussed.

The imaginal exposure technique in CGT is called the revisiting exercise. In this exercise, the patient is instructed to tell the story of the death in the present tense, as if it was currently happening. Patients are told to close their eyes and describe the death and surrounding events, beginning with the point at which she or he heard about or discovered the death. Most patients initially experience distress, sometimes accompanied by crying and heavy breathing, as they complete the revisiting exercise. CGT measures this distress by allowing patients to monitor and quantify their own distress levels. These levels are called Subjective Units of Distress (SUDS). The patient informs the therapist how distressed he or she is feeling on a scale from 0-100, with 100 being the highest level of distress. Early in the treatment, individuals quite frequently report maximum SUDS levels. The rationale behind the exercise is that by repeatedly confronting previously avoided emotions, these painful emotions can be processed. Although these emotions are initially highly distressing for the patient, it is expected that over time the SUDS levels will decrease and the patient will be able to tell the story more easily. The patient is asked to retell the entire story during each of the first three sessions of the revisiting exercise. However, the revisiting exercise in CGT is

not as lengthy as the prolonged imaginal exposure utilized in PTSD treatment, which averages 60 minutes of exposure. Rather, CGT's revisiting exercise lasts as long as it takes the patient to describe the story. For some patients, the death narrative took as long as 45 minutes; for most, however, the narrative was more concise, ranging from fifteen to thirty minutes.

After the patient tells the full story without new information emerging, he or she is invited to conduct an imaginal conversation and focus upon "hot spots" in the story that evoked particularly high emotion and distress. During the imaginal conversation, the patient is encouraged to talk to the deceased loved one and then take the role of the loved one and respond in a conversation. This technique appears to be very powerful in helping patients feel connected to their loved ones. Approximately three sessions are devoted to imaginal conversations and hot spots.

I focused solely on the CGT revisiting exercise in the present study. The revisiting exercise is essentially a death narrative told by the patient, with occasional prodding by the therapist in which SUDS levels and other thoughts and emotions are evoked. Thus, the patient can largely explore the story details as well his or her thoughts and feelings, but with some constraints. For instance, if the patient begins to delve into past reminiscence instead of focusing on the storyline, the therapist may guide the patient back to the narrative. Or, if the patient neglects to offer emotional or cognitive details during the storytelling, then the therapist may ask, "What are you feeling?" at intervals. Such occasional therapist intervention is comparable to the grief narratives conducted in prior studies (Pennebaker, Mayne, & Francis, 1997; Pennebaker & Seagal, 1999) in which interviewers invited

participants to tell the stories of the deaths but also occasionally asked questions if participants did not address the study's target issues.

Utilizing a clinical technique originally intended for treatment purposes in a larger study had its advantages and disadvantages. By using the revisiting exercises, I had a sample of patients who already met criteria for Complicated Grief and for whom information had already been collected regarding patient symptoms scores. Furthermore, the exercises followed the same basic format and offered very rich descriptions of the story of the death. However, since I did not conduct the interviews, I was unable to ask the types of probing questions that I would have in an open-ended interview format. Instead, I was limited to the questions that the therapists occasionally asked. In cases in which patients did not go into as much detail as I would have liked, I could not go back and inquire for more details since the data had already been collected and the treatment completed.

Despite these limitations, I was still able to identify the cognitions and emotions described by the patients. For the most part, patients explicitly voiced their thoughts and feelings throughout their narrative accounts. The following section reviews the literature regarding the exploration of cognitive and emotional processes, particularly in grief and trauma narrative research. Narrative inquiry may encompass various modalities, from examining loosely ordered speech on a variety of subjects to actual stories (Gilbert, 2002). The present study examined the latter; thus, this literature review emphasizes research on narrative stories rather than participants' discussions of their grief-related artwork or textual themes in autobiographical or biographical book accounts, all of which could be considered to be narrative analysis under the most "extreme" definition of narrative research (Gilbert, 2002, p. 227).

2.7 Cognitive and Emotional Processes

To understand the nature of Complicated Grief, PTSD, and natural grief, an exploration of how individuals describe their losses and distress is appropriate (Maercker et al., 1998). Tools for exploring verbal descriptions include self-report measures and narrative analysis, and researchers in the above areas highlight emotional and cognitive dimensions using these tools. The following section emphasizes narrative research, which is most relevant to the present study. Among grief narrative accounts, half of the available research utilizes solely quantitative methods of inquiry, while the other half explores the narratives of specific populations of grievers. The following section describes the first type of research, while section 2.7.2.1 presents the latter type with an emphasis on the research most relevant to the present study.

2.7.1 Emotions

Pennebaker, Mayne, and Frances (1997) studied 167 bereaved caregivers whose partners had died of AIDS during the course of a study on coping (the UCSF Coping Project). The study's goal was to predict participants' later mental health by using content from interviews in which participants described their losses. Mental health of participants was assessed along four dimensions: depressed mood, positive morale, positive states of mind, and the impact of the death. Depressed mood was assessed via the Centers for Epidemiological Studies Depression measure (CES-D; Radloff, 1977), positive morale and positive states of mind via the Affect Balance Scale (Bradburn, 1969) and Positive States of Mind Scale (Horowitz, Adler, & Kegeles, 1988), and the Impact of Event Scale (IES; Horowitz, Wilner, & Alvarez,

1979) was used to measure the impact of the death. The authors used an averaged score of assessments taken at two and four weeks following the death, and a score at 12 months after the loss.

The authors interviewed participants twice. During these interviews, the interviewer asked each participant to describe the death, what he/she was feeling and thinking, and what types of things made the loss easier or more difficult. Pennebaker et al. expected that strong use of negative emotions during the interviews would be associated with better mental health outcomes, based on a prior assumption that inhibiting negative feelings and thoughts augments psychological distress (Pennebaker, 1989). The authors used a preliminary version of a computer package, the Linguistic Inquiry and Word Count (LIWC; Pennebaker & Francis, 1999), to tally the negative and positive emotional interview content. The authors did not describe the specific grief themes utilized by subjects, but the LIWC considers negative emotions to include such dimensions as anger and sadness, while positive emotions include happiness. In this study, patients increased their use of positive emotions from the first interview, but utilized the same mean number of negative emotion words. Although results were not conclusive regarding patient emotions, the authors contended that they did not support their original hypothesis that negative emotions are more beneficial for mental and physical health than positive emotions. I will discuss their results regarding cognitive change in a later section.

Bonanno and Keltner (1997) recruited participants whose spouses had died between three and six months earlier. The authors used interviews to examine whether the course of bereavement could be predicted by facial emotional expression at six months, post loss. Findings indicated that negative facial expressions, specifically anger and contempt, at six

months were most consistently correlated with grief severity over time. Expression of positive emotions at six months, particularly amusement, predicted decreased grief. Outcomes were measured via a structured clinical interview of grief symptoms, the Beck Depression Inventory (BDI; Beck & Steer, 1987), and the Texas Revised Inventory of Grief (TRIG; Faschingbauer, Zisook, & DeVaul, 1987).

In another study of 44 conjugally bereaved individuals (27 women, 17 men), participants were interviewed at six months post loss and 14 months postloss (Maercker, Bonanno, Znoj, & Horowitz, 1998). Interviews were transcribed and coded using a system based on Erikson's (1982) psychosocial theory of crises across the lifespan. The coding scheme included both emotional and cognitive dimensions. Patient symptoms were assessed using the Diagnostic Interview Module for Grief (Horowitz et al., 1997) to address Complicated Grief symptoms, the TRIG (Faschingbauer et al., 1987), the Impact of Event Scale (IES; Horowitz, Wilner, & Alvarez) to address subjective distress, the Beck Depression Inventory (BDI; Beck & Steer, 1987), and the Beck Anxiety Inventory (BAI; Beck, Epstein, Brown, & Steer, 1988).

Themes in the Eriksonian coding scheme did not predict grief symptoms at 14 months. Since Erikson did not intend his developmental stages to describe cognitions and emotions pertaining to grief but, rather, psychosocial changes that occur from infancy to late adulthood, the coding scheme was not particularly applicable to the grief narratives. However, upon collapsing the themes into positive and negative categories ("positive" referring to the optimal outcomes of the Eriksonian scheme and "negative" referring to the undesirable outcomes; for example, trust versus mistrust/fear), the authors discovered interesting findings regarding positive themes. During the two interviews, participants

expressed more positive than negative themes, indicating that even among a sample of bereaved individuals, positive emotions can be identified in narrative excerpts. Secondly, positive emotions were significantly and inversely related to grief symptoms at six months post-loss.

The above studies emphasized quantitative instead of qualitative methods of inquiry. Researchers tallied thematic means and compare them to participants' later physical and mental health. No research paired descriptive statistics with a qualitative exploration of specific themes in Complicated Grief narratives. All the studies compared "negative" and "positive" themes without also exploring sub-themes. The scheme utilized by Maercker et al. (1998), while innovatively attempting to explore specific themes, was eventually discarded by the authors and other researchers have not utilized this scheme.

One early narrative study undertaken by Carter (1989) interviewed 30 bereaved adults about their losses, which were of varying and unspecified types. Carter discerned nine core themes in 30 narratives, one from each participant. Five core themes included Being stopped, Hurting (including expressions of sadness and pain), Missing (including loneliness), Holding (including expressions of love), and Seeking (including descriptions of receiving comfort, searching for help, and asking why the loss occurred). Three meta-themes included Change, Expectations, and Inexpressibility. A final theme was the Personal History of the participants. Current grief narrative work has not applied Carter's themes, and Carter herself did not detail her methodology sufficiently for replication.

It was unknown whether the revisiting exercises of patients with CG would mirror those of naturally grieving participants. Thus, the present study was a unique exploration of grief narratives in that it explored specific themes in addition to overall "positive" and

“negative” themes. Furthermore, the present study explored accounts of patients with CG instead of the narratives of naturally grieving participants. Finally, the present study included a clinical sample of patients receiving treatment, which is a neglected group in grief research.

Research suggests that the use of positive emotions may be important in certain treatment modalities. For instance, Mackay, Barkham, Stiles, and Goldfried (2002) listened to audiotaped therapy sessions of 18 depressed clients (5 men and 13 women). Nine clients received cognitive-behavioral therapy and nine received psychodynamic-interpersonal therapy. The authors found that clients in helpful psychodynamic-interpersonal therapy sessions averaged significantly more negative emotions than did clients in helpful cognitive-behavioral sessions. Helpfulness was a subjective self-report measure of the therapist’s reaction to the session. The authors concluded that the exploration of negative emotions proves more helpful in psychodynamic and interpersonal therapy. While Mackay et al. show that the averaged emotional expression for both CBT and psychodynamic-interpersonal (PI) treatments were negative, PI treatments were significantly higher in negativity. Also, the PI treatments that focused on these negative emotions did not do so in a distressing manner to the patients.

Thus, PI techniques are perhaps more conducive to the expression of negative emotions, and the conversational manner of these techniques may provide a safe environment for clients to express extremely negative emotions. Conversely, helpful CBT sessions might benefit from less negativity and the encouragement of more positive emotional expression. I expected, in the present study, that patients with more positive emotional expression would

evidence greater treatment success and, therefore, lower grief, trauma, and depressive symptoms.

2.7.2 Cognitions

Grief and trauma researchers studying cognitive processes in narrative accounts work under the assumption that “the act of constructing stories is a natural human process that helps individuals to understand their experiences and themselves. This process allows one to organize and remember events in a coherent fashion while integrating thoughts and feelings” (Pennebaker & Seagal, 1999, p. 1243). The following section describes research from groups examining cognitive processes in trauma and grief narratives.

Foa, Molnar, and Cashman (1995) studied narratives transcribed from the imaginal exposure sessions of fourteen sexual assault victims with PTSD. Audiotapes from the first and last exposure session were transcribed for analysis. During the exposure, patients were asked to “recall the memories of the assault as vividly as possible” (Foa et al., 1995, p. 679). The patients were asked to tell the story in the present tense, as if it was currently occurring. Exposure sessions lasted between 45 to 60 minutes.

The authors divided narratives utterance units composed of a single thought, action, or speech utterance. Interrater reliability was derived to assess the proportionate agreement among raters dividing text into utterance units. Raters then coded the utterance units according to a number of categories. Each utterance could only be labeled with one code in order to make quantification more straightforward, since data was only analyzed quantitatively. Foa et al. examined the texts for three major categories: 1) fragmentation, defined as lack of flow in the narrative; 2) thoughts and feelings, which reflected the internal

speech of patients who were focusing on how they were thinking or feeling at the time of the trauma; 3) actions and dialogues, which represented a description of the observable events of the story. Reliability was assessed for coding the utterances according to these categories.

Foa et al. found that the last narrative contained more organized thoughts than the first, the last narrative contained greater expression of thoughts and feelings, and that there was a trend for less action and dialogue utterances to occur in the last narrative. They interpreted these findings as indicating greater internalization and organization from the first to last narrative.

Van Minnen, Wessel, Dijkstra, & Roelofs (2002) sought to replicate and extend the Foa et al. (1995) study. They also compared the first and last session narratives of improved and non-improved PTSD patients. Their categories included (1) Fragmentation due to repetition, unfinished thoughts, and speech fillers (e.g. “um,” “uh”); (2) Organization; (3) Internal Events (introspection); and (4) External Events, including dialogue and details. After developing the codes, two raters applied the system to 40 narratives of patients from an outpatient clinic. All participants met criteria for PTSD. After achieving interrater agreement between 89-94%, the two raters coded parts of all narratives independently.

Van Minnen et al. (2002) found that all patients, improved and non-improved, decreased significantly in the amount of disorganized thoughts and external events, although improved patients showed a greater decrease in disorganized thoughts. An increase in the description of internal events was also observed for all patients. Again, a difference was not observed between improvers and non-improvers.

I consulted with Edna Foa regarding the feasibility of applying her coding schemes to Complicated Grief revisiting exercises. Since PTSD imaginal exposure and the CG

revisiting exercise differ in purpose and execution, we concluded that the precise coding methodologies utilized by Foa et al. and Van Minnen et al. were inappropriate for the CG revisiting exercises. Particularly, Dr. Foa felt that applying her organization codes to these clinical narratives would be problematic and would ultimately not be very informative. Her rationale was that, while her research found that later narratives evidenced greater organization than earlier narratives, the organization codes did not aid in providing any additional information. Secondly, conceptualizing “organization” was a troublesome task in both her research and in other narrative research. Disagreement exists regarding the proper operationalization of this concept. Thus, Foa recommended that I explore the revisiting exercises using novel emotional and cognitive codes and that I not rely on codes that were developed for an entirely different disorder (PTSD) and patient population.

Recent work by Boelen, van den Bout, and van den Hout (2003) focused on the relationship between cognitive themes and psychological functioning among 329 bereaved Dutch individuals (267 women, 62 men). The average time since the loss was 27.79 months. The first author developed the Grief Cognitions Questionnaire (GCQ) to assess negative cognitions in the following domains: global negative beliefs (about oneself, the world, life and the future), self blame, negative thoughts about how others responded to the loss, and negative thoughts about one’s own grief reactions. An example of a GCQ question that targets global negative thoughts is, “Since _____ has died, I realize that the world is a bad place.” The GCQ is a self-report measure with four six-point subscales ranging from 0 (disagree strongly) to 5 (agree strongly). Based on psychometric analyses by the authors, reliability and validity of the measure was found to be adequate. To measure psychological

functioning, the authors utilized the Dutch Inventory of Complicated Grief, in which participants rated how often they experienced symptoms during the past week.

The authors calculated correlations between the ICG and GCQ using Pearson correlations. Significant correlations were found between all GCQ subscales and the ICG. Significance remained after controlling for participants' background variables such as education, age, and time from the loss. The authors concluded that negative cognitions are linked to the severity of emotional problems following bereavement.

In a study discussed in a previous section, Pennebaker, Mayne, and Frances (1997) studied 167 bereaved caregivers. They found that cognitive change, conceptualized as using more insight and causal language, predicted decreased psychological distress at one year post-bereavement. Specifically, increased cognitive change was associated with decreased ruminations, although it was also associated with lower levels of positive states of mind.

Finally, two studies by Bauer and Bonanno (2001- a, 2001-b) explored how bereaved individuals evaluated themselves during narrative accounts. Bauer and Bonanno (2001-b) examined participants' self-descriptions that contained an overt opinion on the part of the participant. Sixty-nine individuals who had been bereaved within the past three to six months participated. The authors correlated patient self-evaluations with grief scores, as measured in structured clinical interviews utilizing 30 grief symptoms. The study found that positive behavioral self evaluations (i.e. evaluations in which participants positively evaluated a behavior that they had performed) were significantly and inversely correlated with grief at 14 months post loss. Using multiple regression, they found that positive behavioral self evaluations, as well as patient descriptions of self-efficacy (a specific type of coded self-evaluation), predicted lower grief levels.

Using the same sample, Bauer and Bonanno (2001-a) examined ratios of positive to negative self-evaluations. Participants reporting an optimal ratio of positive to negative self-evaluations (approximately 5:1) evidenced lower grief levels. Additionally, participants who more frequently evaluated their own behaviors rather than their own character evidenced lower grief levels, although lower grief levels were also evident among those who mixed doing-based and being-based self-evaluations.

These two studies indicate that certain types of cognitive patterns may be related to later grief functioning. To explore cognitive processes in greater detail, however, other studies utilized more qualitative methods. The following section will discuss qualitative studies that explored the cognitive process of making meaning out of a loss. While other qualitative narrative work in bereavement focused on spirituality (Richards, Acree, & Folkman, 1999; Richards & Folkman, 1997) and racism (Rosenblatt & Wallace, 2005), my selective sampling of the literature (see Glaser & Strauss, 1967) focused on topics most applicable to the present study.

2.7.2.1 Meaning Making What is meaning making and why might this issue be important to bereaved individuals? Dorothy Becvar, in her practical guide for bereaved individuals, describes the issue well, “[T]he bereaved individual is faced with the awareness that while life around him or her continues to go on in normal ways, normal no longer has much meaning” (2001, p. 19). When cognitively processing the loss, individuals may re-evaluate the meaning of their lives, their identities, the purpose of the losses, the meaning of the lost loved ones’ lives, the existence of a supernatural realm, and the legitimacy of existing social

support systems. Individuals may grapple with the questions, “Why did this happen?” and “How does this loss make any sense?”

These issues may be important areas of concern for bereaved individuals experiencing either normal or abnormal grief, although some researchers believe that persons grieving a traumatic loss may particularly need to grapple cognitively with what occurred (Pennebaker, Zech, & Rime, 2001). Neimeyer (2000) indicated that persons experiencing the sudden death of a loved one may particularly experience a need to discern meaning in the loss. Additionally, he stated that therapies emphasizing meaning making were the most promising types of grief therapy, since they do not target symptoms alone but promote paradigm shifts in bereaved individual’s minds. His view is informed by the research of Davis, Wortman, Lehman, and Silver (2000).

Davis et al. (2000) interviewed 124 parents who had lost a child due to sudden infant death syndrome (SIDS). The authors asked parents whether they had spent significant time grappling for meaning in the child’s death. Parents stating that they had searched for meaning culminated their searches in one of three ways. Over a third of the parents who expressed searching for meaning in the loss culminated their search in religious explanations, such as claiming that God wanted to bring the child home with Him. A second group of parents concluded their search by finding a positive aspect to the death, such as drawing closer to other loved ones. Finally, a third group ultimately attributed the loss to fate.

Based on interviews with the bereaved parents, the authors documented that 86% of the parents had attempted to discern meaning in the loss of their children within the first four weeks of their loss, while only 14% stated that they never attempted to discern meaning. Outcome measures from this study indicated that those who searched for meaning in the loss

and found it, as well as those who never were concerned with finding meaning in the first place, appeared to be better off on a variety of measures than parents who searched for meaning yet did not find it. Outcome measures included the revised Symptom Checklist (SCL-90-R; Derogatis, Rickels, & Rock, 1976), a measure of subjective well being, and a scale measuring sadness, anxiety, and anger. These findings contradict a previous assumption among grief researchers that all bereaved individuals spend time grappling with meaning issues. This is currently an area of debate in grief research.

Gamino, Hogan, and Sewell (2002), in an attempt to reconcile this controversy, stated that some individuals actively search for and construe abstract meaning in the loss, while others more pragmatically realize the meaning without exploring more abstract, spiritual, and existential issues. These authors neglected a third category of grievers, however; individuals who never express finding meaning and for whom the death is extremely traumatic and stressful many years after the death. Nonetheless, Gamino et al.'s (2002) content analysis of 85 bereaved individuals' answers to the question, "What does the death of your loved one mean to you?" (p. 797), indicates that individuals discern meaning in a variety of ways. Gamino et al. found nine meaning constructs. For instance, bereaved participants stated that the death meant feeling the absence of the lost loved one. To others, the death meant experiencing relief that the person's suffering was over or knowing that their social relationships would be impacted as a result of the loss.

Returning to the SIDS study, Davis et al. (2000) found that bereaved individuals who did express finding meaning tended to do so within a few weeks of the loss. Those who had not found meaning at this point never reported finding it, even by the end of the 18-month study. The authors concluded that some bereaved individuals do not naturally find meaning

as time elapses. The implication is that a subgroup of individuals who search for meaning may not find it or may attribute a very negative meaning, such as taking on survivor guilt, to the loss. This group may be among those likely to meet CG criteria and so might benefit from CGT. While the individuals who did express finding meaning embarked on this endeavor almost immediately following the loss, Davis et al. found that this early exploration did not indicate that the process to find meaning had ended. Even though these individuals expressed finding some meaning, they continued the process of addressing the question, “Why?”

What factors could predict which individuals would express finding some meaning in the loss? Davis and Nolen-Hoeksema (2001) cite the normativeness of the loss and the extent to which individuals possess religious beliefs as two factors that may predict meaning making. This statement is supported by a number of research studies.

Davis et al. (2000) indicate that one’s worldview, including religious worldviews, largely influences whether or not an individual will search for meaning in a loss. A loss that can be conceptualized as fitting the individual’s worldviews may not necessitate extensive meaning making after a loss because the meaning preceded the loss. The loss makes sense within the individual’s framework of the world. For example, one parent in the SIDS study stated that the child died because, “God wanted her. He’s the boss. I’m assuming in faith that he took her for a good reason” (p. 503). However, when an event is inconsistent with a person’s worldview, the individual either must make an interpretation of the loss consistent with the worldview or revise the worldview (Davis & Nolen-Hoeksema, 2001).

Davis and Nolen-Hoeksema (2001) studied a sample of 205 caregivers whose loved ones were dying from a terminal illness. Individuals who reported in the pre-loss interview

that they had religious or spiritual beliefs were 2.65 times more likely to find meaning from the loss. Similarly, in Davis et al.'s (2000) SIDS study, parents who reported greater religiosity were also more likely to find meaning in the loss. Finding meaning was linked with positive affect and less distress for these parents. Yet, a loss may sometimes cause individuals to re-evaluate their religious beliefs as they become embittered and angry with God. Davis and Nolen-Hoeksema conclude, however, that, in general, religious beliefs facilitate rather than hinder meaning making.

Regarding the normativeness of the death, Davis and Nolen-Hoeksema (2001) found that the older the age at which the loved one died, the easier it was for the caregivers to make sense of the loss. Deaths going against societal expectations, such as children dying before parents, may be particularly difficult and therefore may leave individuals feeling stunned and confused. The Western world has sought to control health and wellness to such an extent that death is half-expected to be held at bay or at least delayed. Death is now an event that is expected to occur in old age. In other cultures and in other times, this was not the case. High infant mortality rates plague third-world nations, and the ever-increasing life span is largely a recent phenomenon. In light of this, deaths that occur at an untimely time may be particularly difficult for the bereaved individual in our developed, European and American cultures (Archer, 1999; Davis & Nolen-Hoeksema, 2001).

In the present study, I wanted to explore whether individuals with Complicated Grief who had experienced violent and sudden losses would differ from other individuals with CG regarding meaning making. I found Davis et al.'s (2000) research to be compelling evidence standing counter to assumptions that everyone experiencing the loss of a loved one does and must actively spend time discerning the meaning in the loss, and thus approached the

narratives assuming that not all individuals *actively* search for meaning. The key word, I believed, was *actively*. It might be the case that everyone asks, “Why?”, when a loss happens, but not everyone does so extensively and consciously.

2.7.2.2 Perceived Social Support Research also indicates that *perceived* social support is a key to making sense of a loss (Kaunonen, Tarkka, Panunonen, & Laippala, 1999). Perceived social support refers to the individual *believing* that family members or friends are available and are dependable sources of support. Kaunonen et al. studied 318 conjugally bereaved individuals from Finland. Individuals who did not have a supportive social support network felt constrained in their grieving and meaning making, believing that others were forcing them to operate rationally and normally despite the loss. Similarly, Wortman and Lehman (1985), in studying 94 bereaved adults who had loved ones die in car accidents, found that the bereaved felt that friends and family who gave advice or encouraged recovery were the most unsupportive. Responses perceived as being most helpful were 1) family and friends who allowed the bereaved to express negative feelings without dismissal and 2) simple social interactions with others.

Social support also appears to be related to successful coping after a loss. In a study of 157 bereaved adolescents grieving the loss of a sibling, Hogan and DeSantis (1992) conducted a content analysis of the participants’ interview responses. The authors found that perceived helpful social support was linked to the adolescents’ successful coping after the loss, while perceived unavailability of social support was related to coping problems. Stylianos and Vachon (1993) stated that the single best predictor of bereavement distress is not having available friendship networks after a loss.

Social support, however, is a complex issue. The effectiveness of social support varies, depending on many qualities. For instance, whether or not social support will be perceived as being “good” depends on the actual needs of the deceased individual (Stylianou & Vachon, 1993). Unneeded, annoying, or intrusive support is not helpful. Additionally, other factors such as the timing of the support and the source of support are important.

2.8 Chapter Summary

This chapter presents the history of grief research, particularly emphasizing the history of Complicated or Complicated Grief research. In describing Complicated Grief, I presented the similarities and differences between CG and two disorders, Major Depressive Disorder and Post-Traumatic Stress Disorder, and I briefly argued the case for a treatment geared specifically toward CG. After addressing therapy treatments for all three disorders, I focused on the research most relevant to the present study’s methodology: studies of cognitions and emotions in narratives. The absence of narrative research that a) specifically explores Complicated Grief narratives, b) qualitatively explores a variety of narrative themes, and c) studies a clinical sample of patients meeting criteria for CG results in very little being known about the Complicated Grief narratives. Thus, in this study, I intended to explore the death narratives of persons who told their stories as part of their treatment for Complicated Grief.

In Chapter Three, I discuss the methods with which I approached the revisiting exercises. I describe my operationalization of emotional and cognitive themes and discuss the origins of these themes. Finally, I present my methods for relating the content of the revisiting exercises to patient symptoms.

3.0 METHODS

This chapter describes the data collection procedures and analyses utilized in this study. Specifically, I present a summary of the pilot study that was used to generate themes and coding ideas. I then explore how the current study builds upon the pilot study. I include a discussion of the advantages and disadvantages of the study design and then present information regarding the patient sample and measures.

This chapter summarizes both the qualitative and quantitative methods of this study. Regarding the qualitative portion, I explain at length my narrative coding procedures, including the use of narrative transcriptions, managing NUD*IST, code derivation and revisions, and interrater agreement. Regarding the quantitative portion, I discuss my decisions regarding the use of statistical tools.

3.1 Complicated Grief Content Analysis: Pilot Study

The pilot study served as a beginning exploration of the types of themes present in Complicated Grief Treatment revisiting exercises. As in the present study, the revisiting exercises in the pilot study detailed how the deaths occurred, beginning with when the patients first discovered or were told of the loss. The pilot study also examined the imaginal conversations for each patient who participated in such an exercise. Three members of a coding team transcribed the narratives of six patients. All of the revisiting exercises and

imaginal conversations across 16 weeks of therapy were transcribed for each patient in order to provide more data for thematic exploration. These six patients (5 women, 1 man) were the first patients piloted in the larger Complicated Grief Treatment study. Each had lost a spouse (n=1), parent (n=3), child (n=1), or other relative (n=1). The relatives of four of the patients died due to illness, while two experienced a sudden, violent loss.

Code derivation began with hand coding portions of the transcripts. An initial coding rubric was formulated based on this hand coding procedure. Code derivation focused on themes that were either expressed frequently by patients (anger, sadness, and love being three themes that patients tended to focus upon) or reflected CG symptoms such as numbness and detachment. After an iterative process of reading, hand coding, and consulting with an expert on Complicated Grief, I entered the coding matrix into NUD*IST 4 (Non-numerical Unstructured Data Indexing Searching and Theorizing; Scolari, 1997). NUD*IST can organize hierarchies of data codes in a “tree” format. This aids the researcher in structuring and clarifying desired codes and how they fit in relation to one another. NUD*IST can also generate reports on specific codes. For instance, it can report on all text coded as “anger.”

Once in NUD*IST, codes were arranged into a tree format and each code was given a specific definition to aid future coding reliability. The NUD*IST hierarchy assigns numbers to each code. The next step, then, was to code all of the transcripts using these numbered codes. To do this, a coding team was organized.

The coding team was composed of four female research assistants from the Complicated Grief study, all of whom had a bachelor’s degree in psychology. The team was very familiar with Complicated Grief but generally inexperienced in qualitative research methods. I felt that training should therefore include general instruction on qualitative

research methods in addition to the specific techniques to be used in the pilot study. I used Nelson and Friedlander (2001) as a training guideline, since the authors specified a clear, step-by-step description of applying open coding techniques to transcribed interviews. I assigned team members packets of readings on code derivation, coding procedures, and goals of qualitative analysis in order to orient the research team toward qualitative research. As a team, an example transcript was read and discussed. I gave team members independent assignments in which they applied the coding matrix to a section of a transcript. Based on new insights from team members as well as emerging data in NUD*IST, some revisions were added to the matrix in NUD*IST.

We continued to revise codes until a consensus was reached regarding which codes should be used and how they should be arranged in the matrix. Coding revisions served to clarify our understanding of the themes. For instance, themes based on grief symptoms did not always make good coding themes, since in actual coding practice, clear guidelines on how to recognize the themes in text proved to be problematic. By revising the matrix, we made it more precise and concise, in keeping with the pilot study's exploratory aims. The revision process also opened discussion regarding the definitions of themes so that we could more consistently apply our codes. One thematic category that the team grappled with defining and identifying was grief symptoms, which we initially labeled as "dissociative symptoms" and then broke the category down further into numbness, detachment, and non-acceptance. As will later be described, the present study further refined the difficult categories of grief symptoms and distress, primarily through re-defining the themes and breaking them down into more manageable sub-categories.

The final coding matrix of the pilot study included six major categories: grief symptoms (numbness, detachment, and non-acceptance of the death), emotions, cognitions, and distress, as well as free nodes such as confusion, avoidance, isolation, agitation, and a conflicted relationship with the deceased. Team members applied these codes to all transcripts. They did so by working in pairs in order to ensure coding reliability. Each coder independently coded the transcripts of two patients and then came to a consensus with the other person in her pair.

The unit of analysis was one sentence. This small unit was chosen to maximize the number of themes that could be coded. Each sentence could receive one or more themes, and NUD*IST could be used to examine how the themes intersected and overlapped within paragraphs and across the entire narrative.

This method diverges from the grief and PTSD narrative research described in Chapter Two in that multiple codes could be applied to each unit of analysis. This divergence was intentional; in this exploratory study, I felt it was important to cast a wide net to capture the breadth of themes discussed in the narratives. I also wanted to use NUD*IST to generate reports in order to explore the interrelations among themes, and I wanted to examine situations in which patients simultaneously discussed opposing thoughts and emotions. I believe that applying multiple codes per unit of analysis is also a strength in the present study because patients expressing multiple themes and conflicted ideas within one unit can still have each theme can be represented by a code.

Coded transcripts were then entered into NUD*IST. The computer program was used to search the text for codes to see where and how the patients used these words. I paired analyses in NUD*IST with a constant comparison of the printed transcripts in order to clarify

the context of the recalled text. I used the summaries that NUD*IST provided in the coding matrix to collect the frequencies of the themes, and I generated NUD*IST reports in order to uncover connections between the themes.

Two of the selected themes, grief symptoms and emotions, frequently occurred in the transcripts of all patients, based on the tallies of the sentence units provided by NUDI*ST. Thus, I examined these two categories more extensively than the others. Regarding grief symptoms, numbness and detachment was the most prominent theme. Descriptions of numbness and detachment included saying, “I feel dazed,” “like I’m just not here,” or “I’m out of it.” One of the patients expressed feeling so dazed during the events of her story that she still does not know precisely how her husband died because she tuned out the doctor’s explanation and avoids reminders of the death, such as asking family members for details pertaining to the death.

Regarding emotions, the pilot study indicated that CG patients were likely to express both positive and negative emotions. Positive emotions included happiness, love, and peace. All five female patients expressed feeling happy during certain points of the story, and all patients reported feeling at least “satisfied” or “ok” at some point during their narratives. Patients expressed happiness when talking about the deceased being in heaven with other family members, remembering the good turn-out at the funeral home, and talking in an imaginal conversation with the deceased. For example, during her final revisiting exercise, one patient expressed her happiness that her husband no longer had to suffer from his illness:

I'm happy for him 'cause he doesn't hurt anymore. He was hurting so much, his neck and his head were hurting all the time. All the pain from just trying to get a breath.

All six patients reported feeling love, particularly toward the deceased. For example, one patient reported in her final revisiting exercise that, at the funeral, she and others were “just wishing, and...hoping that she knows how much we love her.” In the last imaginal conversation with her deceased relative, the patient concludes that her loved one did indeed know that she was loved:

We love you very much and it's time for everybody to move on. We love you deeply. But sometimes it's just so hard to move on when you love somebody so much. You gotta feel very special, don't you? Because you know how many people loved you.

The fact that all of the pilot patients described feeling love confirmed that, even among a sample of patients with CG, positive emotions could be discerned in grief narratives.

Frequently expressed negative emotions included anger, guilt, sadness, and fear. One patient, during her first narrative, expressed extreme fear while remembering that her mother went into convulsions in reaction to being given morphine shortly before her death:

I'm remembering now that she's going into convulsions. She's going into convulsions. I'm really scared...But that, I'm really, I'm really scared during the convulsions. Um, hysterical inside. I can't remember who all was there.

The same patient, in a later imaginal conversation, began to reflect on feelings of guilt at fighting with her mother about her brother's behavior:

You understand...we had so many fights about that behavior, and I still feel so guilty from them...And so I'm sorry if I fought with you, or got mad at you, when I should've directed it to him.

Thus, results from the pilot study indicated that patients expressed both positive and negative feelings in their revisiting exercises. Evidence suggested that the later narratives contained more positive emotions and that imaginal conversations were particularly conducive to more emotional content, particularly positive emotions. The present study built upon the work of the pilot study by beginning with the themes generated in this study and exploring additional themes. For the purposes of correlating such themes with symptoms measures, the present study also added a quantitative component that necessitated collapsing themes into positive and negative categories.

Based on the pilot study and consultation conferences with the Principal Investigator Of CGT:RCT and PTSD research Edna Foa, I identified seven emotional grief themes for further analysis: love, happiness, loneliness, sadness, fear, guilt, and anger. Additionally, I revised and reconceptualized other themes from the pilot study in the present study, and the major revisions are charted in **Appendix B**.

For instance, I reconceptualized peace in the present study since patients in the pilot study usually referred to the deceased individual being "at peace" when discussing this

theme. The present study sought to be more stringent in applying codes solely to what the *patient* felt and experienced. Thus, comfort and relief replaced peace in the present study since these codes more accurately described what the *patient*, and not the deceased, was experiencing. Finally, results from the pilot study indicated that patients often discussed symptoms of grief throughout their narratives. However, in the present study it was necessary to further conceptualize and define themes based on these grief symptoms. For instance, I separated the numbness and detachment themes in the present study into two themes: Numbness and Unreality. I then organized them under the Emotions category to distinguish these feelings from grief-related symptoms more related to thought processes pertaining to the loss (such as Blame and Disbelief).

3.2 Design

The present study is a content analysis of the revisiting exercises of Complicated Grief Treatment and, as such, is a secondary data analysis. Further description of content analysis is warranted here. Content analysis may either involve qualitatively deriving codes following grounded theory methods or approaching a text with pre-existing codes. In grounded theory, open-coding occurs, in which text is read line-by-line. A researcher using grounded theory does not set out to address specific hypotheses (although it is acknowledged that all researchers approach data with *a priori* notions of what they expect to find); a theory arises from the data itself (Glaser & Strauss, 1967). Other content analyses are more quantitative, seeking to address specific hypotheses and utilizing statistical tools, such as generating frequencies of coded themes. Procedures for content analysis in general include specifying the unit of analysis, deriving coding categories from theoretical models, and

deriving categories from evidence (Flick, 1998). The present study balanced the qualitative and quantitative branches of content analysis by applying the previously-derived themes from the pilot study to a larger number of transcripts, qualitatively exploring additional themes, and quantitatively comparing the themes to patient symptoms via descriptive statistics and correlations.

As both a qualitative and quantitative design, content analysis receives both the advantages and disadvantages of each method. One of the primary advantages to uniting qualitative and quantitative techniques, as can occur with content analysis, is that the analysis becomes both systematic and descriptive. Furthermore, interaction with human subjects need not occur, since the researcher may first encounter the textual data some time after the subject's interview or therapy session. Thus confidentiality can be maintained with greater ease than would occur in a face-to-face interview with the patients while greater detail may be given than would occur in other research methods, such as self-reports. Disadvantages include being restricted to textual materials and the inability to address causality (Giles, 2002) since, like all non-experimental research methods, content analysis is not appropriate for addressing causal factors.

As a secondary data analysis, I was limited in the present study to narratives that others had already compiled for another purpose; namely, as part of a larger study to treat Complicated Grief and to compare it to another treatment modality. One advantage to using these revisiting exercises, however, was that qualitative narrative exploration was also an original, although secondary, intent in the larger Complicated Grief Treatment study. Thus, from the beginning, the revisiting exercises intentionally included descriptions of patients' emotional and cognitive processes. Although I was unable to directly interact with the

patients or ask the specific questions that I would have had I been conducting open-ended interviews, the narrative nonetheless provided sufficient material for analysis.

3.3 Patient Sample

Subjects included 22 outpatients who participated in the study, Complicated Grief Treatment: A Randomized Clinical Trial (CGT:RCT), at Western Psychiatric Institute and Clinic, Pittsburgh, PA. This larger study compared the effectiveness of Complicated Grief Treatment to Interpersonal Psychotherapy. Patients were referred to the study via general medical professionals, ambulatory psychiatric facilities, palliative care centers, bereavement groups for family members of suicide victims, and other grief support groups. All patients signed written informed consent. At the time of writing, 218 patients had entered the study. Their treatment was provided at no cost, and they were financially reimbursed for their participation. No identifying information was included on interview material, questionnaires, audiotapes, or videotapes, and the CGT study utilized patient pseudonyms on all data.

Patients had been bereaved for at least six months prior to entering treatment. The average time of entry into the study was 40.4 months after the loss. Subjects did not evidence suicidal ideation, mania, schizophrenia, dementia, substance abuse, psychosis, or domestic violence. Patient enrollment proceeded as follows. An initial phone screen was conducted, in which study personnel verified the following: subjects were 18 years of age or older, the death occurred at least six months prior, the subject had no issues that would interfere with treatment, such as pending lawsuits or disability claims. The ICG (ICG; Prigerson, Maciejewski, et al., 1995) was also administered and subjects had to score 30 or greater in order to qualify for the study.

After verifying this information, each subject was scheduled for an initial interview at the clinic for further screening, including a physical examination, the structured Clinical Interview for Complicated Grief (SCI-CG), various self-report forms, the Beck Depression Inventory (BDI; Beck & Steer, 1987) and the Structured Clinical Interview for DSM-IV Axis I disorders (SCID-I; First, Spitzer, Gibbon, Williams, 1997). Of the 218 consenting patients, 102 were randomized to receive treatment. The other 116 were either found to be ineligible for treatment before randomization or became unavailable for further contact. Fifty-one patients were randomized to receive Complicated Grief Treatment and 51 to receive Interpersonal Psychotherapy. Patients were seen for 16 therapy sessions, and had approximately 20 weeks to complete the treatment. At the start of the present study, sixty-one patients had completed treatment: 29 CGT patients and 31 IPT patients.

The present study included the first 22 patients who a) were randomized to Complicated Grief Treatment, b) had completed treatment at the time of transcription, and c) had participated in at least two revisiting exercises. This last stipulation was intended to weed out patients who only had one revisiting exercise due to being unable or unwilling to continue with any additional exercises. I felt that, in such cases, such a narrative would differ too greatly from narratives of other patients who had more experience with telling the story of the death. I did not want to use the first or only revisiting exercise that patients told, since great variety exists in the coherency, content, and scope of first narratives. First revisitings are often fraught with crying outbursts and incoherent verbalizations that can cause transcribers to miss important narrative content. Furthermore, patients who particularly have difficult times with the exercise may not offer a full narrative account early on in the treatment. For these reasons, I used the last full narrative from each patient. Table

3 describes demographic characteristics of the 22 patients. For these patients, the time since the loss ranged from six and a half months to eight years, with a mean of 3.4 years.

After qualitatively analyzing the data, I discovered that three of the patients did not have 16-week or 6-month assessments due to early completion or withdrawals. One patient had simply moved through the treatment quickly, the second patient's treatment was wrapped up due to the patient's physical illness, and the third patient withdrew from the study. They did have baseline measures, however, and their final narratives occurred during the same time frame as the other patient narratives (between weeks five and 15 of treatment). Thus, I included their data in this study, with the exception of their missing data. I conducted an independent samples t-test to explore whether these patients significantly differed from the other 19 in regard to all tallied themes. I found no significant differences between the groups regarding most themes. However, the three patients did differ significantly from the others on one major theme; this difference will be addressed later.

Finally, I examined in-depth a subset of 11 patients from the 22-patient sample for the purpose of exploring revisiting exercises in greater detail and examining patterns among a homogeneous group of griever. These patients possessed similar demographic characteristics, including gender, race, age, and nature of the loss. All final revisiting exercises from these patients occurred near the same point in time of the treatment. Details about and data from this subsample is presented in section 4.6.

3.4 Measures

I targeted the depressive, trauma, and grief dimensions of Complicated Grief with a measure for each. For CG symptoms, I utilized the Inventory of Complicated Grief (ICG; Prigerson,

Table 3.

Demographic Characteristics of Sample

	Number of Patients (N= 22)
<u>Gender</u>	<u>N</u>
Female	19
Male	3
<u>Age</u>	
20-39	3
40-59	16
60+	3
<u>Type of Loss</u>	
Violent	9
Nonviolent	13
<u>Primary Loss</u>	
Child	6
Parent	5
Spouse	6
Other Relative	5
<u>Race</u>	
White	18
Black	2
Asian	1
Other	1

Maciejewski, et al., 1995), the Beck Depression Inventory (BDI; Beck & Steer, 1987) targeted depressive symptoms, and the Impact of Event Scale (IES; Horowitz, Wilner, & Alvarez, 1979) targeted trauma symptoms. Each is described below.

The ICG was developed using a sample of 97 conjugally bereaved elders. It is a 19-item self-report measure that discriminates between natural and Complicated Grief. Each item is a 5-point scale ranging from 0 (never) to 4 (always), and possible scores range from 0 to 76. It has evidenced high test-retest reliability (.80 over six months of bereavement) and an internal consistency of .94 (Prigerson, Maciejewski et al., 1995).

The BDI is a 25-item self-report inventory that targets depressive symptom severity. Patients circle the statement that best describes their feelings in the past week. Questions on the BDI target DSM symptoms of depression, such as depressed mood, suicidal ideas, social withdrawal, insomnia, and loss of appetite. The BDI has high internal consistency. The BDI's test manual (Beck & Steer, 1993) reported that internal consistency, measured using Cronback's coefficient alpha, ranged from .79 and .88 among six samples of patients, totaling 944 people. Test-retest reliability was somewhat lower, explained by Beck as being due to expected changes among patients. Beck, Steer, and Garbin (1988) report that Pearson product-moment correlations for psychiatric patients ranged from .48 to .86, while the figures for non-psychiatric patients ranged from .60 to .90. Split-half reliability estimates range from .53 to .93 (Gallagher, Nies, and Thompson, 1982). The BDI has concurrent validity with other measures of depression. Beck, Steer, and Garbin (1988) found a mean correlation of .73 between the BDI and the Hamilton Psychiatric Rating Scale for Depression (Hamilton, 1960), which is another prominent depression scale.

The IES is a 15-item self-report measure of subjective distress in response to a stressful event. There are two subscales: intrusion and avoidance. Patients are asked to indicate how frequently the statements were true for them during the past week. Items include, “I thought about it when I didn’t mean to,” and “My feelings about it were kind of numb.” Internal consistency of the intrusion subscale ranges from .72 to .92 and internal consistency of the avoidance subscale ranges from .65 to .90 (Sundin & Horowitz, 2002). Test-retest reliability for the two subscales is .87 and .79 for intrusion and avoidance, respectively (Horowitz et al., 1979). In support of the IES’s content validity, Sundin and Horowitz (2002) presented results from eleven studies, in which the average correlation between the two subscales was .63. They concluded that the two subscales are relatively distinct from each other. Correlations between the IES and measures of PTSD, depression, anxiety, somatic, and substance abuse range from .19 to .62 on the intrusion subscale and .20 and .71 on the avoidance subscale (Sundin & Horowitz, 2002). These moderate to low correlations indicated that the IES does not entirely overlap with other related measures.

Thus, all three measures evidence solid psychometric properties and are commonly used (Beck, Steer, & Garbin, 1988; Zilberg, Weiss, & Horowitz, 1982). In this study, I utilized scores from three timepoints: baseline scores, the last treatment session (16 weeks), and the six-month follow-up. Table 4 presents a summary of the instruments administered. I expected the strongest correlations to occur between the 6 weeks timepoint and narrative themes, on the basis that therapeutic effects should occur and would be strongest at the end of treatment.

Table 4.

Summary of Instruments Administered

	Baseline	16 Weeks	6 Months
BDI	*	*	
ICG	*	*	*
IES	*		*

3.5 Transcriptions

The author and five research assistants completed transcriptions of patient audiotapes in the present study. Research assistants were psychology students who had either recently received Bachelor's degrees or were upperclassmen undergraduates with superior academic performance. The students were selected to work as research assistants on the basis of their maturity and high academic standing. I reviewed Complicated Grief Treatment with the student transcribers as part of their training, since during their transcriptions they would encounter unfamiliar terms such as "SUDS levels" and "imaginal exposure" that they might transcribe incorrectly without proper understanding. Transcriptions were standardized according to a format detailed by the author and is presented in [Figure 1](#). I examined the last full treatment narrative for each patient.

3.6 Summary

This study is a content analysis of the revisiting exercises of 22 patients diagnosed with Complicated Grief. In this project, I built upon the work originated in my pilot study of Complicated Grief narratives. Both projects make contributions to grief research in general

...	Skipped section due to incoherent speech
(The timing)	Words enclosed in single parentheses are the transcriber's interpretation of ambiguous dialogue
((crying))	Words enclosed in double parentheses indicate the transcriber's narration of the segment.
[]	Words enclosed in brackets are segments of text that were changed in order to protect patient confidentiality.
-	Vocal cut-off
P:	Patient
T:	Therapist

Figure 1. Narrative Transcription Conventions.

by generating narrative themes in greater detail than typically occurs in grief studies. Specifically, these projects are the first of their kind in that they generate and explore themes described by patients with Complicated Grief, and these themes originate from narratives told in a clinical setting. No known works besides these studies explore the themes in Complicated Grief treatment narratives.

The pilot study implemented my methods of training narrative coders who were experts in the subject area but not the coding process. This process reflected a commitment to accuracy and reliability without overly quantifying narrative coding, which often results in abandoning interesting and important themes. In the following section, I describe the analyses utilized in the present study, specifying the processes by which I addressed the qualitative and quantitative portions of this project.

3.7 Analyses

The following section explores the data analysis procedures used to target the central question in the study, “What is the content of the revisiting exercises”, as well as the secondary aim, which was to explore how content related to patient symptoms.

3.7.1 Content of the Revisiting Exercises

I managed and organized data via QSR NUD*IST 4 (Scolari, 1997), which was the chosen software because I wanted to a) keep a structured account of hierarchically organized codes and b) utilize codes that arose from the Complicated Grief narratives rather than be limited to codes pre-determined by software designers. For example, one software package that I considered was Pennebaker’s Linguistic Inquiry and Word Count (LIWC; Pennebaker, Francis, & Booth, 2001), which does an excellent job of tallying themes, but it only tallies themes that its creators built into the package’s database.

I imported one revisiting exercise into NUD*IST from each CGT patient in my sample, for a total of 22 death narratives. Each narrative was the final complete revisiting exercise from each patient, and this choice was made so that I would be exploring each patient’s most detailed, complete, and coherent narrative. I edited revisiting exercises before importing to insure that a) each document began with the patient starting the story (versus starting with a therapist-led question) and b) each document ended with the therapist saying, “Let’s stop here” in order to make the size of the narratives more uniform and comparable. With this standardization, revisiting exercises still ranged from 72 to 433 text units, with the mean being 229.41. Since the revisiting exercises varied in size, when presenting the Pearson correlations between themes and symptoms I include the percentage

of each session devoted to each theme alongside what I deemed to be the more straightforward method, tallying each theme using the summaries provided by NUD*IST.

I edited documents to permit coding at the sentence level; that is, hard returns had to be inserted into the text so that sentences did not “stick” together when imported. Transcribers had made decisions regarding grammatical units such as sentences, and before I imported each document I also re-examined each narrative to verify that these were appropriate decisions. Sentence units were straightforward in most cases, the exception being in documents evidencing much crying. One revisiting exercise was filled with extensive crying, which resulted in a less coherent narrative. In this instance, decisions had to be made where one sentence began and one ended, since many sentences were left incomplete. The transcriber made the initial decisions, and then I re-edited some sentences. For example, in cases where a sentence unit was originally three lines long, I broke up the unit into two separate sentences to reflect, as best as I could, where one thought had ended and another had begun. The larger Complicated Grief study from which the revisiting exercises originated assigned pseudonyms to each patient. I kept these same pseudonyms as headings in the documents when importing them into NUD*IST in order to maintain patient confidentiality. Other headers included the therapy session’s visit number and the session date. For my presentation of results, I assigned numbers to patients to further protect their confidentiality rather than using names or their therapy pseudonyms.

I solely analyzed patient dialogue, thus focusing on the *content* of the revisiting exercises rather than therapist variables. That said, therapists undoubtedly influenced patient speech by asking specific questions during the narratives. While therapists were generally silent except for asking for SUDS levels, they also occasionally asked for more emotional or

cognitive input from the patient and this certainly guided the scope of patients' narratives. In studying narratives from a therapy session, additional variables arise than would occur in narratives derived solely for content analysis. The therapeutic-patient relationship in itself is a variable, and some therapist-patient dyads exhibited more lengthy revisiting exercises due most often to patient loquacity and occasionally to therapist prodding. A future study could explore at length the relationship between the therapeutic relationship and narrative accounts; however, I chose in the present study to examine the relationship between narrative content and patient symptoms.

3.7.1.1 Code Derivation. As previously described, analyses in the present study began with an initial set of codes generated in the pilot study: love, happiness, loneliness, sadness, fear, guilt, and anger. I generated additional codes both by exploring these seven codes in the 22 revisiting exercises and seeing if novel codes emerged as well as by engaging in constant comparative analysis, which involved examining text throughout the coding process. Through this method, codes are continually refined as the researcher pulls in information from the text, his or her own interpretations, and the developing analyses (Strauss and Corbin, 1990).

I formulated new codes via open coding, which involved naming and labeling units of text to describe the data. During code formation, the unit of analysis was one sentence, in contrast to the paragraph-length thematic units used in some grief studies (see Bauer & Bonanno 2001-a and 2001-b) in order to maximize the types of observations that could be made in each transcript. I felt that by using a smaller unit of analysis and allowing codes to overlap, I would not overly limit the code derivation process to macro-sized codes and would

be able to explore a larger number of themes with greater ease. This was an important goal, I believed, since this was the first study (besides my pilot study) to qualitatively explore CG narratives; I wanted to use a wide lens to observe the types of themes evident in such narratives. I began coding by noting themes that occurred more frequently across patient transcripts. I also noted themes that individual patients repeated multiple times within a single narrative, especially themes repeated within a short span of time such as a paragraph. I did this both by eyeballing the transcripts and by utilizing the “near” query in NUD*IST.

My main intent was to look for patterns across patients. Guiding questions in the coding process were, “What is the central issue?” and “What in the narratives indicates why the patient had major difficulties in grappling with the loss?” Coding notes were written into the transcript margins. Throughout this time, I maintained a research journal to organize my thoughts and impressions and insights as well as to document and guide my decision-making.

After this process, I organized the codes into overarching categories. My methodological process included triangulation, or deepening the data by utilizing multiple sources, by examining both the transcribed revisiting exercises and the imaginal conversations for each patient. Even though I examined one revisiting exercise per patient in the present study and did not use imaginal conversations and additional revisiting exercises in final analyses (for purposes of making this study more parsimonious by not mixing narrative types having different aims and procedures), I used these documents to develop additional codes beyond those generated in the pilot study as well as to determine which of the prior codes should be kept. These additional documents provided information regarding issues present in the revisiting exercises and the types of emotional and cognitive themes that patients discussed. This helped to provide greater context for deriving codes and it allowed

me to have a greater depth of understanding regarding patient narratives. That is, I became more familiar with patient stories so that, if the final narrative omitted certain explanations or references, I was more likely to comprehend the text than I would have had I only read one narrative from each patient.

For instance, the imaginal conversations reflected the importance and prevalence of certain emotions, such as love and anger. After exploring additional revisiting exercises, I was struck with the frequency with which patients discussed social networks and knew that this had to be a thematic category even though I had originally intended to explore more straightforward emotions and cognitions. Additional explorations indicated that topics pertaining to death were frequent and important and that the present study should explore such themes in greater detail than occurred in the pilot study, in which emotions were the primary themes.

Although the pilot study offered only a cursory acknowledgement of cognitive themes, further reviews of grief literature indicated potentially important types of cognitive themes. In conferring with committee members regarding what to look for in the transcripts, it was suggested that I refer to Bauer and Bonanno's (2001-a, 2001-b) work in addressing cognitive themes. As described in Chapter Two, this research focused on bereaved individual's self-descriptions in grief narratives. After reading this work, I included Bauer and Bonanno's themes alongside the unique cognitive themes that arose in the present study. Their themes (2001-a) were: Doing-based self-evaluations and Being-based self-evaluations. Doing-based self-evaluations, as defined by Bauer and Bonanno, were evaluations of one's behavior during narrative events. Being-based evaluations were evaluations of one's character and person. I utilized the same definitions when entering these codes into my

matrix. Like Bauer and Bonanno, I also included codes for positive and negative self-descriptions of each type (Doing-based and Being-based). Positive evaluations were evaluations in which patients approved of how they acted or what their character was like, while negative evaluations were evaluations in which patients disapproved of their own actions or character.

I entered codes into NUD*IST iteratively. NUD*IST permits a researcher to create an evolving coding matrix of the hierarchical codes. Each of these codes was assigned a unique address representing its location in the coding matrix. At this point, I utilized this coding matrix to re-code each revisiting exercise. A final node tree was developed into NUD*IST, and additional free nodes were still added during new readings of the narratives. Due to NUD*IST's flexibility, new codes can be added throughout this process. One example of a new code that I added was "relief." Coders rated vague emotional descriptions that, in the narrative, appeared to have a positive connotation as "General Positive Emotions." But upon further examination of the documents, some units previously rated in this manner could be identified more specifically as feelings of relief. In most of these cases, patients directly stated that they felt relief, as evidenced in NUD*IST string and pattern searches.

I completed the coding for all 22 patient revisiting exercises. To verify my interpretations, a second coder, who had served as a research assistant on the Complicated Grief study for nearly two years, also examined all 22 revisiting exercises. Interrater agreement between the two coders was .80 for all thematic codes, calculated using Hartmann's commonly used percent agreement formula (Hartmann, 1977). Overall perfect agreement for each coded sentence of text was assessed, and agreement for each major

coding category ranged from .76 to .85. These agreement figures were based on 43 codes, which were the total codes developed at that point. Discrepancies were discussed and resolved; that is, in cases of disagreement, coders met to discuss the discrepancy and together came to a conclusion regarding what the code should be for that line of text. Throughout the coding process, codes were added and refined, based on the insights from the two coders. Coders also discussed the appropriate arrangement of codes in the hierarchical coding matrix. Both coders were blind to patients' scores on the ICG, BDI, and IES. Coders utilized the unique addresses in the coding matrix and were free to allow codes to overlap.

After completing coding with my co-rater, I began analyzing the data and writing the results. I continued the iterative data analysis process throughout this time. It became clear that codes needed further revisions. Emotional themes that were too vague to be categorized as any particular emotion were labeled as either General Positive Emotions or General Negative Emotions. Upon further inspecting these general categories, I found that I could break them down further. I created two themes, Relief and Comfort, from General Positive Emotions. I broke General Negative Emotions into feelings of Helplessness, Confusion, Worry, and Distress. While some emotional text was still unclear (for example, Patient 19 stating, "I feel really emotional about it.") so that I kept the categories General Negative Emotions and General Positive Emotions, I believe that breaking these categories into more specific codes bettered the matrix and made it more sensitive to patient meaning.

The Distress category also required additional refining. Initially, we had created the code, Shock, to describe the anxiety that patients said that they felt. As I broke General Negative Emotions into more specific themes, I created the category Stress. However, in further refining these themes, I utilized NUD*IST to explore how much Stress and Shock

overlapped. Since the themes almost completely overlapped, I revisited the text pertaining to these categories and re-coded under the designation, Distress. Through this process of breaking down categories, recombining equivalent categories, and shifting nodes, a total of 25 additional themes emerged.

3.7.1.2 Coding Decisions. Four major coding categories emerged from the revisiting exercises: Emotions, Social Support, Cognitions, and Focus on Death. Emotions included overt emotional statements that patients made regarding their own emotional states as well as more indirect statements that could be reasonably categorized as patient descriptions of their emotional states. Social Support referred to patient descriptions regarding the perceived help or hindering provided by friends and relatives. Cognitions included patient descriptions of their own thoughts and thinking patterns. Finally, Focus on Death referred to instances in which patients focused directly on death itself, whether discussing the nature of death in general, focusing on the appearance of the corpse, or grappling with the reality of death.

The initial matrix that the coders utilized included 58 codes, and we collapsed this list into 43 codes. We dropped codes from the 58-code matrix when a) the code was never utilized in any patient document and b) coders could not come to a conceptual agreement regarding the definition and nature of the code. For example, Extreme Negative Emotions was a code intended to describe highly emotional patient responses. However, the differentiation between extreme emotional responses and the typically distressed responses of the CG patients proved to be too fine a distinction for coders to make.

After coders used this 43-code matrix to code all texts, I continued to revisit the matrix and refine codes throughout my analyses. I formed additional sub-categories from

these 43 codes and added a branch of demographic codes, culminating in a total of 84 codes arranged hierarchically in a tree format. This list is presented in **Appendix A**, which also presents definitions for each code. We also explored four free nodes in the texts; I kept these as free nodes since these codes were neither connected to other themes nor the theoretical underpinnings of this study. However, we coded them as we went along, in case the codes would be relevant at a later point or in a future study. For example, only three patients described feeling physically ill (coded as a free node) in response to hearing of the loss, and I decided to focus on themes more relevant across patients in the present study.

I conferred with my co-rater when making decisions how codes should be organized in the matrix. For instance, we discussed whether codes should best be construed as emotions, cognitions, or another category. We also studied each code in the context of surrounding narrative text to decide how to describe each code. While many codes were fairly straightforward and fit nicely within one of the four major categories, other codes required more careful deliberation. For instance, I ultimately conceptualized blame under Cognitions, since we defined this code as patient thoughts regarding whom they held responsible for the death. We concluded that while a corresponding emotion might be anger, we wanted to also code the patients' thought processes regarding who they thought was at fault for the loss. Thus, many of the coding decisions included setting limits regarding how interpretive we should be in this study. As the principal investigator of the study, I set a precedent for relying on the patients' literal words as much as possible and interpreting what we thought patients meant when we could make a case for applying the code given the context of the surrounding text.

Since grief narrative literature describes the process of meaning making as being an important and interesting one, I wanted to target this issue. However, there are various types of meaning making, as discussed in Chapter Two. After reading and re-reading the narratives, it was clear that one specific meaning issue took precedence: Asking Why the loss occurred. The patients in this study were most concerned with finding the reason for the loss. I did not observe other types of meaning making specifically being addressed by patients in this study, at least during the confines of the narratives. I was not so presumptuous as to conclude that this was the only type of meaning making in which the patients engaged, since researchers such as Neimeyer (2001) warn against ignoring the multiple facets of meaning making. However, in the revisiting exercises that I utilized, clear instances of other types of existential grappling were not apparent to me or my second coder. Indeed, very few spiritual and existential references occurred in the revisiting exercises, although patients certainly discussed sources of meaning in other segments of CGT. Rather than reading too much into the texts, I decided to focus on the one major meaning category that patients clearly described: Asking Why.

3.7.2 Narrative Content and Patient Symptoms

I explored narrative content by tallying, via NUD*IST, the number of text units (length= one sentence) that pertained to each theme. This method was the most straightforward method of generating narrative frequencies, and I emphasize results from these tallies in the following chapter. While most patient narratives fell between 100 and 300 text units, some patients had longer or shorter narratives. For this reason, I also computed the percentage of time that

patients devoted to relevant narrative themes and included this information alongside the tallied text units when presenting the correlational data.

I conducted Pearson Product Moment correlations among selected theme frequencies (as well as the percentages of each session devoted to specific themes) and patient symptom scores on the BDI, ICG, and IES using SPSS for Windows. I also calculated Spearman rank correlation coefficients to verify whether results obtained using one calculation were unduly influenced by outliers. I collapsed emotional themes into positive and negative categories since the specific emotion themes were too infrequently described for meaningful statistical analysis. I divided emotional themes based on whether patients described the themes as being pleasant or unpleasant to them; that is, given the context of the surrounding narrative text, I based my decision on whether patients expressed enjoyed what they were feeling or whether they found it to be distressing. Emotions that I judged as being Positive were Happiness, Relief, Love, Pride, Comfort, and General Positive Emotions, while the Negative Emotions were Sadness, Helplessness, Anger, Fear, Distress, General Negative Emotions, Guilt, Unreality, Loneliness, and Numbness.

After conducting statistical analyses, I revisited patient transcripts stored in NUD*IST. I used findings from the statistical correlations to brainstorm new ways to qualitatively study the texts. For example, I looked at intercorrelations among themes to see which themes significantly related to each other, and I further examined the relationship among these themes through NUD*IST index searches and reports. For more in-depth analyses, I focused on a homogeneous subgroup of patients. Having a smaller group aided my observation of patterns across patients without being encumbered by a larger sample.

3.8 Conclusion

In this project, I blended qualitative and quantitative methods for the purpose of exploring the content of Complicated Grief Treatment revisiting exercises. While building upon grief and PTSD narrative research, I ultimately derived coding themes from a pilot study on CG narratives and from the CG narratives utilized in the present study. I paired qualitative coding procedures in which a primary rater, with work verified by a second rater, examined all narratives, with both qualitative and quantitative analyses in order to target the central research question: What is the content of the revisiting exercises?

These methods improve upon prior content analyses in grief research by utilizing a qualitative coding scheme specifically created for Complicated Grief Treatment narratives. That is, most themes in this study come from the literal and implied words of the patients themselves rather than sources only marginally applicable to patients with Complicated Grief. Secondly, the coding scheme was qualitative and did not try to overly quantify how much text needed to pertain to a particular theme before it could be coded. Codes could overlap and any amount of text pertaining to a theme could be coded as that theme. Furthermore, the code derivation process resulted in a greater number of themes and delved to a greater depth than occurs in studies solely examining two categories: positive or negative themes. Unlike wholly qualitative case studies or ethnographies on bereaved individuals, the present study also included quantitative analyses intended to compare narrative themes to patient symptoms. This quantitative portion was intended to connect the present study to prior grief narrative studies that correlated positive and negative themes with mental health outcomes. Grief researchers Neimeyer and Hogan (2001), in speaking of a mixed methods approach to studying bereavement stated:

Because most grief researchers operate exclusively within either a quantitative or qualitative frame of reference, few exploit the possibilities for integration of both methods *in the same research program*. And yet this more eclectic approach may have significant advantages...(2001, p. 113)

It was my intent that the methods utilized in this study improve upon prior grief narrative work and focus specifically on a clinical sample of Complicated Grief patients. Studying narratives from a treatment developed specifically for use with patients with CG, I utilized codes derived with this population in mind.

4.0 RESULTS

This chapter addresses findings regarding the central question and subquestion in this study: a) What is the content of the revisiting exercises? and b) How is narrative content related to patient symptoms? The following section begins with an overview of the frequencies of narrative themes, followed by a more detailed exploration of narrative content. In this study, I focus on the four primary thematic categories (Emotions, Cognitions, Social Support, and Focus on Death) and the most prevalent themes from these categories.

4.1 Overview of Narrative Themes

In addressing the question, “What is the content of the revisiting exercises?” four major categories emerged: Emotions, Cognitions, Social Support, and Focus on Death. **Appendix A** provides definitions of all themes. At the start of this project, I specifically sought to explore emotional and cognitive themes, knowing from the pilot study that patients routinely discussed their thoughts and feelings pertaining to their losses. However, the Social Support and Focus on Death categories emerged as primary categories as I engaged in more in-depth exploration of narrative texts. **Table 5** presents the most frequently described narrative themes by all 22 patients.

All 22 patients described their emotional and cognitive states during story narration. The specific emotions described by the greatest number of patients were anger and sadness,

Table 5.**Descriptive Statistics of the Most Frequently Occurring Narrative Themes (N=22)**

Themes	N	Total Units	M	SD
Emotions				
Positive Emotions	19	92	4.8	5.6
Love	9	22	2.4	1.4
Negative Emotions	22	308	14.0	13.6
Anger	16	69	4.1	4.4
Sadness	11	46	4.2	3.0
Unreality	8	35	4.4	4.8
Distress	7	32	4.6	4.7
Social Support				
Good support	13	128	10.0	14.6
Lack of support	13	226	17.4	23.2
Cognitions				
Doing-Based Evaluations	13	55	4.2	3.1
Negative-Self-Evaluations	12	62	5.2	4.6
Being-Based Evaluations	10	23	2.3	2.3
Positive Self-Evaluations	9	16	1.8	1.3
Focus on Death				
Appearance of the deceased	13	127	9.8	7.2
Neg. reaction to appearance	11	93	8.5	8.1
Wanting to see body	7	16	2.3	2.6

*The N column refers to the total number of patients utilizing this theme. "Total Units" refers to the total number of text units in all 22 documents pertaining to this theme. The mean and standard deviation figures refer to text units.

while self-evaluations were the cognitive themes described by the greatest number of patients. Most patients devoted large portions of their narratives to critiquing available social support, although patients devoted a greater number of text units to discussing unsupportive networks. Finally, regarding Focus on Death, eleven patients described adverse reactions to the deceased's appearance. Yet seven patients also discussed a desire to see the body.

The following section serves as an overview of themes from each of coding category: Emotions, Cognitions, Social Support, and Focus on Death. I display patient quotes and discuss thematic frequencies to support my interpretations regarding the results. I assigned numbers to each patient in the study in order to organize patient material, and each patient quote is preceded by the patient number. For some quotes, additional textual material is provided for context even though the full quote was not coded under the given theme.

4.1.1 Emotional Responses

Emotional responses were portions of the narratives in which patients either overtly labeled their emotional states during narrative events or when they communicated how they felt during narrative events. Emotional responses were overwhelmingly negative, as would be expected when describing the death of a loved one. The specific emotions described by the greatest number of patients were anger and sadness, which were also the emotional themes represented by the greatest number of text units. What were patients angry about? The majority of patients expressed anger (11 out of 16 patients) toward non-supportive friends, family, and medical and religious personnel:

P7: I remember being angry at the pastor because he never visited her when she was sick and I just didn't think it was very nice to do that to a member of the church...

P12: Just sorta angry at my brothers, especially the one...being selfish.

Only three patients expressed anger toward the deceased; of these, two had lost the loved ones to suicide and one to a car accident. Two patients expressed anger at death itself; specifically, at the fact that the loved ones died. Finally, one patient was angry both at unsupportive family and at death itself.

Five patients described themselves yelling or wanting to yell statements in anger during narrative events. As one patient stated,

P3: I want to scream and yell, "Can't you all just do this? Your mom wants to die and you're all talking about where you're going to eat!"

Patients describing these overt expressions of anger were angry about the same topics mentioned above. However, two of the three (67%) patients who described feeling angry at death itself described yelling in anger, compared to 33% of patients who were angry at the deceased and 27% of patients who were angry at living individuals.

Regarding feelings of sadness, patients appeared to have difficulty expressing precisely how they felt. Patients either stated very matter-of-factly that they felt sad (8 of 11 patients), without attempting to further describe this feeling or they voiced problems

expressing their sad feelings (3 of 11 patients). Examples of each type of expression are presented below:

P18: I am feeling sad that he is dead.

P22: I'm just so sad.

P4: I can't even describe that feeling. It's a feeling that I wouldn't wish on anybody. It was just ah...it was the worst day of my life. It was the worst day of my life. It's just sad.

P7: Then I just felt so sad and I can't put it into words.

For some patients, then, sadness was the closest emotion to what they were feeling. Yet, the succinct and vague responses probably belie intense and more complicated emotions behind the expressed words.

Besides anger and sadness, other common emotional descriptions included focusing on love, feelings of unreality, and distress. Nine patients described feeling love. All nine patients spoke specifically of loving the deceased individual. Expressions of love often overlapped with more negative feelings, such as loneliness and guilt. These overlaps will be discussed in a later section. Of the nine patients reporting feelings of love, four had lost spouses, three parents, one a child, and one a cousin. Thus, 44% of patients describing

feelings of love were conjugally bereaved. Only two conjugally bereaved individuals in the present study did not report feeling love

Every patient who spoke of loving the deceased described kissing the deceased individual during the narrative events. Excerpts of descriptions of both loving and kissing the deceased are presented below:

P9: We were the last ones to say goodbye. I kissed his forehead, and told him how much I loved him, and how much we were going to miss him.

P6: I kiss her and I tell her I love her. I'll be here tomorrow, and I love you.

Interestingly, all three male patients in this study described kissing the deceased, and they constituted 3 of the 10 patients who did so. Two of these male patients repeated the fact numerous times (twice and thrice, respectively) that they kissed the corpse at the funeral.

Over a third of the patients described experiencing feelings of unreality at the time of the loss, as if the events were not currently happening. Examples are presented below:

P6: I'm dazed. I feel like I'm floating. I feel like I'm not even here right now.

P13: I feel like I'm not here. I feel like I'm watching a movie. I feel neglected. I feel there's no way this could possibly be happening. But I know it is because I'm hot and sweaty and have grass marks on my knees.

P19: And I can remember being there and it was like my body was there but my spirit was somewhere else and I felt like it was something I couldn't accept as really being happening.

Such descriptions usually occurred in narrative sections where patients first discovered that the death occurred, although two patients described having this feeling throughout the narrative events.

Seven patients described feeling distressed. Patients describing their distress cited the shock and out-of-control feelings experienced when first discovering the death but also in the aftermath of the loss. This category incorporated descriptions of stress, anxiety, and shock.

P6: I'm a nervous wreck right now. I'm sorry. My legs are shaking, my hands are shaking. I barely feel like I can walk right now.

P7: I'm so shaken up, I thought, "I've got to be with somebody..."

P16: And it's, I feel a tightness in my chest like things are a bit out-of-control and this tense feeling I have, because things are out-of-control and I can't, there's nothing more I can do.

As can be noticed in the excerpts above, this distress usually manifested itself physically, although these physical descriptions were entirely separate (both in narrative distance and conceptually) from the free node, Physical Sickness, in which patients describe feelings of

nausea and the need to throw up in response to worrying about circumstances in the narratives.

4.1.2 Descriptions of Social Support

Social Support referred to a patient's focus on his or her perceived social support. Even though therapists instructed patients at the beginning of the revisiting exercise to "tell the story of the death" and did not specifically ask to hear about relational issues, the story of who was supportive or unsupportive was central for most patients (n=19; see **Appendix E** for therapist instructions for the revisiting exercise). This topic permeated entire revisiting exercises; patients repeatedly addressed whether they felt supported by others or whether their social relations were combative and unsupportive.

Patients devoted more total narrative space to discussing unsupportive networks than discussing supportive networks (see Table 5), although 13 patients discussed supportive networks and 13 discussed unsupportive networks. Patients described unsupportive people as having three qualities: cold and rude, unhelpful or unavailable, and combative. Each will be discussed below.

Four patients felt unsupported when they found the behavior of friends and family to be cold or rude:

P7: My sister was a nursing instructor...I wanted her to be there for us and she wasn't...She just said... to me on the phone, "Well, I want the body embalmed," because I told her that they said that mother was dead and she said, "Well, I want the body embalmed... As my sister said so cruelly, "I want

my mother embalmed.”...(At the funeral), she handled it very business-like, like just describing my mother in general, just describing her interests, nothing really touching that really related to her and my mother, nothing that really made you cry.

P8: I guess I expected to be somewhat comforted when [he] came. He made it more of a social visit, gave us restaurant reviews, it was awful.

P19: I can remember being there at home, with my brother and he seemed to have, I can remember he had no compassion...He seemed to me like he was indifferent. And I told him how bad I felt and he said, oh well, in a month or so you'll forget all about that. I can always remember him saying that and thinking to myself, how can anyone think like this? I thought how could anyone think like this. After all these years, that everything would be over in a month.

P16: And the doctor says these condescending things, like, um, like he wouldn't expect a layperson to understand, but there is some, because the, because the brain shrinks after a person is so old. And there's space between the brain and skull and I said, "Wait a minute, wait a minute, just tell me what happened." He says, "I'm trying to explain to you, and you're obviously not listening to me, maybe you don't understand"...And then [another doctor on call] goes like this and wipes her hands...like she was dirtied by it or something, and

then she says to the nurse, right in front of my mother, "...comfort measures."
In other words...put her down...And then she turns and walks out. This person was to turn up in my poetry class just recently, and emerge as a really caring, sensitive poet!

As evidenced in the excerpt from P16, coldness and rudeness was also galling when displayed by medical personnel, particularly when patients perceived these individuals as being condescending or domineering. Such persons, while not the friends and family typically associated with supportive networks, have much potential for giving comfort or for making an already troubling situation even more difficult.

Five patients felt unsupported when friends and family failed to help in practical ways or even be available for them. Some of these patients had basic expectations regarding the aid that they should receive and when such aid was absent, they voiced their frustration:

P7: There weren't that many people that sent things over.

P21: I need someone to hold me, but I didn't have that. I had my kids to hold me but I didn't have the strength of a man, you know, a husband, or a lover, or whatever you want to call it. I really missed that, and I really think it would have helped me but I didn't. So I planned the funeral on my own, did everything on my own and I don't want to do anything on my own anymore.

In text prior to the excerpt above, P7 named four individuals by name who did send meals to her house in the aftermath of the loss, but was disappointed that more people did not offer practical support. P21 simply did not have the types of adult aid available to her that she thought she needed.

Others felt unsupported when friends and family were physically absent during the immediate aftermath of the loss, particularly when such persons were absent at the funeral:

P7: It took a half an hour to locate her. I don't remember her being there at all...I was so sad my sister didn't show up. I don't know why [my mother's brother]...didn't come out to the funeral...I don't know but I was upset that [my great uncle's family] didn't come out. I found out they were in Florida vacationing.

P14: And my daughter didn't come over at all. She said she couldn't stop crying, and her face and eyes were all swollen. I do think she should have come.

P21: I had two close cousins that we used to stay at each other's houses all the time and the two of them never came and it just hit me about a month ago and it really upset me. All through childhood we were extremely close and not a card or a call. Their parents came, and I thought, "How dare you?" I know I shouldn't think that way but I couldn't believe this.

No patient in the current study reported being completely isolated in his or her grief; all 22 patients talked about friends and family members who were present during the story events. Even patients who felt disappointment at the absence of certain friends and family at the funeral did not report that the funeral was poorly attended. Rather, their dissatisfaction was with specific loved ones whom they felt should have been there. Thus, even though many people were physically present, the absence of certain key individuals resulted in the patients feeling dissatisfied and unsupported.

Finally, five patients felt unsupported by family members when conflict and fighting erupted during the already-stressful events of the death:

P3: Then [she] and the kids come in and out and it was horrible because nobody wanted the kids to come in (to the hospital room)...I don't know if I'd ever tell anyone that, but in my heart, being a mom, they did have the right to see her, and she them. She wasn't unconscious, she wasn't in a coma, she was alert and not much different than she had been in her home...I was in the hall with [him], who was bitching and screaming about them being there.

P10: My sister...says that she'll take care of everything. And [my brother] is arguing, you know, "What do you mean?" I said, you know, "Well, what about Dad? Dad should have a say in what goes on"...First they talk about picking out the caskets, and that's when they're walking around and they're laughing.

These five patients devoted 98 total text units to this topic. Therefore, more than the other categories describing poor perceived social support (e.g. Coldness and Rudeness: 48 text units; Failure to help or show up: 32 text units), Conflict was a pervasive theme in the narratives of those who addressed it.

Regarding supportive networks, patients described four ways in which people showed their support: being there, being helpful, giving affection, and giving honor. First, patients most frequently (n= 10) described how having friends and family simply be there for them was supportive:

P1: We go home. Get back to the house. There are people there, a couple of my cousins, some neighbors and friends. I recognize more than ever before the importance of family. These are people, like myself who are busy going about their daily business, trying to pay their bills. Then at the first sign of trouble, of major trouble, they're sitting at my kitchen table keeping company. That's not lost on me.

P3: It was good that my dad was with me because he's a cool guy. He's always able to make me comfortable when nobody else could.

Of these patients, four pointedly listed the names of individuals who showed up at the funeral. For them, the sheer physical presence of persons at the funeral was perceived as being supportive.

Another important support theme was the physical affection received from loved ones during this difficult time (n =6):

P5: [My wife] joined us. She put both of us in her arms. All three of us standing there. Feeling the closeness, I think we never felt before...The three of us were walking real slowly with our arms wrapped around each other.

P6: Soon after we're all hugging, and we're crying on the couch together.

One patient in particular emphasized this theme, and he was one of three male patients in this study (none of the other male patients described physical affection). While the five other patients describing the physical affection received from friends and family only devoted one or two text units each to this theme, P5 devoted 17 text units to descriptions of hugging and embracing loved ones.

Good social support was practically helpful (n = 6), from friends and family providing food to helping with the task of informing others of the loss:

P2: [He] was tremendous. We had to call up my parents and they were away from the phones...then we had to call my cousin...then he had to go out to tell my parents.

P7: I remember the neighbors coming over and bringing platters of food and trying to comfort me...I remember them. My friend...from high school sent a tray luncheon cheeses over and I do remember other people sending things over.

P9: It was just so wonderful to know that you have so many people that love you and care about you, because all the neighbors came over with food and support, and told us if there was anything they could ever do just let them know.

Being helpful, like the theme “being there” versus “unavailable,” was the complete opposite of the theme “failure to help or show up.” Thus, patients in this study emphasized how the practical aid or presence of others can be an important source of support while the lack of such aid and presence can be disheartening and make an already heart wrenching situation more difficult.

Finally, behaving in ways that honored the deceased at the funeral made the patient feel supported in his or her grief (n =3):

P1: I realize how important it is for people to pay their respects. It's not- it's testimony to the fact that they didn't ignore his passing. It makes me feel good that students, neighbors, friends, former co-workers in some cases, and former bosses would show up just to honor his presence.

P3: [The priest] talked about [my daughter], and he said such wonderful things, it was almost as if he knew her well. He managed to pick up so many of her good points, what she meant to all of us. He mentioned how she had been looking forward to going to college. Tried to help us remember that she was no longer with us, that she was now going to be with God, a much better place.

When others honored the deceased, the patients seemed to be able to sense solidarity with other grievors sharing a similar love for the deceased individual. Thus, honoring the deceased also helped the grieving patient to feel less isolated in his or her grief.

Descriptions of either supportive or non-supportive social networks were the most frequently described specific themes examined in the study, next to negative emotions. The four most prevalent themes in terms of number of text units were, in order, negative emotions, bad social support, good social support, and appearance of the deceased. Patients devoted more narrative space overall to discussions of non-supportive networks (226 units) than to supportive networks (128 units).

4.1.3 Descriptions of Cognitive Processes

Text coded as cognitions in this study included segments in which patients discussed their thought processes during narrative events. The most frequently described cognitions in the narratives were self-evaluations ($n = 16$), in which patients evaluated their own behaviors and character. More patients evaluated behavior than character, and more patients offered negative evaluations of themselves than positive evaluations and spoke of these negative

evaluations for longer periods of time (see Table 5). The following examples illustrate doing-based, or behavior-based, self-evaluations. The first two examples illustrate positive doing-based self-evaluations while the second two illustrate negative doing-based self-evaluations.

P5: Some of us would like to say a few words (at the funeral)...And I got through that with just a couple sniffles.

P1: I read the eulogy. I start with some of [my son's] words and I do okay.

P6: The little bit of sleep we do get, the next day have to plan for funeral arrangements. We have to get it very quick, because December 18th is so close to Christmas. We're scrambling around. We're trying to get things done. Well, I can't even say "we" because I'm sitting back like I can't do anything. I can't help with anything.

P7: So I tell the paramedics, "Come quickly, I think my mother's dead." I wish I hadn't said that, instead I wish I had said, "My mother is sitting in a chair and is not doing anything. I don't know what's wrong. Please come over immediately." I wish I hadn't put words in their heads that she was dead because maybe if I hadn't done that, they would have tried to jump her.

The following examples illustrate one positive, followed by one negative being-based, or character-based, self-evaluation:

P9: Because [my husband] and I had such a wonderful marriage, the children never saw us fight and we never left each other.

P13: I feel dumb. I feel clueless. Like I have no knowledge of anything. That this person that I knew, I don't know and never did know. ((after she discovers her sister's suicide note))

Guilt, which was expected to be a common theme in the present study, was more frequently coded in these narratives as a negative self-evaluation. In cases in which patients described guilty feelings, we decided to code the text as "Guilt," but if patients offered matter-of-fact statements indicting their own behaviors or character, then "Negative Self-Evaluations" applied. The distinction between emotions and cognitions being very fine in this case, it was advantageous to be able to simultaneously apply both codes when needed.

While prior work (Bauer & Bonanno, 2001-a) identified a 5:1 positive to negative ratio of self-evaluations as optimal for grief outcomes, only one patient in the present study exhibited a similar ratio (5:3). Fourteen patients made more negative than positive self-evaluations, and for many of these patients, negative self-evaluations overwhelmed the number of positive self-evaluations. For example, negative to positive ratios for patients included the following figures: 4:0, 7:0, 11:0, 17:1.

When patients evaluated themselves negatively (whether doing-based or being-based), their descriptions could be summarized in one of four ways: what they should have done during the story events (n= 5), feeling emotionally out-of-control and feeling embarrassment about that (n=7), and a complete inability to function (n = 8). Patients evaluating themselves positively either were pleased at maintaining control of themselves during the difficult events (n = 7) or took pride in the fact that they had contributed to a vibrant relationship with their loved ones before they died (n =2).

Two cognitive themes, although described by fewer patients, were particularly informative in describing narrative content: Asking Why the loss occurred and Blame. Six patients debated why the loss had occurred. All six patients had experienced sudden and/or violent losses: murder, car crash (n=2), drug overdose, heart attack, or suicide. Two excerpted segments of these patient texts are presented:

P8: He's just so cold. And he didn't look any different...And then I started yelling at him, what did you do to yourself, why did you do this?...I just wanted to see him again. I just ask why did you do this, why did you have to do this? ((son died from a drug overdose))

P10: She tells me that, uh, Mommy has died. I see the nurse. I'm asking the nurse, "Why? She wasn't sick, what happened?" The nurse said, "We just lost her."
((mother died suddenly of a heart attack))

While the other 16 patients may have grappled with various issues pertaining to meaning making, they did not do so in their death narratives. Such results are consistent with the contention in grief research that persons experiencing sudden losses may devote more time to grappling with the meaning of the loss. Patients who experienced a violent loss did not differ from other patients regarding any other theme or symptoms score, based on independent samples *t*-tests.

Regarding blame, only four patients overtly discussed this topic in their narratives. However, these patients focused on blame for a total of 36 text units, for an average of nine units per patient, giving blame the fifth highest text unit average in the study. One patient blamed the doctor who punctured her husband's lung for his rapid decline. Another blamed a nurse whom she believed to be negligent, since her mother suffered a serious fall under the nurse's unwatchful eye. She also blamed her mother's doctor for the cover-up of her mother's injury. The remaining two patients blamed non-medical persons whom they held at least partially responsible for the deaths. One such patient blamed her ex-husband for wearing her mother down and contributing to her decline and ultimate death: The fourth patient was suspicious toward two neighbors and thought that they might have been responsible for her granddaughter's murder: As will later be discussed, blame and anger frequently overlapped within the narratives.

In conclusion, many patients evaluated themselves in their narratives, although such self-evaluations tended to be succinct. In contrast, fewer patients described Asking Why and Blame. However, these themes seemed to be pivotal to the revisiting exercises since they permeated the texts from these patients.

4.1.4 Focus on Death

Many patients focused directly on death itself, either musing on the nature of death or the effects of death. Most frequently, patients repeatedly returned to the image of the corpse. While patients experienced various reactions to the appearance of the deceased, from being struck with the unsightliness of death (and being unable to remove the image from their minds) to approving of the deceased loved one's appearance, more patients (n=11) had extremely averse reactions:

P1: He doesn't look the way he looked at the morgue, he looks bloated, like he's been in a fight. She says, "I don't know what they did when they did the autopsy."

P6: She was there laying in the coffin, looking unlike she ever looked to me. She looks sick. She looks bloated. She looks, her face is coming off on one side. And her hair. They have her hair looking like she's 60 years old. She's only 23 years old. Why her hair?

Positive reactions to the appearance, although described by fewer patients (n=5), involved commenting on how the loved one looked to be "at peace" (P1), "pretty" (P4), and "like the mother I used to know and love" (P7). Thus, over twice as many patients described their disgust and abhorrence of the deceased's appearance as those discussing their satisfaction with the appearance. Also, patients describing their negative reactions did so for longer periods of time than those describing positive reactions (93 text units versus 23 units).

Even though negative reactions to the deceased's appearance were more common, more patients spoke of wanting to see the body (n=7, 16 total text units) than those not wanting to see the body (n=5, 5 total text units). These themes, Negative Reaction and Wanting to See the Body, tended to occur in the same narratives. Five of the seven patients who wanted to see the body also had a negative reaction to the deceased's appearance. Most (n =4) of these patients simply wanted to see their loved ones and then reacted negatively to the blunt reality of the death that accompanied the image of the corpses. For example:

P17: I just keep thinking that I want to see him and keep thinking that I don't want him to be dead...I don't understand why he is so cold and why his eyes are open and he feels very heavy.

However, one patient first had a negative reaction and then spoke of being drawn to and desiring to see the loved one anyway:

P6: Why do they have her hair like this? Why does her nails, they still have this nail polish on her. The nails that I seen a week prior. This dress, I hate this dress. It's nothing that she would wear. She didn't even like blue...I have to stare at her. I have to inspect every little thing I can about her to make sure it's her, because it looks nothing like her...I have to look at her. I have to see her. It feels like every time I move away from it, I want to go back up...We got to stay. We gotta. I don't know how much we're going to be able to look

at her. We gotta touch her. I don't know what it is that keeps drawing me to want to touch her and hold her.

In total, 13 patients discussed the appearance of the deceased, thus marking this theme as a prevalent and pervasive one.

4.2 Relationships between Narrative Themes and Symptoms

Using the Pearson Product Moment Correlation Coefficient and Spearman's Correlation Coefficient for Ranked Data, I examined the relationships among narrative themes and three patient symptoms measures: the Beck Depression Inventory (BDI), the Inventory of Complicated Grief (ICG), and the Impact of Events Scale (IES). Table 6 presents the correlations between the most frequently described major themes and symptoms measures. Correlations between the tallied themes and symptoms are presented, with correlations between theme percentages and symptoms listed below each theme. Tallies and percentages of each theme are based on all twenty-two patients.

I expected positive emotional themes to inversely correlate with symptoms measures, particularly the 16-week assessments. That is, the more the patients discussed positive emotional states in the revisiting exercises, the lower their depression, grief, and trauma scores would be. Since the unit of analysis was a sentence, the total number of sentence units in all 22 revisiting exercises pertaining to each theme was tallied and then correlated with symptoms scores. Percentage frequencies also were tallied to address the variety in narrative length. While Positive Emotions significantly and directly correlated with the BDI

Table 6. Correlations Between Themes and Symptoms Measures, Frequencies and Percentages

	BDI		ICG			IES	
	Baseline	16weeks	Baseline	16weeks	6months	Baseline	6months
	(n=22)	(n=19)	(n=22)	(n=19)	(n=19)	(n=22)	(n=19)
Pos. Emotions							
Frequencies:							
Pearson r	.20	.61**	.19	.41	.29	.10	-.19
Spearman rho	.11	.27	.02	.22	.11	-.02	.07
Percentages:							
Pearson r	.29	.69**	.34	.46*	.37	.14	.03
Spearman rho	.20	.36	.19	.33	.26	.01	.26
Neg. Emotions							
Frequencies:							
Pearson r	.02	-.25	-.24	-.45	-.51*	-.09	-.39
Spearman rho	.08	-.19	-.07	-.29	-.43	-.41	-.45
Percentages:							
Pearson r	.09	-.12	-.23	-.28	-.32	-.26	-.13
Spearman rho	.10	-.16	.06	-.31	-.38	-.30	-.28
Lack of Support							
Frequencies:							
Pearson r	.14	-.09	.34	-.20	-.25	-.22	-.06
Spearman rho	.02	.13	.19	-.01	-.10	-.11	.08
Percentages:							
Pearson r	.09	-.07	.32	-.17	-.22	-.30	-.03
Spearman rho	-.01	-.00	.02	-.09	-.13	-.22	-.12
Good Support							
Frequencies:							
Pearson r	.04	.11	-.04	.14	.05	.02	-.27
Spearman rho	.12	.35	-.30	.37	.27	.15	-.19
Percentages:							
Pearson r	.06	.24	-.03	.23	.13	.05	-.31
Spearman rho	.12	.42	-.19	.36	.24	.12	-.33
Neg. Reaction to Appearance							
Frequencies:							
Pearson r	.11	-.18	-.01	-.33	-.37	.12	-.23
Spearman rho	-.04	-.00	-.09	-.14	-.26	-.16	-.10
Percentages:							
Pearson r	-.24	-.04	-.18	-.07	-.11	.10	-.15
Spearman rho	-.40	.05	-.31	-.02	-.11	-.18	-.19

*Correlation is significant at the .05 level (two-tailed).

**Correlation is significant at the .01 level (two-tailed).

using Pearson Product Moment correlations, the correlation was nonsignificant using Spearman's rho. Upon further inspection, two outliers are apparent. Outliers were defined as having a BDI score at least 10 points over the mean BDI for the 22-patient sample as well as having at least 10 sentences over the sample mean for positive emotions. Specifically, the two outliers had BDI scores 12 and 33 points, respectively, over the mean BDI. While the mean number of sentences containing positive emotions for the 22-patient sample was 4.18, the total number of sentences containing positive emotions for the outliers was 17 and 19 sentences, respectively. Removal of the outliers resulted in nonsignificant correlations using both Pearson and Spearman's correlation coefficients.

Three patients completed treatment prior to the standard 16 weeks. These three patients significantly differed from the other 19 patients regarding one major theme, anger, $t(20) = -3.55, p < .01$. Upon exploring their tallied themes, it appears that these patients spoke more of their anger than did other patients. The 19 patients devoted, on average, 1.58 text units to anger, while the mean for the three patients was 8.33. In addition, the three patients represent half of those (two out of four patients) discussing feelings of fear in their narratives. No similarities could be observed among the three patients in regard to demographics or type of loss.

There was a statistically significant difference on the BDI between patients who described at least one positive self-evaluation ($n=8$) and patients who had no positive self-evaluations ($n=11$), based on an independent samples t -test: $t(17) = 2.32, p < .05$. The mean BDI (16 weeks) score of patients describing at least one positive self-evaluation was 19.4, while the mean BDI of the other patients was 8.8.

Using an independent samples t-test, no differences were observed between responders (defined as decreasing at least 20 points from baseline ICG to post-treatment ICG) and non-responders on the number of sentences referring to positive emotions, negative emotions, good social support, or poor social support.

4.3 Relationships Among Narrative Themes

I used the Pearson Product Moment Correlation Coefficient and Spearman's Correlation Coefficient for Ranked Data to examine intercorrelations across narrative themes; that is, across the thematic categories Emotions, Cognitions, Focus on Death, and Social Support. In order to verify that correlations were not unduly influenced by outliers or low frequencies, I compared both correlation coefficients as well as correlations based on tallies of themes and percentages of each narrative pertaining to each theme. Using these stringent criteria, two pairs of themes significantly correlated with one another: Fear and Anger, and Wanting to See the Body and Unreality. [Table 7](#) presents the intercorrelations among these themes.

Since only four patients described experiencing fear during their revisiting exercises, I further explored how patients utilized this theme in conjunction with anger. Reports run in NUD*IST revealed that all patients describing fear also described feeling angry and they described such themes near one another (within 50 sentences). All four patients began their narratives expressing their fear pertaining to the death, such as being afraid that the person was about to die or afraid as one is encountering the body. Twenty sentences later (fifty sentences later for one of the patients), each began to discuss anger, which was primarily directed toward living persons. While the fear and anger did not seem to be conceptually related, the sequence of emotional expression was always fear followed by anger.

Table 7. Intercorrelations Among Emotional and Focus on Death Themes

	1	2	3	4
1. Fear				
Frequencies:				
Pearson r				
Spearman's rho				
Percentages:				
Pearson r				
Spearman's rho				
2. Anger				
Frequencies:				
Pearson r	.76**			
Spearman's rho	.53*			
Percentages:				
Pearson r	.43*			
Spearman's rho	.41			
3. Want to see body				
Frequencies:				
Pearson r	-.16	-.22		
Spearman's rho	-.28	-.22		
Percentages:				
Pearson r	-.21	.02		
Spearman's rho	-.28	-.16		
4. Unreality				
Frequencies:				
Pearson r	-.03	-.19	.80**	
Spearman's rho	.16	-.12	.55**	
Percentages:				
Pearson r	-.01	.02	.42	
Spearman's rho	.14	-.05	.51*	

*Correlation is significant at the .05 level (two-tailed).

**Correlation is significant at the .01 level (two-tailed).

Among the six patients expressing a desire to see the bodies and eight patients discussing feelings of unreality, four discussed both issues in their narratives. These four patients all had wholly negative responses to the appearance of the corpses once they did see them.

Correlations that were inconsistent across the two correlation coefficients and/or means of tallying themes are not presented here but were used to generate hypotheses for which reports to run via NUD*IST. Results from this exploration are presented in the following section.

4.4 Thematic Exploration

Results summarized in the prior sections indicated three areas important for further analysis: the relationship between love and negative emotions, social support, and reactions to the deceased's appearance. The following section presents the results from this exploration.

4.4.1 The Interplay between Love and Negative Emotions

Negative emotions were the most prevalent themes in the study. Patients tended to weave negative and the less-frequently occurring positive emotional themes together rather than discuss them separately. Specifically, I examined the theme, Love, to see how patients spoke of experiencing this emotion. As previously mentioned, all patients who spoke of feeling love referred to the deceased as the recipient of that love.

Three patients who spoke of loving did so in the absence of negative emotions; that is, they spoke of negative emotions at least 25 sentences away from discussing love and the two topics were unrelated conceptually. Six patients, however, discussed love and negative

emotions within ten sentences and integrated both in the same subject matter. When they did so, two spoke of loneliness, two of sadness, one of guilt, and one of anger. Indeed, most patients (four out of six) who spoke of feeling lonely and missing the deceased loved one also spoke of loving this person.

P5: I had to see her one more time, too. And I went back. And I stood there and I looked at her, her smile in my mind. I told her how much I'm going to miss her. And I loved her and I always would. And I put my hands on her shoulders. I said, "I love you." I said goodbye. I turned around and started walking back.

P9: I told him how much I love him...How much I missed him, and I love him, and I know that I will miss him but I thank the Lord that he is no longer in pain...We were the last ones to say goodbye. I kissed his forehead, and I told him how much I loved him, and how much we were going to miss him.

In the above two excerpts, love and loneliness are integrated themes that the patients seamlessly related to each other. In both cases, the patients were describing their last words to the deceased at the funeral. The loneliness in these examples was a very specific type of lost feeling; that is, feeling separated from a loved one rather than feeling lonely and isolated. Generally, there was no pattern to whether love preceded negative emotional discussions or vice versa except that patients often concluded their narratives with a focus on love. Since revisiting exercises tended to conclude shortly after describing the funeral, patients often

spoke of telling the deceased loved ones of their love at the funeral. For eight of nine patients speaking of love, most of the text units pertaining to this theme occurred in the last half of the revisiting exercises.

The two patients who integrated feelings of love and sadness did so when describing their feelings at the family viewing before the funeral:

P6: I hope that she's hearing us right now, that she knows how much we love her...We all go home, and my friend's there. The house is all decorated, but nobody's happy right now. There's lights everywhere, candy canes, and fruit. It's just like, "Why?"

P7: Then I did something I've never done in my life. I reached down, and I kissed her. I kissed her face and I said, "Mom, I love you so much." To the best of my recollection, that's what I said. Then I just felt so sad and I can't put it into words. It's like a part of yourself died or something. The world will never be the same. Your life would never be the same.

For these patients, then, the viewing was a time of realization at the immensity of the loss, and this loss touched upon their present and future outlook. The sadness went beyond mere feelings of blueness and the above excerpts appear to be an attempt to describe feelings of grief when directly confronted with the loss, such as at the viewing.

Most patients (19 of 22) incorporated both positive and negative emotional themes in their revisiting exercises. Of the three who did not, two succinctly expressed solely negative emotions while the third patient focused narrative content on feelings of loneliness.

4.4.2 Focusing on Social Support

Patients devoted much narrative space to discussing unsupportive social networks (226 units) and supportive networks (128 units), making these the most prevalent themes following negative emotions. The following sections explore content pertaining to supportive and unsupportive social networks, respectively.

4.4.2.1 Social Support and Pride A primary emotion that patients who focused on good social support expressed was pride. Patients who described both feeling proud of and honoring the lost loved one did so when they described the funeral events:

P1: It makes me feel good that students, neighbors, friends, former co-workers in some cases, and former bosses would show up just to honor his presence. We tell everyone how proud we are of him, even in death. That we know he brought the plane down amid several houses, obviously making sure that no one was going to be hurt.

P5: He ((the preacher)) talked about [my daughter], and he said such wonderful things, it was almost as if he knew her well. He managed to pick up so many of her good points, what she meant to all of us. He mentioned how she had

been looking forward to going to college. Tried to help us remember that she was no longer with us, that she was now going to be with God, a much better place...And I told everybody (about) [my daughter] and who she was. I told them what my little girl had taught me. She taught me patience, compassion...understanding...She taught me the importance of showing everyone that I love that I love them.

Both patients who spoke of honoring the deceased and feeling pride were male. Indeed, two of the three patients speaking of pride were male. All three patients who described taking pride in the deceased also focused on supportive social networks, including at least two social support subcategories.

Patients describing both pride and the remaining social support categories (Being There, Helping, Affection) always did so by first describing the persons physically present to give support and then spoke of pride in the deceased loved one. For example:

P1: Then at the first sign of trouble, of major trouble, they're sitting at my kitchen table, keeping company. That's not lost on me...Again, people are still arriving with food...We tell everyone how proud we are of him, even in death.

Similar to Love, then, Pride was always discussed in the second half of narratives, and usually at the very end of the texts.

4.4.2.2 Social Support and Negative Emotions Negative emotions tended to overlap with descriptions of unsupportive social networks. The theme, Failure to Show Up or Help, overlapped with Anger:

P7: I don't know why her brother...didn't come out to the funeral. Her ((other)) brother...and his wife who were out in Indiana didn't come out. I don't know but I was upset that [the first brother and his wife] didn't come out. I found out they were in Florida vacationing.

P21: I had two close cousins that we used to stay at each other's houses all the time and the two of them never came and it just hit me about a month ago and it really upset me. All through childhood we were extremely close and not a card or a call. Their parents came, and I thought, "How dare you?" I know I shouldn't think that way but I couldn't believe this. I didn't want an excuse, especially eight months later. They could have called and said, "Hey, I had a flu that day, sorry I couldn't make it," but they didn't have the guts and that bothered me.

Coldness and Rudeness usually overlapped with discussions of Anger or Sadness:

P16: And I, and he uh, I can't, I can't remember too much, but I just remember being so upset. And ((the doctor's)) attitude and how goofy he acted. His behavior wasn't serious at all, it was goofy...And, uh, and then, the next thing

I remember is, the arrogant brain surgeon coming in...he didn't have his scrubs on or anything. And he starts to tell me, in this really pompous way, that she's just come back from surgery, and that they couldn't operate on her because she would bleed to death.

P19: I can remember being there at home, with my brother and he seemed to have, I can remember he had no compassion...He seemed to me like he was indifferent...I thought how could anyone think like this. After all these years, that everything would be over in a month. And then after that I just went into a depression, and I was in a depression.

The majority of people (four out of five) who described fights and conflicts also described feeling relieved. However, in only one instance was the experienced relief a result of solving the conflict:

P22: So I'm talking on the phone with the hospice, begging, pleading them to take ((my husband)) in because the nurses said he could have lived for months- if you call that life, he could have been on those machines for months...Then right before all of this, the medical ethics experts come and she said, "This is the clearest case I've ever seen in my entire career that someone should not be kept alive"... So we take him in and I put him in bed, which was such a relief

because there were no machines. No machines! No machines!
Oh my God, it's wonderful not to have all of those machines!

The other patients experienced relief as a result of the death, when they no longer had to wait in tension for the inevitable to happen, or when they had a momentary reprieve from bad news:

P3: Part of me is relieved because the waiting is over and now we know when it's going to happen because it did.

P16: And I feel, I don't want to leave her there ((at the hospital)), I was afraid...Oh, I kept checking the phone and nobody called...And so, I was scared, and relieved at the end of that day when I hadn't heard.

Thus, the theme, Relief, was often conceptually linked to the death itself.

4.4.3 Reactions to the Deceased's Appearance

When patients reacted negatively to the deceased loved one's appearance, most (eight of 11) described reacting this way when first encountering the corpse at the morgue or at the family viewing. Interestingly, patients never described having negative reactions at the funeral itself. Three patients reacted negatively to the appearance of the deceased *while the person was still alive*; that is, they were appalled at the appearance of a dying individual.

Patients tended to discuss positive reactions to the deceased's appearance and family and friends who were there for them close together in the revisiting exercises, within 25 sentences.

P1: Friends from Montana and New York, family from Alaska and Bethlehem. People start arriving...I go back and he's against the wall in the hallway. The body bag is unzipped to the middle of his chest. He has his leather flight jacket, he has his...pullover, all the things that were important to him. He looks quiet. He looks at peace.

P7: They put their homemade (afghan) over her and I have to admit, when they did that, she looked like the mother I used to know and love...There were a lot with my mother being the age that she was, 79. She had a nice amount of flowers and then there was a little cherub arrangement inside her coffin that [people] had sent...

P9: I told [the embalmer] what a great job he did. I told everybody that hadn't seen him for awhile. I told them that he always looked good. He never lost weight, he never got really sick. It was just with pain that really brought him down...I feel that it's really good to have your family, your children and your loved ones, and your friends around because when you're talking to a lot of people you kind of put aside that [he] had passed away.

Focusing on supportive family and friends alongside a positive reaction to the corpse did not occur in the absence of negative emotions, however. All patients, except one, who discussed Being There and/or Positive Reactions first expressed their extremely emotionally charged reaction to the loss:

P1: I can see myself just shaking my fist in the air saying, “No, no, no!” ((when first hearing of the death))... I go back and he’s against the wall in the hallway....He looks quiet. He looks at peace.

P4: It’s just an awful feeling. I can’t even describe that feeling. It’s a feeling that I wouldn’t wish on anybody. It was just ah...it was the worst day of my life. It was the worst day of my life. It’s just sad. It was just a sad time...It was just a sad time for all of us...it was just awful...terrible...it was a sad time for all of us...sad...sad...She ((the deceased)) had pink on...she looked real pretty...she looked real pretty.

P7: I’m so shaken up I thought, “I’ve got to be with somebody,” so I picked up the phone and called [my best friend] and [her husband] and [her mother] and my mother had been best friends all of their lives...I was so shaken up, I didn’t even think to tell them to call her doctor... They put their homemade (afghan) over her and I have to admit, when they did that, she looked like the mother I used to know and love...

Thus, “positive” themes such as Being There and Positive Reaction to the Deceased’s Appearance, when taken in their full context, occurred only after describing extremely negative and emotionally charged reactions.

4.5 Subsample Results

Since half (n=11) of the total sample possessed similar demographic characteristics, I examined common themes and similarities inherent in this group. Each person in the subsample met the following criteria: a) female, b) experienced a non-violent loss, c) Caucasian, d) over age forty. The primary losses described in the narratives were as follows: five patients lost a mother or mother-in-law, two a child, and four a husband. Narratives from each person in the subsample were either from the second, third, or fourth revisiting exercise in Complicated Grief Treatment. While these were the patients’ last full revisiting exercises, none occurred at the end of treatment.

4.5.1 Anger and Social Support

The core theme for this subsample was anger. Ten women in the subsample expressed angry feelings throughout their narratives, particularly toward unsupportive living individuals. One patient in the sample, while not expressing the overt anger shown by the others, nonetheless voiced deep dissatisfaction regarding family members’ behavior. Typically, the families of the patients were the recipients of the anger but in two cases, medical or religious professionals were the recipients. The following section summarizes the central issues angering the patients.

Patient Three

Patient Three's mother-in-law died in a hospital while the patient and other family were present. However, the patient felt that no other family members except her father offered support during this time. She was upset that others acted normally when faced with death.

I feel like there shouldn't be any talking or laughing. I find it such a strange place to be. I can't imagine people talking like it's normal and interacting like it's normal.

I want to scream and yell, "Can't you all just do this? Your mom wants to die and you're all talking about where you're going to eat!" I seem to be the only one that is fazed by any of this. I think maybe everyone is putting on a good face. I'm just feeling like I have to try to keep it together. I'm just sitting in this chair where I've become very (comfortable), watching as though I'm not even there. But I'm there.

Part of her discomfort arose from feeling like an outsider with her husband's family. Thus, her only true support came from her immediate family. Her father offered practical support such as driving her to the hospital as well as simply being there for her. However, her extreme discomfort with her in-laws, compounded by the distress she felt at the death resulted in her expressing her feelings as anger, although she did not describe actually lashing out at her relatives. Rather, she kept her angry feelings to herself. She was a bystander for much of the family discord, as she watched relatives bicker over the extent to which the children should be present at the hospital and the aftermath.

Patient Seven

Patient Seven's mother died in the patient's house due to congestive heart failure, and the patient discovered her mother's body hours after death. The primary recipient of her anger is her sister, whom she felt did was not there for her, did not offer the medical assistance that she could have given her training as a nurse, and was essentially cold and unfeeling. Patient Seven was also dissatisfied with the poor turnout at the funeral and with relatives who did not attend and neglected to send flowers. This behavior communicated to her that no one cared, and in response, Patient Seven felt angry and alone.

It took a half an hour to locate her. I don't remember her being there at all. She just said ((unclear)) to me on the phone, "Well, I want the body embalmed," because I told her that they said that mother was dead and she said, "Well, I want the body embalmed. I wanted her to say, "I'll be right over, don't let anyone touch her, have they tried to jump her or anything?" I wanted her to be there for us and she wasn't. ((Therapist asks for SUDS level)) Ten, it's definitely at a ten. I was so sad my sister didn't show up.

While Patient Seven mentions by name friends and family who did come to the funeral, offered food platters, and helped to honor her mother, she concludes each discussion of helpful support with declaring that there was not nearly enough people doing such things and the primary individuals who should have been there were not.

Patient Eight

Patient Eight's son died from a drug overdose. She did not seethe with the anger described by the previous two patients, but she describes being annoyed by others and having a short fuse.

We stopped somewhere and had some lunch. The rabbi showed up. I guess I expected to be somewhat comforted when [he] came. He made it more of a social visit, gave us restaurant reviews, it was awful. ((Therapist asks for SUDS level)). It's around 50. It's just, I don't know. All I can remember is all these people being around. The next day the funeral was at ten o'clock in the morning. I guess the limo picked up my daughter, son-in-law, and her girlfriend at their house and then they picked us up and we went out to [location deleted]. I remember having a very inadequate driver, he didn't know how to get there. It was just very annoying having to give directions. I didn't give directions but just having to listen to them, you know. Directions on where they found him, where he was going.

The revisiting exercise ends with Patient Eight mentioning the kindness of friends who arranged a brunch after the funeral, although she does not express receiving much comfort from the gathering and instead criticizes the party-like atmosphere.

Patient Nine

Patient Nine's husband died from lung cancer, but his decline was precipitated by a doctor's error. In contrast to the previously described patients, Patient Nine felt supported by her family members, who surrounded her throughout the ordeal and offered practical aid. Her

anger, then, was directed solely at the medical professionals whom she blamed for her husband's suffering.

We called a doctor from [the hospital] and we were talking to the doctor after we got his blood pressure up. We said we couldn't understand how fast he was going down, and he was the one who told us that [our doctor] punctured his lung, which [my husband] was very upset about, and I was very upset, and the children, and the family and everybody.

Throughout her revisiting exercise, Patient Nine became increasingly worked up at this incident. However, the revisiting exercise closes with her emphasizing the importance of family and having your loved ones around you.

Patient Ten

Patient Ten's mother died of an illness in the hospital. The narrative is filled with anger at a number of individuals: the hospital and the nurses for mysteriously allowing her mother to rapidly go downhill, her siblings for constant fighting over funeral plans and other arrangements, her father for embarrassing her at the funeral, for other family members preventing her from expressing her grief.

I walked out to the waiting room, um, my brother [name omitted] is there, my [other brother and his wife], and they're trying to discuss, you know, what are we going to do with mom, the arrangements. My sister [name omitted] says that um,

she'll take care of everything. And [my brother] is arguing, you know, "Well, what do you mean." I said, I said, you know, "Well what about Dad? Dad should have a say in what goes on."

Although family members were present throughout the death and aftermath, Patient Ten does not describe receiving any clear support from any of them. She struggles with her realization that she is grieving harder and longer than the rest of them, even at that early stage.

And [my nephew] sat in the chair at the end of my mom's bed. And after the priest, after the nurse told me that the priest did not come because there was a minister there the night before, and the minister said that there was no need for the priest to come, because my [sister's friend] was the minister. Um, after she told me that I tried to go back in the room only [my nephew] was in there. ((Therapists asks for SUDS level)) Eighty. And I walk, I walk in and I try to talk to her, and I, and I look at [my nephew]. And I just feel bad. [He's] so little, he's my, he's my mother's grandson. So I go out. And I stand in the hallway, and I just stare in the window. And Matt just doesn't leave. But everybody else wanders in and out, and then they come out, and then [my nephew] just stays there. Finally, it's, it's time – ((Therapist: You're thinking as you're standing.)) It's not fair, why can't I go in? Why can't I just say to [him], "Do you mind if your Aunt [name omitted] stays in here for a little bit?"

Patient Ten's entire narrative, then, focuses on her internal struggles versus the strife she experiences in her family.

Patient Twelve

Patient Twelve's husband died from cardiac arrest while she was away visiting her ailing father who dies eventually as well. Like Patient Ten, Patient Twelve's siblings are present at the hospital with her at her father's bedside but their presence is extremely troubling to her. Her husband seemed to be the one person whom she usually relied upon and his death completely overwhelms her.

I decided I should go home and call [my husband] and tell him about the meeting with the doctor and my brother, so I could talk with him. I wanted to talk with [my husband]. ((Therapist: So are you still upset from that meeting?)). With my brothers. ((Therapist: Yeah. So what are you thinking and what are you feeling about that?)) Just sorta angry at my brothers, especially the one saying, being selfish ((unintelligible)) my dad on his i.v. And I want to talk with [my husband]. He knows how much I care about Daddy. He knows how I feel. He's my partner. He wants to hear this from me because there's no one else I can talk to about this. So I go home, I call him. His line's busy.

At the end of the revisiting exercise, Patient Twelve also expresses anger at the fact that her husband died. Thus, her revisiting exercise begins with her anger at her brothers and ends with her anger at the loss.

Patient Fourteen

Patient Fourteen's husband died in a hospital from prostate cancer. While she experienced various mixed emotions at his death, including anger over a previous extramarital affair of his, she did not discuss her anger in her narrative or in any revisiting exercise. Rather, this anger is discussed in other aspects of the therapy, particularly the imaginal conversation with the deceased. Patient Fourteen did describe in her last revisiting exercise, however, her dissatisfaction at her daughter failing to come to the funeral, and she does not describe any available social support.

Patient Sixteen

Patient Sixteen's mother died in the hospital after suffering from an illness as well as a serious fall at the facility. She expresses extreme anger, and her revisiting exercise includes expletives directed at the doctors and nurses whom she holds responsible and whose attitudes infuriated her.

And the doctor says these condescending things, like, um, like he wouldn't expect a layperson to understand, but there is some, because the, because the brain shrinks after a person is so old. And there's space between the brain and the skull, and I said, "Wait a minute, wait a minute. Just tell me what happened." He said, "I'm trying to explain to you, and you're obviously not listening to me, maybe you don't understand." He said something condescending and I got so angry, and I said to him, I said, "Enough of the anatomy lesson. What the f--- happened here?" And then he got really mad, because he didn't like my language.

Her sole supporter is her husband, and she describes his comforting presence. However, he is limited by his own health in the amount of support he can give.

Patient Eighteen

Patient Eighteen's infant son died suddenly and inexplicably from cardiac arrest. She directed a mild anger toward her rabbi for his pushiness in making funeral arrangements.

I call the rabbi and he gets on the phone and I tell him that [my son] is dead and we are at [the hospital]. That they are going to do an autopsy tomorrow and he asks how long are they going to keep the body and I say I don't know and he says that we should have the funeral on Wednesday, but he doesn't know what time and he asks what funeral home we are going to use and I tell him [the name of the funeral home] and he says that he is going to be there tomorrow for a funeral and he will let them know what time [my son's] funeral will be and they can let me know. He says that the only appropriate thing to do is to have a graveside service and I say okay, but I am really thinking I really don't want a graveside service. ((Therapist asks for SUDS level)). About 30. I am a little bit mad about the graveside service but the rabbi didn't make it sound like I had any other choice and then I get off the phone with the rabbi and I go into the room where [my baby] is.

Patient Eighteen also is upset at the hospital for their inability to help her son or to officially explain the cause of death.

Patient Twenty-one

Patient Twenty-one's mother died in a hospice, and her anger is aimed at medical personnel whom she feels caused harm to her mother by defeating her hope.

I'm upset at one of the nurses because she told my mom that she (didn't need) to continue her ((unintelligible)) injections, because she had cancer. If I was there I would have ripped her head off because it (hurt) my mother. Her spirits were totally down in the gutter because of this one person. The ((unclear)) was for the blood clots and she gave them to herself twice a day in the abdomen, it was a needle. She said, why take the ((unclear)) if I'm just gonna die and the nurse said, "Well, you know, you don't have to take it." Then I called hospice so I said I know one...person who...she's giving her no hope. I said, "I don't care if the shots work or not, it's still something she wants to do, it's just a little grain of hope."

Patient Twenty-one was also furious at friends and family who were not supportive to her; specifically, she was angry when others did not show up to simply be with her in her grief.

I went back and I felt her pulse and all that and there was nothing there. I thought, "Admit this is it, this is life without Mommy." I called Dave ((name changed)) to come and he didn't. ((Therapist asks for SUDS level)) A hundred! ((crying)) He didn't come. The question I have is, I don't know if I can forgive him and I forgive

everybody for whatever happens and that's the same for me. He didn't come and I can't get that out of my mind.

Fifty sentences later, Patient Twenty-one focused on how the absence of two relatives at the funeral angered her:

I had two close cousins that we used to stay at each other's houses all the time and the two of them never came and it just hit me about a month ago and it really upset me. All through childhood we were extremely close and not a card or a call. Their parents came, and I thought, "How dare you?" I know I shouldn't think that way but I couldn't believe this. I didn't want an excuse, especially eight months later. They could have called and said, "Hey, I had a flu that day, sorry I couldn't make it," but they didn't have the guts and that bothered me.

Thus, Patient Twenty-one repeated themes of anger and frustration throughout her entire narrative.

Patient Twenty-two

Patient Twenty-two's husband died from a brain tumor. She reports having a lot of conflict with the hospital regarding terminating medical procedures and allowing him to come home.

So, [the doctor], the junior partner surgeon, who [name omitted] and I loved and trusted, he called and I said, "Please [doctor], let me get him out of here."

And he said, "[the other doctor] wants to put him on kidney dialysis." Well, I just lost it, I mean, why? I said, "Please, you've got to let me take him out of here." He said, "Well, [the other doctor] isn't here and as long as he isn't here, you can go."

While she does not describe receiving any support from friends or family, she does express relief at the hospice care that she was eventually able to procure for her husband. He ultimately dies in the hospice.

4.5.2 The Relationship With the Deceased

In this section, I presented excerpts from the revisiting exercises among 11 subsample patients. The unifying theme among the subsample was anger, and the patients directed anger at living, unsupportive persons in their lives. Since none of the 11 patients experienced a violent loss, other variables, such as unsupportive social networks, contributed to the heightened and persistent grief experienced by these patients. Six of the 11 patients described wholly unsupportive social networks (that is, they never described receiving any support from friends and family), and many of the patients were still furious about this, long after the loss.

Secondly, patients utilized language indicating extremely close relationships with the deceased. Many of the patients who lost parents, specifically, mothers, used very tender language when discussing the deceased parents. For instance, Patient Twenty-one tells herself, "Admit this is it, this is life without Mommy." Patient Sixteen describes her upset feelings at her mother's injury in the hospital, "And this is how I'm finding out about this

experience, and I'm looking at my precious mother, who is so beautiful and she's, her face is covered by this white bandage, and to see her face."

Patients whose husbands passed away emphasized the marital bond and love that was shared. Patient Twelve says of her deceased husband, "He's my partner." Patient Nine states, "Because [my husband] and I had such a wonderful marriage, the children never saw us fight and we never left each other..." Patient Fourteen narrates, "So I got up, and I kissed him, and I said to him, 'Goodnight, Sweet Prince.'" The two patients who lost their sons (one an infant, and one adult) did not speak tenderly of their relationships and did not focus on the quality of the pre-loss relationships.

For those who had lost parents or spouses, then, the relationships appeared to be extremely close. The heart of many of the patients' distress seems to be the loss of a primary (if not *the* primary) relationship in their lives combined with unsupportive social networks that made the grieving process even more difficult. Perhaps the loss of a child is a sufficient stressor for heightened grief, whether or not it qualifies for Complicated Grief, regardless of the quality of the relationship or the age of the child.

In the following sections, I explore two additional issues that troubled the patients: blame for the loss, and the appearance of the deceased.

4.5.3 Blame

Three of the four patients who blamed others in their revisiting exercises belonged to the subsample. As mentioned in section 4.1.3, blame and anger overlapped in the narratives.

Patient Nine blamed the doctor who punctured her husband's lung for his rapid decline. In this excerpt, she continues precisely where her last excerpt left off.

'Cause like I said, we all make mistakes- none of us are perfect. But he could have told us what happened, which I think would have made it easier on us and [my husband] knowing what the problem was and how it was going to affect [his] life. After that, he was on oxygen 24 hours a day. As the weeks went on, it got worse, and they turned up the oxygen just as high as they possibly could.

As with all of the patients blaming others, Patient Nine's descriptions of blame permeate the entire narrative. She resumes her meditation on the doctor's culpability sixty sentences after the above excerpt ended.

After I finished my cigarette and finished my tea, I went into the house and the children were there, and my friends and that. I said to them "Do you know who that was on the phone? It was [the doctor]." I said, "He has to be guilty, because doctors when you call them don't call you back, let alone 11:00 at night." But everybody tried to comfort each other, and we were to be at the funeral home. I put aside [the doctor] at the time, but he was still in the back of my mind. I was still very angry with him.

Thus, Patient Nine ruminated on this issue throughout her narrative and apparently throughout described events.

Patient Sixteen blamed the hospital in general and the overseeing doctors for her mother's accident in the hospital. Primarily, however, she blamed the nurse on call. The

following excerpt continues immediately after Patient Sixteen's expletives toward the doctor, as previously presented.

He didn't like the language, and so, he's very angry, and I'm angry, and somehow, somebody tells me to leave. I think he did. And um, (I wasn't out of control or anything). I was angry. And then, whenever I was sort of ushered out into the hall, there was this cluster of nurses, and I'm still trying to find some answers, and that I'm really mad. And the nurse that I had told you had been negligent was a black nurse, and she takes my hand and she says, "Listen, it was an accident, don't you know accidents happen? It was an accident. It's nobody's fault." And I just went like this, and took her hand off my wrist and I said I want to know what happened. She fell, she fell, things happen, and so on. Now I can see that I'm getting lessons in behavior, I'm getting lectures.

Patient Seven blamed her ex-husband for contributing to her mother's decline.

You've hurt my mother so badly, including her daughter, through everything you've put me through, making her life rough and causing her to have buy car insurance for your kids. That was your responsibility, not hers. Probably stressed her out in her old age.

Thus, two people who were close to her relationally, her sister and her ex-husband, were the prime recipients of her blame and anger.

For the patients in both the full study and subsample, blame never occurred in the absence of angry tirades, although most patients described angry feelings without directly blaming anyone.

4.5.4 Appearance of the Deceased

The majority (seven of eleven) of patients in the subsample focused on the appearance of the deceased. Similar to the full sample, most of these reacted negatively to their loved one's appearance. Which patients repeatedly focused, in their revisiting exercises, on the corpse's appearance, and which did not? The four subsample patients who did *not* focus on the deceased's appearance were not present for the death itself. Rather than being distressed at the appearance, then, they were upset that they missed the precise moment of death.

P14: *After a while, [name omitted] said "This is going to take awhile- why don't you try to take a little nap?" So I said ok, and I sat in the chair and I guess I fell asleep, 'cause it had been a long day, and I don't know how many hours we had already been there. So after a while, I don't know how long it was, [name omitted] awakened me, and he said "He's gone." Well, that was a shock. I didn't want to be asleep while he was in his last moments of life. So I got up, and I kissed him, and I said to him "Goodnight, sweet prince."*

P12: *If he wasn't alone. ((crying)) I could've kept him alive until the ambulance came. I could have, I know I could have. And I wasn't there.*

*And I wasn't there. And nothing came in time. And he's gone.
He's gone.*

The patients who *did* focus on the deceased's appearance, then, all were either there as the person died or discovered the body shortly afterward. Patient Eight, who neutrally discussed the deceased's appearance, rushed to her family's side as they pieced together the facts of her son's drug overdose. For those who focused on the deceased's appearance and had a strong reaction, all maintained a mental image of the corpse that they had observed in person.

P7: *Right at this moment I'm walking into my mother's house and it's very still and I go into the kitchen and into the living room. I can't believe what I'm seeing. It's just this form that's sitting straight up in the recliner that has the pink thermal blanket that she always used in the winter. It's just so still and I call out, "Mom, mom, mom." There's no movement, there's no answer. There's no nothing.*

Thus, subsample patients who were troubled by the appearance of the corpse had seen the deceased loved ones at the moment of death or shortly afterward. This finding translates to the full sample as well: both the full sample and subsample patients who had negative reactions to the appearance had either been present for the death or had to identify the body at the morgue, with the exception of three patients. Of these, two had lost a child, and the image of the dead child at the family viewing was startling to them even without having seen the corpse at the time of death.

Additionally, both the full sample and subsample patients who described having negative reactions to the deceased's appearance also described such reactions in conjunction with events at the family viewing or the morgue rather than the funeral itself.

For two of the subsample patients, the distress at the loved one's appearance began even before the death itself. For instance, Patient Three couldn't stop staring at her mother-in-law's appearance, altered by Lou Gehrig's disease:

P3: *She was—she's very, very, very thin. We kept asking how much she weighs and I know they're lying. She's so frail, skeletal-like...She's crying and her face is in this ALS face; I'd never seen that face before, but since she passed away I watched a TV show and the people they showed on it had the same face. It's sort of—she's sort of scowling. Well, she's scowling, but her jaw is kinda locked open and her eyes are kinda back. Sorta like a skeleton. Her slobber is coming out...She's telling me that she's going into the hospital, that she doesn't want to do this anymore. I don't tell her that, but I know I'm thinking I want her to stay...I'm having a conflict in my head because if she stays she's not going to get better, she's getting worse.*

Patient Sixteen, concerned over her mother's unhealthy appearance at the hospital, stated:

I didn't think that my mother would be going home because she looked so grave; she didn't look healthy...Just judging from what she looked like, I

don't think that she, deep down inside, I didn't think that she was going to come home.

Both patients, whether knowingly or otherwise, used imagery connoting death when describing their dying loved ones. Patient Three saw her mother-in-law as a skeletal figure, unlike the woman that she had previously known. Patient Sixteen uses an odd word, “grave” that makes little sense when applied to her mother’s sickness. While perhaps a description of her mother’s sad countenance, the narrative context indicates that Patient Sixteen was focused on the physical changes in her mother that were convincing her of her mother’s imminent death. These two patients illustrate that it is not only observing a corpse that distresses patients with Complicated Grief; evidence of the patient’s difficulty coming to terms with the physical manifestations of death may be present even prior to the death. This may particularly be the case for patients such as the two presented above, for whom the contrast of a lovely mother figure and the image of a dying and disfigured individual proves to be too troubling.

4.5.5 Subsample Summary

Narrative content in the subsample followed similar trends as the full sample. Most patients responded negatively to the appearance of the deceased and described these negative reactions at similar times within the revisiting exercises. Anger was the most frequent emotional theme. However, exploring a homogenous subsample of patients in-depth revealed one unifying theme for all 11 members of the subsample: anger. Anger was the one theme that was present and pervasive in all 11 revisiting exercises.

Other important themes connected to this central one. Patients primarily directed anger at unsupportive individuals in their lives, and many patients in the subsample kept returning to their angry feelings throughout the revisiting exercises. A smaller number of patients were angry at individuals whom they blamed for the loss. It is unclear from the narratives whether patients were suspicious of certain individuals and became angry at them or whether their elevated grief and depression resulted in lashing out at persons whom they thought were culpable; that is, whether grief and anger caused blame or vice versa. However, it was clear that feelings of anger always accompanied blame.

Finally, exploring the subsample revealed that persons struggling the most with the appearance of the deceased tended to be persons who had seen the corpse at the time of death. In the revisiting exercises, describing the family viewing seemed to trigger this fixation on the appearance of the deceased. Since none of the subsample patients suffered a violent loss, it was not the maimed remains of a loved one that traumatized them but rather the visual contrast between a greatly valued loved one and his or her inanimate body. This was particularly evidenced by patients who became fixated with the loved one's macabre appearance prior to the death.

4.6 Chapter Summary

This chapter explores the content from the last revisiting exercises completed by 22 patients who received Complicated Grief Treatment. Major thematic categories included Emotions, Cognitions, Social Support, and Focus on Death. While the most frequently described emotion was anger, nearly all revisiting exercises contained both negative and positive emotions. The level and quality of social support was a primary focus for most patients,

particularly if patients felt that they had non-supportive social networks. Patients tended to evaluate themselves, usually negatively, during their narrative accounts. For a fewer number of patients, relegating blame and asking why the loss occurred were important cognitive themes. Finally, most of the patients focused upon the image of the deceased individual, and these patients most frequently described having negative reactions to the deceased's appearance.

Correlations between themes and symptom scores did not occur in the expected direction; positive emotions directly correlated with depression scores. However, correlations were not consistently significant.

Collapsing themes into positive and negative categories revealed that the revisiting exercises contained more negative than positive themes. Patients more frequently discussed negative emotions than positive and devoted more time to specific negative emotional themes. Patients devoted more narrative space to discussing non-supportive rather than supportive social networks. When patients evaluated themselves, they devoted more narrative space to negative self-evaluations than positive self-evaluations. Finally, having a negative reaction to the deceased's appearance was more common than having a positive reaction.

However, the use of themes in the revisiting exercises was more complicated than anticipated, and "positive" and "negative" categories did not do justice to patients' narrative content. For example, descriptions of love did not occur in the absence of describing loneliness, sadness, guilt, and anger.

Exploring a subsample of patients confirmed the prevalence of anger in the narratives, particularly in revisiting exercises from the first half of treatment. Studying this

subsample also revealed that patients experiencing negative reactions to the deceased's appearance had either been present for the death or arrived shortly after and observed the shocking image of the corpse. Furthermore, they described responding negatively to the deceased at the family viewing or the morgue rather than at the funeral.

This content analysis of the revisiting exercises of Complicated Grief Treatment indicated that patients weaved positive and negative themes together but primarily focused on themes that troubled them, such as unsupportive family and the corpse's appearance. Although patients were told to tell the story of the death, for most, living friends and family and how they aided or obstructed the patient's grieving was integral to their stories. In the final chapter, I interpret the results from this research and indicate its relevance to Complicated Grief research.

5.0 Discussion

This study explored the content of revisiting exercises, stories patients told regarding the death of a close loved one. These exercises were conducted in therapy sessions; all of the patients in this study were receiving treatment at the time for Complicated Grief. The intent of the study was to observe themes and patterns within the stories, with the intent of gaining an understanding of the nature of the disorder as well as the experiences of patients in the study. Exploring the revisiting exercises entailed tallying thematic frequencies and mining narrative text as well as utilizing statistical tools to compare narrative themes and symptoms scores. In this chapter, I first revisit the central narrative themes as I address the primary question of the study, “What is the content of the revisiting exercises?” I conclude this chapter by presenting implications and recommendations for Complicated Grief and narrative research.

5.1 Content of the Revisiting Exercises

In interpreting results from this study, it is important to note the full context of the revisiting exercises. First, patients participated in structured revisiting exercises as part of their psychotherapy treatment for Complicated Grief. Each patient was instructed to tell the story of the death beginning when he or she realized that the death was imminent and ending at the burial or cremation. While therapists invited patients to discuss their thoughts and feelings when doing revisiting exercises, therapists did not specifically instruct patients to focus on

any topic other than the story of the death. The narratives from the present study represented the last full revisiting exercise available for each patient.

It is also important to note that patients in this study received treatment because their symptoms were intolerable to them. Thus, this project includes a group of individuals who met criteria for Complicated Grief, sought help for their symptoms, and participated in the treatment long enough to tell their stories in the revisiting exercises. This distinguishes this project from grief narrative studies with samples of grieving participants who were not screened for Complicated Grief symptoms and did not tell narratives as part of their treatment.

With this context in mind, what themes were evident in the revisiting exercises? The following sections discuss the three primary and prolific themes in this study: Negative emotions, Social support, and Appearance of the deceased.

5.1.1 Emotional Content

The narratives in the present study contained more negative than positive content, in the domains of emotions, cognitions, and perceived social support. Patients devoted more narrative space to negative themes than positive themes and negative themes occurred more frequently, overall, than did positive themes. Specifically, negative emotions were the most frequent theme in the study and patients primarily focused on feelings of anger and sadness.

However, patients in this study integrated negative and positive emotional themes. For purposes of collapsing the themes for quantitative analysis, I labeled the following emotional themes as “Positive”: Happiness, Relief, Love, Pride, Comfort, and General Positive Emotions. “Negative” emotional themes included Sadness, Helplessness, Anger,

Fear, Distress, General Negative Emotions, Guilt, Unreality, Loneliness, and Numbness. I based this judgment on the text surrounding each emotional discussion and evaluated whether the patients experienced the emotions as being pleasant or unpleasant.

Analyses revealed that patients described positive and negative emotional themes near each other. Specifically, patients focusing on feelings of love also discussed loneliness, sadness, guilt, and anger nearby in the narratives. It was clear that a supposedly “positive” emotion such as love possessed bittersweet qualities for the patients.

In explaining these findings, one must consider the nature of Complicated Grief. While traumatic distress symptoms such as numbness and bitterness make up the second criterion of CG (Prigerson et al., 1999), separation distress symptoms such as yearning for the deceased and loneliness make up the first criterion. Thus, the very nature of this disorder reflects that symptoms are bittersweet, as CG expert M. Katherine Shear described in a meeting with me (June, 2005). The person is both distressed because of the death yet loves and longs for the deceased individual. Narrative content in this study reflected these dual characteristics. Thus, positive themes such as love and comfort are not entirely “positive” themes. Themes in this study were more complex than simple “positive” and “negative” categories indicate. The following section addresses the finding that patients integrated negative and positive themes.

5.1.2 Integration of Themes

Patients’ mixed emotions were most evident when they described their feelings at the funeral. It was primarily here that patients described looking at the deceased and feeling love for that person, but also described many mixed emotions such as grief and loss. Patients also

sandwiched descriptions of love for the deceased between angry tirades at unsupportive friends and family, although love often closed the revisiting exercises. Perhaps it is remarkable that patients meeting criteria for Complicated Grief and exhibiting elevated levels of anger and sadness were able to describe emotions such as love at all. Yet, nine patients did so. It is evident the patients did not have cold, distant relations with the deceased loved one prior to the loss; rather, they strongly loved the individual and still feel that love, intermixed with grief and anger.

While it was expected that greater expression of positive emotions in the revisiting exercises would be associated with lower patient symptoms at the end of treatment, non-parametric correlations found no significant relationship between positive emotions and patient symptoms. However, the direction of the correlations was consistently positive for both the BDI and ICG, opposite the direction that was expected. Further explorations of the revisiting exercises revealed that emotional content was so mixed and bittersweet that discussing a “positive” emotion such as love also brought up unhappy and lonely feelings for the patients. This suggests a different trend than is found in natural grief narrative studies, which report exclusively positive emotions as being the most prevalent themes (for instance, Maercker, Bonanno, Znoj, & Horowitz, 1998).

In Maercker et al.’s (1998) work, positive narrative themes significantly and inversely correlated with grief symptoms. Negative and positive themes were not found to be inter-related. Other studies such as Bauer & Bonanno (2001-a, 2001-b) found significant, inverse correlations between positive cognitions and grief symptoms. Indeed, some of the greatest success in terms of finding statistical significance has come from exploring positive cognitions and grief symptoms rather than positive emotions (see Pennebaker, Mayne, &

Francis, 1997; Boeler et al., 2003). In the present study, neither positive emotions nor positive cognitions significantly correlated with patient symptoms. Rather, patients discussed positive and negative themes near one another and conceptually integrated them in the narrative text. For instance, patients layered themes of love and loneliness when speaking of the deceased loved one, often at the end of the revisiting exercises.

No study on natural grief has found negative and positive themes to be as integrated as was observed in the present study. Two explanations are possible. First, none of the prior studies exploring the relationship between narrative content and symptoms analyzed the data qualitatively; thus, they did not engage in an iterative examination of specific themes and may have missed complex relationships among the themes. While their work was extremely helpful for revealing that griever may speak of many positive themes in their narratives and this positive emphasis may be related to later outcomes, their work does not extend our current knowledge of emotional expression. As will later be discussed, work in related fields is revealing that specific emotions may have differential outcomes on various cognitive processes. It is simply not the case that all “positive” emotions and all “negative” emotions have the same effects. Future work would benefit if the fields of grief and emotional research became more conversant with each other so that each becomes more aware of these complex issues.

Second, the clinical sample of persons diagnosed with CG in the present study differs from samples of naturally grieving participants. Thus, another explanation for the integration of positive and negative themes is that this population differs from samples of naturally grieving participants in myriad ways, including, potentially, the ways in which they speak of their emotional states. In support of this explanation is the preponderance of negative themes

in all thematic categories in this study, while the totality of grief narrative studies report greater positive thematic expression in their participants' narratives. Indeed, the present study was unable to even explore the optimal ratio of positive to negative self-evaluations described by Bauer and Bonanno (2001-a) since only one patient in the sample had more positive than negative self-evaluations. Such a difference suggests that, even if natural grievers express emotions in more complex ways than previously noticed in narrative studies, it is likely that patients with CG still may emphasize more negative themes (and perhaps in more complex ways) than non-complicated grievers.

An additional difference between this study and natural grief studies is that grief researchers tend to over-sample conjugally bereaved individuals, whereas the Complicated Grief sample in the present study included four types of losses: the loss of a child, parent, spouse, or other relative, in approximately equal numbers. How might the type of loss experienced be associated with narrative differences? Of the nine patients who described feelings of love toward the deceased, four were conjugally bereaved. Furthermore, only two conjugally bereaved individuals in the present study did not report feeling love. Perhaps people experiencing conjugal losses are more likely to focus on love. In the present study, conjugally bereaved individuals did not appear to differ from other individuals in terms of other positive emotions such as happiness and relief. In studies examining samples of exclusively conjugally bereaved individuals, narratives of such individuals may contain more positive emotional content due to more frequent descriptions of love toward deceased spouses.

5.1.3 The Relevance of Social Support

Although therapists did not explicitly direct patients to critique their available social support during the revisiting exercises, most patients incorporated such critiques into their narratives. For many, social support was the central theme. This was especially the case among patients reporting particularly unsupportive social networks.

It is surprising that no connection was found between social support themes and patient symptoms, particularly since perceived social support is so heavily documented in the literature as being important for mental functioning (for example, Stroebe, Stroebe, Abakoumkin, & Schut, 1996). However, similar to the literature on the benefits of positive emotions in narrative content, closer inspection reveals that the benefits of good social support are not always straightforward. Stylianos and Vachon (1993) described how individuals' perception of good support depends on the person's actual needs. Support, even if well-meaning and potentially helpful, can be viewed negatively when it is unneeded or intrusive. Factors such as the timing of the support and the source of support are also important.

Furthermore, Stroebe et al. (1996) qualified their research on social support by asking whether good social support can ever truly compensate for the loss of a loved one. Stroebe et al. failed to find a buffering effect for conjugal bereavement and they debated whether social support could have a buffering effect for the death of a loved one. Death of a close loved one may be so troubling that even good support can do little to protect one from experiencing various grief symptoms. Particularly in a sample of persons with Complicated Grief, good social support may be impotent in decreasing grief symptoms. Relational Loneliness theory, which is built upon attachment theories, concurs with Stroebe et al. and states that no

friendship or social relationship can compensate for a lost attachment (Weiss, 1973). Dutch researcher van Baarsen (2002), in studying elderly widows and widowers, found that pre-loss social support did not protect the participants from emotional loneliness. Additionally, increases in network support after the spouse's death did not help the individual recover from emotional loneliness in the first two years of bereavement.

While good support may not buffer the effects of a loss, perceived unsupportive networks may add to the psychological effects of the loss. Indeed, the detrimental role of unsupportive social networks is clearly documented, while the benefits of supportive networks is a more complex issue, dependent on many things such as the actual needs of the bereaved individual, the timing of support, and the precise source of the support (Stylianos & Vachon, 1993). These multiple facets were beyond the scope of this study. What is clear from this study is that the connection between social support and CG is not a simple one; it is simply not true that any type of social support will result in lowered grief. One must take into account many facets of the support as well as the role of grief itself in influencing the perceptions of the bereaved.

It is possible that patients in this study overemphasized unsupportive social networks. Bonanno and Kaltman (1999) indicated that bereaved persons in general report having inadequate social networks, and they are especially likely to report unsupportive networks if they are depressed. Patients with Complicated Grief, then, may be particularly likely to emphasize unsupportive networks, since they evidence depressive symptoms as well as traumatic symptoms. Patients in this study described social networks that most people would acknowledge as being unsupportive. In some cases, however, patients viewed others' attempts at being supportive in a negative light. Depression makes an individual more likely

to perceive others through a dark lens, and may make the individual more likely to emphasize the bad support versus the good. Indeed, Ott (2003) found that a group of persons with Complicated Grief reported significantly more life stressors and perceived less social support than did a bereaved group without Complicated Grief. Two conclusions are possible: either persons with CG tend to have unsupportive networks or they view their networks more negatively. Further research could illuminate this issue more clearly. Results from narratives in the current study indicate that both conclusions may be true in this sample.

As the researcher analyzing the narratives, it was important for me to remember that narratives “are always representations of a lived experience and are subject to change and reinterpretation...Narratives organize memory, but are not pure memory storage devices” (Gilbert, 2002, p. 225). I relied on the patients’ descriptions of what occurred, although I also realized that all persons misremember events and that mental health can particularly cloud one’s recollection. From my perspective as a researcher, it appeared that many of the patients described startlingly unsupportive networks and that the stresses associated with fighting with loved ones over funerary plans, for instance, would be sufficient triggers for stress responses in many people. In other cases, however, patients seemed to not want to be comforted, and they pushed away available help or nitpicked the help that was given.

Results from exploring the subsample of eleven patients revealed that anger towards unsupportive individuals was the core unifying theme for this group. When I first began reading the revisiting exercises, I asked myself, “What is the central issue for this patient?” and “What in the revisiting exercises indicates why the patient had major difficulties in grappling with the loss?” Studying the subsample enabled me to conclude that that anger toward unsupportive individuals was the primary theme in the exercises that linked these

eleven patients. This anger seemed to be connected to other emotions. For instance, Patient Three felt alone in her anger; this heightened emotion separated her from other family members and forced her to grieve separately. For others, the blame and anger that they felt toward doctors and hospitals permeated their narratives. It was apparent that blame and anger were not simply past emotions that these patients felt at the time of the loss but were feelings that continued into therapy. Causality is impossible to determine in the present study, but results from this study raise issues for future and suggest that unsupportive social networks greatly contributed to the grief experienced by patients in this study.

5.1.4 Focusing on the Deceased's Appearance

Another theme that emerged repeatedly from the revisiting exercises was a focus on the deceased's appearance. Over half of the full sample focused on the appearance and the majority of these patients reacted negatively. These negative descriptions coincided with patient narration of the family viewing or morgue visit rather than the funeral itself.

Patients who focused on the deceased's appearance typically were present at the moment of death or shortly afterward. Nearly all patients who had a negative reaction to the deceased had seen the body at the time of death or had to visit the morgue to identify the body.

In interpreting these results, it is important to keep in mind that patients in his study had been bereaved for at least six months prior to entering treatment, and the average time of entry into the study was 40.4 months after the loss. Thus, three years on average after the loss itself, most still focused on the appearance of the deceased and many kept coming back to the startling and disturbing image within the narratives. This focus was more than just

remembering the person who died; most bereaved individuals think about their deceased loved ones frequently. Patients in this study fixated on what the person looked like as he or she died or what the person looked like in the coffin, the image etched firmly in the patient's mind.

Even patients who reacted well to the appearance (that is, making favorable comments on how well the deceased looked) initially responded to the death itself with extreme shock and emotional outbursts. Thus, it was not the case that the revisiting exercises of those having positive reactions had more positive emotional themes. Whether or not the reaction was positive or negative, patients who focused on the image of the deceased generally were present around the time of the death itself and had other strong emotional reactions elsewhere in the narratives. This fixation with the image of the loved one's corpse was present across types of loss; that is, people experiencing violent and non-violent losses alike described this dual aversion and fascination with the image.

Explorations of the subsample indicated the deep, close relationships between the patients and the deceased individuals prior to death. In many cases, patients described the loved ones as beautiful or looking good for their age. Even though none of the loved ones died a violent death, most patients who described the deceased's appearance felt repulsed and shocked at the image. For many, then, it seems that patients were unable to reconcile the contrast between their beautiful loved ones and the image of a corpse in their minds. Thus, the qualities that most disturbed the patients in the image were aesthetic issues such as makeup, clothing, and hair design. Patients seemed particularly troubled when the corpses did not look like the person that they had known and loved. Describing their feelings as they looked down at the corpse at the family viewing evoked a fixation and usually negative

reaction to the appearance. It seems that patients, when describing funeral events, were too distracted by social concerns and practical details to be troubled by the image. Thus, it was in the privacy of the family viewing that they were confronted with the troubling image. For most, this viewing was the second time that they had seen the corpse and their minds seemed to stray back to that first shocking image of the deceased when they looked down at their loved one at the viewing.

5.2 Implications for Complicated and Non-Complicated Grief Research

Analyses supported the notion that Complicated Grief is a syndrome in which patients experience mixed and often bittersweet symptoms: traumatic responses to the death, accompanied by persistent images of the deceased individual even years after the loss, as well as feelings of love and longing after the person who died. Complicated Grief is not currently included in the DSM but is under consideration for DSM-V. While excellent work has been done to identify and describe the core symptoms of Complicated Grief (see Horowitz et al., 1997, & Prigerson et al., 1999), it is important for researchers to further explore CG using a variety of methods in order to understand the nature of this disorder.

Narrative content in the present study included many symptoms described in the Complicated Grief consensus criteria from the research of Prigerson et al. (1999) and Horowitz et al. (1997), even though my original coding scheme targeted only emotional and cognitive themes. The theme, focusing on the appearance of the deceased, indicated the intrusive thoughts about the deceased that most patients in the study experienced, and this theme repeatedly emerged in the revisiting exercises. Another criterion of Complicated Grief, excessive anger, was unexpectedly prevalent. I expected anger to be present in the

revisiting exercises, but did not realize how pervasive and strong this emotion would be, years after the loss. Other criteria addressed in the revisiting exercises included distress symptoms of numbness and shock (subsumed under the thematic category, distress) and loneliness. Symptoms pertaining to patients' shattered world views and pessimistic outlook toward the future were not prominent themes in the stories of the death, but were addressed elsewhere in Complicated Grief Treatment.

In contrast to grief narrative studies (Bonanno & Kaltman, 2001; Bonanno, Mihalecz, & LeJeune, 1999; Maercker et al., 1998), the present study found negative emotional content to be much more prevalent in the revisiting exercises than positive emotional content. The most apparent explanation for the increased negative content in the present study is the difference between samples of naturally grieving participants and patients with Complicated Grief such as those in this study. The latter group represented people who a) met criteria for Complicated Grief, b) and evidenced sufficient personal distress to seek treatment.

It is important to keep in mind that the participants in the present study were a clinical sample. Natural grief research does not study patients seeking treatment for CG. Narrative studies of clinical samples of patients with PTSD, such as Foa's (1995) research and replications and extensions of her work (van Minnen et al., 2002) explored cognitions rather than emotions and it is unknown whether trauma narratives from psychotherapy treatments would also exemplify the elevated negativity observed in the present study. This study, then, is the first of its kind, exploring Complicated Grief treatment narratives obtained in a clinical setting and mining it for emotional content in addition to other themes. Furthermore, the

current study is the only known study to date that explores the narratives of patients diagnosed with CG.

Maercker et al. (1998), who studied the prediction of Complicated Grief by narrative themes, did not actually use a sample of patients with Complicated or Complicated Grief but accepted all participants who had been bereaved within a certain frame of time and who did not have bipolar disorder. Thus, it was not determined whether these participants met criteria for Complicated Grief, and these participants did not receive grief treatment. Maercker et al. examined a varied sample of griever to explore the connection between their narratives and Complicated Grief symptoms. They found that persons whose narratives *lacked* positive thoughts and emotions scored higher on Complicated Grief symptoms. The revisiting exercises in the present study were not exclusively negative, but they devoted more space to negative emotions and cognitions. It makes intuitive sense that Complicated Grief narratives, particularly in a clinical sample, would evidence greater negativity, and future research can explore whether this finding in the present study is observed in other studies of Complicated Grief. Based on the present study and Maercker et al., Complicated Grief narratives appear to have a more negative focus than the narratives of naturally grieving participants, although a comparison study would certainly be preferable for comparing the two groups.

Future work can also explore whether the central themes in this study are reported in other samples of persons with Complicated Grief. For instance, the large amount of narrative space devoted to critiques of social support could be important for future CG research. Understanding how to predict who is at risk for CG is an important issue, and it is likely that social support plays an important role.

The following sections explore specific issues for Complicated Grief research: the relationship between narrative content and symptoms, and meaning making by patients with Complicated Grief.

5.2.1 The Relationship between Content and Symptoms

While the correlations between patient symptoms and emotional content were not statistically significant, it is interesting that positive emotions *did not* correlate directly with lower patient symptoms, not even for study responders. Due to the small sample size, the presence of outliers elevated the Pearson correlations. However, the direction of the correlations was consistent, and correlations between the 16-week BDI and positive emotions ranged from .27 to .69.

Despite the limitations in the present study, the results suggest that positive emotions may not always predict good grief outcomes. Again, interpretations from the quantitative results in this study must be tentative due to the small sample and outliers. However, the results raise the possibility that positive emotions may not always directly correlate with lower symptoms in grief narratives. Upon closer inspection of natural grief research, it is clear that the field is fraught with mixed results and that positive emotional expression is not always beneficial even for samples of persons with natural grief. For example, Pennebaker et al., (1997) reported two studies, one of which found an increased use of positive emotions to be related to health benefits, and one which found no relationship.

Inconsistent findings in the literature could be attributed to incomparable samples. For instance, some studies examine emotional narrative accounts of traumatic losses, not restricted to death. Inconsistent findings might also result from methodological differences.

Pennebaker's research is a good example of work that consistently utilizes the same methodology: having participants write trauma narratives. However, his research has included widely differing groups, from non-bereaved college students to bereaved gay men. It is entirely possible and even likely that different results are found in different sample populations.

Recent research has virtually eradicated the long-held premise that "working through" grief (that is, delving deeply and directly into negative thoughts and emotions pertaining to the death) is necessary for recovery from one's grief (Stroebe et al., 2001). In criticizing the fallacies of the grief work position, however, an all-too-common reaction is overemphasizing the importance of positive emotions. While some researchers carefully state that it is not necessary to go through heart-wrenching stages of grief and that avoidance of negative emotion may be fine, the preponderance of work emphasizing the benefits of positive emotions implies that avoidance of negative content will result in optimal outcomes. This is as simplistic a position as the original grief work perspective. Lindstrom (2002), in arguing for a more moderate position, declares,

As professionals, we should certainly not recommend traditional grief work...However, we should not make the opposite mistake either: suggest that people...sedate and divert themselves by all means, or warn people about possible negative consequences of their loss-related thoughts or emotions. Such avoidance reactions may also become obsessive (p. 15).

The field may benefit from a more moderate position, holding that neither grief work nor the avoidance of negative emotions is necessary for all grievers.

Future work could explore the implication in the present study regarding the positive, although statistically nonsignificant, relationship between positive themes and depression levels among CG patients. Research should do so by solely examining death narratives, as opposed to the mix of trauma, grief, and other narrative accounts that often muddy narrative research. Narratives from patients with Complicated Grief may greatly differ from natural grief narratives; thus, future research exploring the relationship between content and symptoms should not mix samples of CG patients with samples of other grievers.

5.2.2 Meaning Making Issues

Rime (2001) as well as Neimeyer (2000) indicated that persons experiencing the sudden death of a loved one may especially need to search for meaning in the loss. All six patients in the present study who spoke of grappling with the meaning of the loss experienced a sudden or violent loss. This finding was identical to the results indicated in natural grief research, and it is likely that participants in prior studies who had experienced sudden or violent losses would have met criteria for Complicated Grief. It is not necessary for persons with CG to have experienced a traumatic loss. But, such a loss perhaps is *sufficient* to trigger Complicated Grief symptoms.

Meaning making, operationalized in this study as Asking Why the loss occurred, was not associated with lowered patient symptoms. Nonetheless, the fact that six patients grappled with this question many years, on average, after the loss, is an important one. These patients did not devote narrative space to searching for deep, existential answers nor did they

focus on questions pertaining to an afterlife. Rather, they stuck to more practical issues such as why a loved one had a heart attack without prior symptoms, why someone would murder a loved one, and why a loved one was driven to suicide.

In interpreting the narrative content, it is important to note that all patients in this study entered treatment a minimum of six months after the loss occurred, and the average time since the loss was approximately three and a half years. Davis et al. (2000) found that if patients did not find meaning in the loss within a few weeks of the death, they never reported finding it. It may be the case that, despite having Complicated Grief, 16 patients had already discerned some sort of meaning in the loss, and the six patients who explicitly searched for meaning in the loss had not previously found meaning. Perhaps these six patients did not find meaning shortly after the losses due to the traumatic nature of their particular losses. Davis and Nolen-Hoeksema (2001) indicated that making sense of the loss depends on the type of loss experienced and the patient's pre-existing worldview and that patients experiencing a violent or sudden loss may be more likely to grapple with meaning making. Likewise, a patient whose loss makes no sense in terms of his or her worldview might have trouble finding meaning and may therefore spend more time grappling with this issue. Thus, the six patients in this study focused on one primary meaning-based question, "Why?"

Neimeyer (2000) indicates that "Asking Why" is a meaning making question that typically occurs early in the grieving process. Meaning making is a dynamic process and grievers grappling with this issue typically focus upon many types of meaning making, from asking why the loss occurred to finding purpose in the deceased loved one's life. When cognitively processing the loss, individuals may re-evaluate the meaning of the lost loved ones' lives, the existence of a supernatural realm, and the legitimacy of existing social

support systems. Yet the six patients in the present study who overtly grappled with the meaning of the loss focused on the question, “Why did this occur?” For example, the following excerpts display the central issue each patient addressed when asking why the loss occurred:

- I was just wondering...I wonder if she was screaming, and if she was, why didn't those people hear?
- I just don't understand why this had to happen to her...I'm asking her, “Why? Why can she leave me like this? Why does she?” Why did my cousin die?
- And then I started yelling at him, what did you do to yourself, why did you do this? I just ask why did you do this, why did you have to do this?
- I'm asking the nurse, “Why? She wasn't sick, what happened?”
- And in the back of my mind I just keep picturing her laying in bed up there. And I want to know more...I want to know why.
- I was thinking, “You were supposed to work with (Jane), what did you do?”

Since these six patients' queries easily fit into my “Asking Why” category, it seems that this label is an accurate descriptor of their meaning making concerns. It may be that these patients never moved past this type of meaning making to consider other questions pertaining to the loss. This focus on a central issue may indicate that such grievors did not address other types of meaning making and ruminated on this one aspect of the loss: Why did it occur? Future research should further examine Neimeyer's contention that asking this question is a preliminary type of meaning making.

It is also possible that limiting the scope of the revisiting exercises to telling the story of the death contributed to the infrequent instances of patients discussing meaning making in the present study. Having an interviewer probe for descriptions of meaning making such as occurred in the Gamino, Hogan, and Sewell (2002) study may result in additional meaning making themes. Given the limited scope of the revisiting exercises (i.e. simply telling the story of the death), six patients nonetheless grappled with why the loss occurred within the confines of their stories, and all six had experienced sudden or violent losses.

5.3 Implications for Complicated Grief Treatment

Results from this study indicate that therapists addressing CG patients may expect a more negative focus among this sample than samples of natural grievers. Patients in this study delved heavily into their traumatic and distressing thoughts and emotions, and increased negative content was not related to increased symptoms. The present study supported the importance of CGT's goal of not avoiding but addressing negative content. Indeed, one of the theoretical underpinnings for CGT is that this treatment should be more successful than traditional IPT because typical depression treatments do not sufficiently target the intense grief that patients feel (see Reynolds, Miller et al., 1999). While Mackay et al. (2002) indicated that helpful cognitive behavioral sessions emphasized less negative emotions than did helpful psychodynamic-interpersonal sessions, it is important to note that overall emotional content tended to be negative in the cognitive behavioral sessions as well. Furthermore, Complicated Grief Treatment, although primarily cognitive-behavioral, has PI components. It may be that the mechanisms for patient improvement in this treatment are more akin to PI treatments than traditional cognitive behavioral treatments. Future research

could further explore these issues and indicate mediators and moderators of therapeutic progress in CGT.

The three patients who finished the treatment early in the present study exhibited more anger in their narratives, although they did not differ from the other patients on the three symptoms measures. The revisiting exercises of patients in this study ranged from visit five to visit fifteen in treatment. However, neither the patients who completed treatment early nor patients in the subsample had revisiting exercises later than visit nine. Among patients whose revisiting exercises used in this study were from visits ten or later (n=4), one text unit total referred to anger. These four patients either did not have imaginal conversations later in the treatment or only had one conversation. In general, the subsample patients spent extensive time having imaginal conversations once they had completed a number of revisiting exercises. CGT allows the option later in the treatment for therapists to continue on with the revisiting exercises, add imaginal conversations as needed, or opt for interpersonal interventions. It is likely, then, that the therapists noted various issues in the subsample that could best be addressed in an imaginal conversation; thus, the final revisitings for this group occurred before visit 10. Anger and rage could have contributed to these lingering issues.

Based on the subsample patients and the three patients who finished early, then, it seems that earlier CGT revisiting exercises were characterized by more anger, while the four revisiting exercises from later parts of treatment were essentially anger-free. While not the central goal of the treatment, it is possible that the treatment successfully targeted rage in these patients. However, these patients may have differed from the rest of the sample in various unknown ways. To appropriately address this issue, then, would require examining

individual patients and how they changed over treatment rather than comparing patients to one another. While this study cannot definitively address why patients with final revisitings in earlier sessions expressed more anger than those having their final revisiting in a later session, future work can explore whether there is a technique within this treatment (perhaps the imaginal conversations) that is effective at targeting patients' anger, whether time spent in the treatment is the actual mechanism for this change, or whether there are other factors contributing to this issue.

The integration of emotional themes observed in this study has relevance for other interventions for persons experiencing grief at the intensity observed here. Since persons with Complicated Grief may describe feelings of anger in conjunction with their love for the deceased individual, it is beneficial for practitioners to be aware of this layering of themes so that they do not address the angry emotions as a wholly separate issue from other symptoms. Furthermore, the close connection between themes of love and loneliness observed in this study indicates that the bittersweet nature of this disorder should be emphasized in future descriptions of Complicated Grief. Like persons with other disorders, someone with CG is more than the sum of his or her symptoms. These symptoms may interact with each other, so that one is both yearning for the deceased and yet having disturbing intrusive thoughts about the same loved one.

5.4 Implications for Narrative Research

The present study indicated that emotional processes in narratives are often described in counterintuitive ways. Furthermore, populations such as the one in the present study may mix negative and positive emotional themes. Current grief narrative research often limits

itself to code derivation without offering conclusions regarding the meaning of such themes, or relies on positive and negative categories solely without exploring specific themes. This approach is limited and does not adequately target complexities of the themes. Research on the effects of emotional expression on cognitive processes indicate similar complexities. Lerner and Keltner (2001) found that, in non-grieving samples, even “negative” emotions such as fear and anger can have very different outcomes. In their research, the effects of anger on cognitive appraisals are more similar to the effects of happiness than fear. Grief narrative researchers cannot persist in reducing themes into two categories and expect to find meaningful results. Indeed, the field finds inconsistent results regarding emotional valences in grief narratives. Emotions are far more complex than valence-based models indicate, and the deep and intense emotions and cognitions described by grieving individuals may be even more complex.

This study presents a methodology distinctly suited to exploring grief narratives. Current trends in grief narrative research focus on the application of quantitative coding schemes, opting for large, paragraph-length units of analysis that disallow coding overlap in order to make quantification and standardization more straightforward. However, the present study indicated that quantitative analyses could also be drawn from text approached from a qualitative stance, although having a larger sample of narratives would improve the power in the present study. This study (and the pilot study) implemented a training protocol for coders that included tests for interrater agreement but did not overly quantify coding procedures and emphasized the patients’ own words and the coders interpretations based on discussions in coding meetings. Thus, it balanced the aims of standardization and qualitative exploration. Future grief narrative researchers can utilize similar hybrid methods, as suggested by

Neimeyer and Hogan (2001), for the purpose of exploring narratives in greater depth while also establishing a clearly defined methodology for this area of research.

As the first study to describe a methodology specifically tailored for exploring Complicated Grief (rather than grief) narratives, it informs future work regarding the types of themes evident in stories of the death. Qualitative grief narrative work has already addressed highly specified topics such as ethnicity, race and, to a lesser extent, gender. Complicated Grief narrative work may profit from focusing directly on the narrative content for the purpose of describing CG and differentiating it from natural grief, MDD, and PTSD. Future CG narrative work can then apply methodologies, such as the one utilized in this study, specifically to CG narratives to study subpopulations according to gender, race, ethnic, age, and type of loss. Future work could focus more in-depth on the meaning of themes in Complicated Grief narratives, starting with the central themes in the present study.

Finally, the narratives in this study were treatment exercises. Results suggested potentially important variables in understanding patients' grief and recovery, such as the relevance of social support, the role of anger in perpetuating grief, and the issues surrounding patients' fixation with the deceased's appearance. While clinical samples of grieving patients are an understudied population, the present study indicates the breadth of themes that can be drawn from narrative treatment interventions. Future work could more specifically study what narrative content can indicate for patient improvement.

5.5 Methodological Integration

I believe that the mixing of quantitative and qualitative methods in the present study successfully exemplified Strauss and Corbin's (1990) description of a methodology in which

qualitative analyses inform quantitative analyses and vice versa. At every level of analysis, I compared results utilizing both methods. For instance, upon analyzing correlational data, I returned to the transcribed narratives to explore how the correlation made sense in the context of the stories. I would then perform searches and reports in NUD*IST for further clarification. Conversely, exploring revisiting exercises using NUD*IST provided me with additional ideas for quantitative analysis.

Grief research, according to Neimeyer (2004), is in a period of revolution as new theories and methods are displacing old practices in grief research. Qualitative work in grief research, as in many fields, is gaining momentum. Many researchers laud the advantages of mixing qualitative and quantitative methods, but psychological research is still exploring how best to implement such an integration. The current study presents a tangible means of integration. Although far from perfect, it is a beginning step to linking the two methodologies in Complicated Grief narrative research.

5.6 Study Limitations

Study limitations include disadvantages inherent in mixing quantitative and qualitative methods, likelihood of bias, and transferability of findings. Each is discussed below.

Combining qualitative and quantitative methods of inquiry has a number of advantages, as described previously. However, such a combination also results in having the disadvantages of both methods. Regarding my statistical analyses, a larger sample size is necessary to more adequately explore the relationship between narrative themes and symptoms. In the present study, the small sample resulted in the data being highly susceptible to the effects of outliers. Regarding qualitative analyses, it was difficult to

explore deep and meaningful relationships among themes in the study in the full sample of 22 patients. Being cognizant of these deficiencies, I strove to minimize them by both qualifying the legitimacy of the correlations and restricting the sample for further qualitative analyses.

Additionally, the nature of correlational research is such that causal relationships cannot be discerned. Although I attempted to interpret the findings in this study, causal relationships could not be appropriately discussed. It is unlikely that true experiments could be performed to more legitimately address causation, given the nature of the topic at hand. Finally, among many frequently-described themes, the standard deviations were quite large and should be taken into account.

A second limitation is the potential for bias any time a researcher interprets participants' words. The very nature of narrative content analysis, in which coders rate specific narrative themes, necessitates that coders make decisions regarding which sections of text are represented by which themes. I tried to use the patients' specific words as much as possible and not make too many inferences beyond the patients' own words regarding textual meaning. It must be acknowledged, however, that this type of narrative research involved a researcher making judgments about patient text. Other researchers analyzing the same narratives might make different interpretations.

Finally, while the results of this study have implications for future work in Complicated Grief, natural grief, and narrative research, the sample of this study represents a specific group of patients who met criteria and received treatment for Complicated Grief. Their revisiting exercises were a specific treatment intervention. As previously discussed, the results observed here are noticeably different from results in natural grief narrative

studies. It should not be expected that future natural grief narrative studies will find identical results to those displayed here for reasons discussed throughout this study. Future grief narrative work would do well to observe carefully the differing samples utilized across various studies, since discrepancies in the results are likely due to differences in the samples.

5.7 Conclusion: What is the “Story” Regarding the Narratives?

This study examined 22 revisiting exercises in which patients with Complicated Grief repeatedly told a complete narrative of a primary loss that occurred. These narratives contained various emotional and cognitive themes as well as other themes of great importance to the patients, such as the support received from friends and family. Other themes illustrated how patients with Complicated Grief differ from other grievers; for instance, the fixation on the corpse that many of the patients displayed.

Studying these narratives helped me to have a greater understanding when confronting loss in my own life. While these narratives were from persons in a distinct subgroup, they contained some themes relevant to many grievers. Over the course of writing, I attended three funerals; one for the death of a friend’s parent, one for the death of a friend, and one for the death of a friend’s newborn baby. I found that, first of all, understanding the nature of even an extreme form of grief such as Complicated Grief does not necessarily help one know what to say to other grievers! However, I also found myself understanding the need to form a cohesive story about the loss, whether that meant struggling to make sense of the loss, finding a higher purpose in the loss, or exploring one’s own thoughts and feelings about the loss. This study indicated the types of themes evident in clinical CG narratives, and these themes aid in understanding the nature of Complicated

Grief. These stories also give us insight into the experiences of patients experiencing grief at this intensity. While many aspects of their stories exhibit the heightened emotions and psychological concerns most relevant to a clinical sample, their themes of love and loss can be understood by all.

Appendix A

Coding Matrix and Code Definitions

- (1) Emotions--Patient descriptions of emotional states during narrative events
 - (1 1) Negative Emotions--Emotional descriptions connoting negativity, as judged by coders
 - (1 1 1) Helplessness--Patient feeling that there was nothing he/she could do
 - (1 1 2) Sadness--Patient descriptions of feeling sad or depressed
 - (1 1 3) Fear--Patient descriptions of feeling frightened
 - (1 1 4) Guilt—Patient feeling responsible and at-fault
 - (1 1 5) Anger—Patient descriptions of rage and anger
 - (1 1 5 1) Toward unsupportive family
 - (1 1 5 2) Toward death
 - (1 1 5 3) Toward deceased
 - (1 1 5 4) Yelling and cursing—Patient describing manifestations of rage
 - (1 1 6) Confused—Patient feeling befuddled
 - (1 1 7) Loneliness—Patient feeling alone or descriptions of missing someone
 - (1 1 8) Worry—Patient descriptions of feeling worried
 - (1 1 9) Distress—Patient feeling stressed, shocked, or frenzied
 - (1 1 10) General negative feelings—various unspecified negative emotions
 - (1 1 11) Hopelessness—Patient feeling that all hope was lost
 - (1 1 12) Numb—Patient describing an inability to feel
 - (1 1 13) Sense of unreality—Patients feeling hazy and “out-of-it”
 - (1 2) Positive Emotions—Emotional descriptions of a positive nature, as judged by coders
 - (1 2 1) Love--Patient describing feelings of love
 - (1 2 1 1) Kissing--Patient descriptions of kissing someone
 - (1 2 2) Happiness--Patient descriptions of pleasure and joy
 - (1 2 3) Comfort—Patient receiving comfort from various sources or circumstances
 - (1 2 4) General positive feelings—various unspecified positive emotions
 - (1 2 5) Pride—Patient taking pride in his/her own or another’s accomplishments
 - (1 2 6) Relief—Patients experiencing an emotional reprieve from traumatic events
- (2) Social Support-- Patient descriptions of interactions with friends, family, and others
 - (2 1) Lack of support—Patients describing a perceived lack of support from social network
 - (2 1 2) Coldness and Rudeness—Lack of support due to cold or offensive people
 - (2 1 3) Failure to help or show up—Lack of support due to unhelpful or unavailable people
 - (2 1 4) Conflict—Lack of support due to fighting and strife

Appendix A

Coding Matrix and Code Definitions (cont.)

- (2 2) Good support—Patients describing a social network perceived as being helpful
 - (2 2 1) Being There—Helpful support due to physical presence
 - (2 2 2) Helping—Helpful support due to tangible aid given
 - (2 2 3) Honoring—Helpful support due to efforts to honor the deceased
 - (2 2 4) Affection—Helpful support due to physical touch and love
- (2 3) Futile Social Support—Support described as being present yet not efficacious
- (3) Cognitions---Patient descriptions of thoughts and thought processes
 - (3 1) Making decisions—Descriptions of facing and making difficult decisions
 - (3 2) Causal language—using key words “because” and “since”
 - (3 3) Asking why—Patients asking why the loss happened
 - (3 4) How does life go on?—Patients wondering if it is possible to resume a normal life without the deceased
 - (3 5) Blame—Patients attributing blame for the death to certain persons
 - (3 6) Self evaluations—Patients evaluating themselves within the narrative
 - (3 6 1) Positive Self-evaluations—Evaluating oneself in a positive light
 - (3 6 1 1) Kept control—maintained emotional control after the death
 - (3 6 1 2) Loving relationship—maintained a close relationship with the deceased before the death
 - (3 6 2) Negative Self-evaluations—Evaluating oneself in a negative light
 - (3 6 2 1) Should have done---what they patient should have or should not have done
 - (3 6 2 2) Out of control—believing that one was emotionally out-of-control
 - (3 6 2 3) Unable to function—having a complete inability to function and take care of practical details
 - (3 6 3) Doing—Self-evaluations based on actions performed by the patient
 - (3 6 4) Being—Self-evaluations based on the patient’s character and nature
 - (3 7) Wanting—Patients using the word “want” to describe what they wanted to have happen or not happen
 - (3 7 1) To turn back time—Patients describing a desire to stop the death or the events leading to the death
 - (3 8) Disbelief-- Patients describing struggles with believing that the death occurred
- (4) Focus on Death—Patient thoughts and feelings pertaining directly to the death itself
 - (4 1) Discussing death itself—Talking about the nature of death in general
 - (4 2) Appearance of the deceased—Focusing on the deceased individual’s appearance
 - (4 2 1) Positive reaction—Having a positive reaction to viewing the corpse
 - (4 2 2) Negative reaction—Having a negative reaction to viewing the corpse
 - (4 2 3) Wanting to see body—Describing a desire to see the corpse
 - (4 2 4) Not Wanting to see Body—Describing a desire to avoid seeing the corpse

Appendix A

Coding Matrix and Code Definitions (cont.)

- (4 3)Not accepting death-- Statements indicating that patient has not accepted the death, such as attributing lifelike qualities to the deceased.
- (4 4)Avoiding the death-- Patients actively blocking persons, places, or thoughts that remind him/her of the deceased individual
- (4 5)No closure-- Patients stating that they were unable to do or say something before the loved one died.
- (4 6)Realization-- Patients describing the moments when they realized that the person truly had died.

(5)Demographics

(5 1)Gender

- (5 1 1)Male
- (5 1 2)Female

(5 2)Type of loss

- (5 2 1)Violent
- (5 2 2)Nonviolent

(5 3)Age

- (5 3 1)20s and 30s
- (5 3 3)40s and 50s
- (5 3 5)60s and 70s

(5 4)Relationship

- (5 4 1)Parent
- (5 4 2)Child
- (5 4 3)Spouse
- (5 4 4)Other

Free nodes

Various miscellaneous codes

1. Moral discomfort--Feeling moral compunctions at decisions faced during the story
2. Physical Sickness--Patient descriptions of being physically ill during narrative events
3. Supernatural events--Patients describing supernatural occurrences, such as premonitions and interactions with the spiritual world.
4. Spirituality--Patients describing their personal faith

Appendix B
Major Coding Revisions From Pilot Study to Present Study

Pilot Themes	Early Matrix	Final Matrix
Dissociative symptoms (pre-pilot), Numbness, Detachment, & Non-acceptance (Pilot)	Grief Symptoms (Numbness, Detachment, Non-acceptance)	Numbness, Not Accepting the Death, Feelings of Unreality. Not Accepting the Death specified a particular type of non-acceptance since the open-ended prior definitions proved to be problematic. Feelings of Unreality were a more specific and precise form of detachment.
Happiness, Loneliness, Anger, Love	Retained as themes	Subcategories added to both Love and Anger
Shock	Shock, General Negative Emotions	General Negative Emotions further broken down into various categories including Stress. Stress and Shock combined as one theme, Distress
Helplessness (organized under Cognitions)	Retained as a theme	Helplessness (organized as an emotion: "I feel helpless.")
Sense of support (construed as "present" or "not present")	Retained as a theme	Due to the huge amount of narrative space devoted to this theme, various subcategories generated under "Lack of Support" and "Good support"
Physical reactions to loss	Not retained initially, due to low frequency	Retained as a free node (Physical Sickness); recognized as being important in some patient descriptions
Peace	Not retained, due to low frequency and relevance (peace usually referred to what the deceased was experiencing. Under the more stringent guidelines in the current study, only patient feelings were explored)	Related themes Comfort and Relief created to more accurately describe patient feelings

Appendix C

Excerpts from my Research Journal

5-15-04

Coding---line-by-line analysis. Will focus on emotions, thought processes, and story themes. A guiding question: What is the root issue for this patient---why was this loss so difficult? Will a core variable—a target in grounded theory—even be possible or useful for this project?

6-10-04

Should I examine only the last narrative for each patient? But for some patients, the last one occurs in Visit 15, for others Visit 5. Perhaps I should only examine those patients whose last revisiting occurs after Visit 10 (more than halfway through the treatment).

7-29-04

Decided to code the last full revisiting for each patient. I will have a co-rater, who will examine all narratives independently of me. We will come together to discuss questions/problems and refine codes.

8-7-04

Decided to enter NUD*IST codings by text unit, divided by turn. However, the rating was done for each sentence, to maximize the types of codes utilized.

8-30-04

For the qualitative analysis, will examine patient talk turns. But need to be more stringent for the quantitative portion. Many studies utilize Thematic Units. I'm not sure that that makes sense here---these are narratives, all one story, with patient thoughts, feelings, and tangents. But to use TU's that I or any other rater decided upon would be artificial, based on story events and not patient-directed themes---which start, stop, and pick up again in various places throughout the narrative.

Appendix C

Excerpts from my Research Journal (cont.)

And to divide by sentences—these are also somewhat artificial and are partially based on transcriber decisions (i.e. when does patient crying sufficiently interrupt a sentence to start on a new line?).

I like the idea of using patient turns---which amount to paragraphs broken up at regular intervals. But some therapists are more “chatty” and these intervals are not mathematically uniform. What is my purpose? To explore how *patients* describe their *stories*. Thus, talk turns make sense, but they should be at least 3 sentences (to constitute a real paragraph). “Orphan” sentences should be connected thematically to nearby paragraphs.

9-8-04

Decided to use Talk Turns and Meaningful Units when necessary. I have excellent reliability with co-segmenter. I will also examine coding reliability.

11-30-04

Since all of the codes were entered on a line-by-line basis, it makes the most sense to analyze the units in the same way. Thus, segmentation is unnecessary. By examining each line, I can utilize NUD*IST more readily and continually explore themes in the text not be limited by percent frequency of themes.

12-14-04

Out of seven patients who talk about not accepting the loss, four of them speak about anticipating or realizing that death was imminent before it actually happened.

No overwhelming differences are observed between the male and female patients. If anything, all three male patients exhibit extremely detailed and particularly emotional narratives. This is likely a function of being the type of male participant who would volunteer for this type of study—more emotive than average, perhaps?

Appendix C

Excerpts from my Research Journal (cont.)

3-18-05

Need to re-examine Negative Emotions, Positive Emotions, Social Support categories, and Wanting. These are codes for which there are extremely large corresponding text units, and these can be broken down into further categories.

3-21-05

There is absolutely no relationship between my codes of sadness and the BDI. This is an interesting finding.

4-5-05

Examining clusters of themes using both SPSS and NUD*IST. I will use NUD*IST to conduct reports to see how themes relate to one another. I will then conduct correlations between themes and then revisit the narratives in NUD*IST to further examine what the correlations revealed.

6-22-05

Generated change scores between assessment timepoints to control for patients who had higher base scores. Change scores rarely correlated with narrative themes, and when they did, it was with themes that did not significantly correlate with any assessment timepoint.

10-5-05

Exploring interplay between love and negative emotions. Love and distress never occur near one another, despite the intercorrelation. It seems that there are two types of patients represented in this correlation: there are those whose distress and love discussions increase together and those who have low levels of each. Another example of zero-order correlations. However, the link between love and negative emotions is more promising.

Three patients who spoke of loving did so in the absence of negative emotions; that is, they spoke of negative emotions at least 25 sentences away and were discussing a new line of thought. Six patients, however, discussed love and negative emotions within 10 sentences and integrated both in the same subject matter. When they did so, three spoke of loneliness, two of sadness, and one of guilt. Indeed, people speaking of loving the deceased represent the majority (4/6) of people who spoke of feeling lonely. It appears that discussing the love that was felt evoked feelings of loneliness (“I miss her”) and sadness. Finally, for 8/9 patients speaking of love, they did so in the last half of their narratives.

Appendix D

Informed Consent

CONSENT TO ACT AS A SUBJECT IN AN EXPERIMENTAL STUDY

Complicated Grief Treatment: A Randomized, Controlled Study

Description: You are invited to participate in a research study to compare two different types of psychotherapy for the treatment of Complicated grief. One is called Complicated Grief Treatment (CGT) and the other is called Interpersonal Psychotherapy (IPT). Researchers at the University of Pittsburgh Medical Center hope to learn whether one treatment is more effective than the other in reducing symptoms of Complicated grief. “Complicated grief” is a state of bereavement in which there are symptoms similar to those experienced by individuals exposed to a psychological trauma.

If you decide to participate, you will receive a thorough medical and psychiatric evaluation to determine your eligibility for the treatment. You must meet our specific criteria for Complicated grief which will be assessed by a clinical interview and a self-report form called the Inventory of Complicated Grief (ICG) and you must be in good physical health. Your medical condition will be evaluated by routine laboratory tests of blood and urine, including the following: Complete Blood Count w/ Differential, Chloride, Creatinine, Potassium and Sodium levels, Thyroid Profile, Urea Nitrogen, Urinalysis and Urine Drug Screen. Approximately 3 ½ tablespoons of blood will be drawn for your blood test. Laboratory procedures may be performed at the Bellefield Towers, WPIC Hill Satellite Center, and occasionally at the WPIC main laboratory. There will be no charge for these studies and the results will be discussed with you. If you are found not to be eligible for this study, you will be offered participation in another study, or given an appropriate treatment referral.

If found eligible, you will be assigned randomly (by chance) to one of the two treatments. The treatments are Complicated Grief Treatment and Interpersonal Psychotherapy. The two treatments have the same assessments, and the number of treatment sessions is the same. All eligible subjects will receive one of these treatments.

CGT is similar to treatment that is known to be effective for patients with other kinds of traumatic reactions. CGT is a treatment that helps people to work on changing the way they think about the death of their loved one, and how to become less frightened of their memories. CGT involves repeatedly telling the story of the death and other related events to get used to upsetting thoughts, memories and situations, as well as exercises intended to help stop people from avoiding situations that trigger upsetting feelings. This is done by working with your therapist to repeatedly revisit those feelings or situations which cause you emotional distress. These revisiting exercises will be audiotaped during each session and you will be asked to listen to this audiotape each day until your next treatment session. CGT also includes procedures for helping the bereaved person find a comforting way to think about the person who died and to re-engage with other people in their lives.

Interpersonal Psychotherapy (IPT) is a well-studied treatment for depression. This treatment involves working with a therapist to identify one of four common interpersonal problem areas (unresolved grief, role transitions, role disputes, or interpersonal deficits) and then learning specific strategies and tactics in order to resolve the problem.

You will be seen in treatment for approximately 16 sessions. You will have approximately 20 weeks to complete the treatment phase of this study. A study evaluator will interview you when you start treatment and after you complete the treatment phase of this study. In addition, you will be monitored by a study evaluator monthly for approximately 6 months after you have completed treatment. At the end of this monitoring period, you will complete a final interview with a study evaluator. The purpose of these evaluations is to determine the effect of the treatment on your condition. All study treatment sessions and evaluations will take place at the Bellefield Towers or WPIC Hill Satellite site. Referrals to alternative treatments will be provided if you have not improved enough. In addition to these evaluations, you will also be asked to complete self-report assessments prior to each session during

Appendix D

Informed Consent (cont.)

the time that you are receiving treatment. These self-report forms will take approximately 15 minutes to complete and will consist of standard questionnaires and rating forms that will be used to evaluate your progress. There are times, however, when the self-reports may take as many as 45 minutes to complete. You also agree to keep a set of self-monitoring forms that will help you directly in using the treatment effectively.

While in the study you should not start another type of treatment or take medications without discussing it with us. You will agree to have Dr. Shear or a physician under her supervision monitor and prescribe your psychotropic medications while you are in this study. If you must take a medication that would interfere with the study protocol, we may ask you to discontinue study participation. You should not use any recreational drugs (e.g., marijuana, cocaine, PCP). You should limit your alcohol intake to one drink a day. If you use alcohol or drugs during the course of treatment, you agree to record the amount and frequency.

You will be asked to provide written consent for videotaping and/or audiotaping of each therapy and assessment session. Treatment sessions are video and audiotaped so that we can evaluate whether the treatment is carried out according to guidelines. Additionally, audiotapes may be made available to other researchers conducting sub-studies directly related to this project. You will be asked to specify on your video consent whether your videotape can be used in a similar manner. You will also be asked to specify on your video consent whether your videotape can be used for CGT training purposes. In addition, an audiotape will be made for you to listen to at home between sessions if you are receiving CGT.

Risks and Benefits: Your participation in the project involves the following risks: The major risk is failure to respond to the treatment. There is a risk of discomfort or anxiety resulting from discussion of personal or anxiety-provoking subjects. CGT is meant to be intense and temporarily distressing. The effect of it may depend on having a high enough level of emotions to be sure that the new ways of thinking “take hold”. Your therapist is a highly experienced clinician who is skilled in managing distressed subjects. Therapists also have experience working with patients on a once a week basis. There is a risk of bruising from the needle puncture during the routine blood test. If, at any time during the study participation, you are experiencing troublesome symptoms or side effects, you may contact the study staff during regular business hours at 412-624-5500, or contact the 24-hour emergency paging system at 412-958-1537. You may benefit by receiving relief from grief symptoms. You may also benefit from the medical evaluation (routine blood tests, urinalysis) performed for this study. However we cannot promise that you will benefit from this study.

Alternative Treatments: Alternative treatments for this condition are antidepressant medications such as paroxetine, sertraline, or other similar medications, and other forms of psychotherapy. There are not yet any proven treatments for this condition because studies have not been done. If you decide to participate in this study, we will ask that you not use alternative treatments. If you decide to do so, we will have to discontinue your participation in this study. There is no documented reason to believe that these alternative treatments are more effective than the treatments offered in this research study.

New Information: You will be promptly notified if any new information, either good or bad, about the treatment you are receiving develops during the course of this study and which may cause you to change your mind about continuing to participate.

Costs and Payments: Neither you, nor your third-party insurance provider, will be billed for the research procedures which include the pretreatment labwork, other evaluations, and treatment sessions during the time period that you are in the study. You will be offered compensation: \$30.00 for completing your pretreatment assessment,

Appendix D

Informed Consent (cont.)

\$10.00 for each treatment session and associated questionnaires completed, \$30.00 for completing your post-treatment assessment, and \$50.00 for completing your final follow-up assessment.

Confidentiality: Any information about you obtained from this research, including answers to interviews, questionnaires, and audio or videotapes will be kept strictly confidential. Neither your name nor any other identifying information will be included on the interview summary, the questionnaires, or the audio or videotapes. These materials will be coded by number and kept in locked files until five years past the completion of the study. All tapes will be erased, with a magnetic tape erasure, five years after the completion of the study. Only Dr. Shear (and her designate(s)) will have access to information linking names and code numbers.

Any information about you or your treatment will be handled in a confidential manner consistent with other hospital medical records. You will not be specifically identified in any publication of research results. However, in unusual cases, your research records may be inspected by appropriate government agencies, be released in response to an order from a court of law, or be reviewed as part of an audit of research performed by the University Research Conduct and Compliance Office.

Right to Participate or Withdraw from Participation: Your participation in this research study is completely voluntary. You do not have to take part in this research study and, should you change your mind, you can withdraw from the study at any time. Your current and future care at a UPMC HS facility and any other benefits for which you qualify will be the same whether you participate in this study or not.

If you agree to take part in this research study, the investigators can remove you from the study without your consent if you should start another type of psychotherapy for grief or have a change in your medications that would interfere with the study protocol. If asked to discontinue participation in the study a referral will be provided so that you may seek treatment for your grief.

If you choose to withdraw or, if you are withdrawn from the study, your interview summary, questionnaires, and audio and videotapes will continue to be stored in locked files maintained by the Panic, Anxiety and Complicated Grief Program for a period of 5 years past the completion of this study.

Compensation for Illness or Injury: University of Pittsburgh investigators and their associates who provide services at the UPMC Health System (UPMC HS) recognize the importance of your voluntary participation to their research studies. These individuals and their staffs will make reasonable efforts to minimize, control, and treat any injuries that may arise as a result of this research. If you believe that you are injured as a result of the research procedures being performed, please contact immediately the Principal Investigator or one of the co-investigators listed on the first page of this form.

Emergency medical treatment for injuries solely and directly relating to your participation in this research will be provided to you by hospitals of the UPMC HS.

It is possible that the UPMC HS may bill your insurance provider for the costs of this emergency treatment, but none of these costs will be charged directly to you. If your research-related injury requires medical care beyond this emergency treatment, you will be responsible for the costs of this follow-up care unless otherwise specifically stated below. You will not receive monetary payment for, or associated with, any injury that you suffer in relation to this research.

Appendix D

Informed Consent (cont.)

Voluntary Consent:

I certify that I have read the proceeding, or that it has been read to me, and I understand its contents. Any questions I have pertaining to the research have been, and will continue to be answered by the investigators listed at the beginning of this consent form, at the phone numbers given. Any questions I have concerning my rights as a research subject will be answered by the Human Subjects Protection Advocate at the University of Pittsburgh IRB Office (412-578-8570). A copy of this consent form will be given to me. My signature below means that I have freely agreed to participate in this project.

Signature

Date / Time

INVESTIGATOR'S CERTIFICATION

I certify that the nature and purpose, the potential benefits, and possible risks associated with participation in this research study have been explained to the above individual and that any questions about this information have been explained

Investigator's Signature

Date / Time

Appendix E

Revisiting Exercise Instructions

Excerpt from the TGT Manual, January 2001, pages 84-85

To begin imaginal exposure, the therapist asks the patient to close her/his eyes and try to imagine being back at the time they realized their loved one was about to die, or, if there was no warning, when they first learned about the death. The patient is asked to tell this story as though it is happening right now- to try to put themselves back in the situation, speak in the present tense and recall as many details as possible. The patient tells the story of the death beginning when they realized that it was imminent, and from this point forward, to the end of the burial or cremation, paying attention to what they are thinking and feeling.

Example: “During the exposure, I am going to ask you to recall the memories of Sarah’s death, beginning with...(when the patient first understood that this was a terminal episode) until...(the point where you returned from the funeral and walked into your home). I would like you to close your eyes during the re-experiencing so you won’t be distracted and you can recall the whole episode as vividly as possible. Try to feel as though you are actually re-living the death. We call this re-experiencing. I would like you to tell me the story in the present tense, as if it were happening here, right now. I would like you to close your eyes and tell me what is happening in as much detail as you can. We will work on this together. If you start to feel too uncomfortable and want to stop by leaving the image, I will help you to stay with it. We will audiotape this exercise so that you can take the tape home and listen to it. Are you ready to start?”

REFERENCES

- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: Author.
- Archer, J. (1999). *The nature of grief: The evolution and psychology of reactions to loss*. New York: Routledge.
- The Associated Press. (2005). Beyond depression: When grief doesn't go away. Retrieved June 9, 2005 from www.msnbc.com.
- Bauer, J. J., & Bonanno, G. A. (2001-a). Doing and being well (for the most part): Adaptive patterns of narrative self-evaluation during bereavement. *Journal of Personality*, 69, 451-482.
- Bauer, J. J., & Bonanno, G. A. (2001-b). I can, I do, I am: The narrative differentiation of self-efficacy and other self-evaluations while adapting to bereavement. *Journal of Research in Personality*, 35, 424-448.
- Beck, A. T., Epstein, N., Brown, G., & Steer, R. A. (1988). An inventory for measuring clinical anxiety: Psychometric properties. *Journal of Consulting and Clinical Psychology*, 56, 893-897.
- Beck, A. T., & Steer, R. A. (1987). *Beck Depression Inventory Manual*. San Antonio, TX: The Psychological Corporation.

- Beck, A. T., & Steer, R. A. (1993). *Beck Depression Inventory Manual*. San Antonio: Harcourt Brace & Company.
- Beck, A. T., Steer, R. A., & Garbin. (1988). Psychometric Properties of the Beck Depression Inventory: Twenty-five years of evaluation. *Clinical Psychology Review*, 8, 77-100.
- Becvar, D. S. (2001). *In the presence of grief*. New York: The Guilford Press.
- Boelen, P. A., van den Bout, J., & van den Hout, M. A. (2003). The role of cognitive variables in psychological functioning after the death of a first degree relative. *Behavior Research and Therapy*, 41, 1123-1136.
- Bonanno, G. A., & Kaltman, S. (1999). Toward an integrative perspective on bereavement. *Psychological Bulletin*, 125 (6), 760-776.
- Bonanno, G. A., & Keltner, D. (1997). Facial expressions of emotion and the course of conjugal bereavement. *Journal of Abnormal Psychology*, 106 (1), 126-137.
- Bonanno, G. A., Mihalecz, M. C., & LeJeune, J. T. (1999). The core emotion themes of conjugal loss. *Motivation and Emotion*, 23, 175-201.
- Bowlby, J. (1961). Childhood mourning and its implications for psychiatry. *American Journal of Psychiatry*, 118, 481-498.
- Bowlby, J. (1980). *Loss: Sadness and depression (attachment and loss)*, volume 3. New York: Basic Books.
- Bradburn, N. M. (1969). *The structure of psychological well-being*. Chicago: Aldine.
- Charmaz, K. (1983). The grounded theory method. In R. Emerson (Ed.), *Contemporary field research* (pp. 109-126). Boston: Little, Brown.
- Carter, S. L. (1989). Themes of grief. *Nursing Research*, 38, 354-358.

- Chen, J. H., Bierhals, A. J., Prigerson, H. G., Kasl, S. V., Mazure, C. M., & Jacobs, S. (1999). Gender differences in the effects of bereavement-related psychological distress in health outcomes. *Psychological Medicine, 29*, 1-14.
- Cooper, N. A., & Clum, G. A. (1989). Imaginal flooding as a supplementary treatment for PTSD in combat veterans: A controlled study. *Behavior Therapy, 20*, 381-391.
- Davis, C. G., & Nolen-Hoeksema, S. (2001). Loss and Meaning. *American Behavioral Scientist, 44* (5), 726-741.
- Davis, C. G., Wortman, C. B., Lehman, D. R., Silver, R. C. (2000). Searching for meaning in loss: Are clinical assumptions correct? *Death Studies, 24*, 497-540.
- Derogatis, L. R., Rickels, K., & Rock, A. F. (1976). The SCL-90 and the MMPI: a step in the validation of a new self-report scale. *British Journal of Psychiatry, 128*, 280 - 289.
- Ericsson, K. A., & Simon, H. A. (1984). *Protocol Analysis: Verbal reports as data*. Cambridge, MA: MIT Press.
- Erikson, E. H. (1982). *The life-cycle completed*. New York: Norton.
- Faschingbauer, T., Zisook, S., DeVaul, R. (1987). The Texas revised inventory of grief. In S. Zisook, (Ed.), *Biopsychosocial Aspects of Bereavement* (pp. 111-124). Washington, D.C.: American Psychiatric Press, Inc.
- First, M. B., Spitzer, R. L., Gibbon, M., Williams, J.B.W. (1997). *Structured Clinical Interview for DSM-IV Axis I Disorders: SCID-I Clinical Version : Administration Booklet*. Washington, DC: American Psychiatric Press.

- Flick, U. (1998). *An introduction to qualitative research*. Thousand Oaks, CA: Sage Publications.
- Foa, E. B., & Meadows, E. A. (1997). Psychosocial treatments for post-traumatic stress disorder: A critical review. *Annual Review of Psychology, 48*, 449-480.
- Foa, E. B., Molnar, C., & Cashman, L. (1995). Change in rape narratives during exposure therapy for post-traumatic stress disorder. *Journal of Complicated Stress, 8*, 675-690.
- Foa, E. B., Rothbaum, B. O., Riggs, D. S., & Murdock, T. B. (1991). Treatment of Post-traumatic stress disorder in rape victims: A comparison between cognitive-behavioral procedures and counseling. *Journal of Counseling and Clinical Psychology, 59*, 715-723.
- Frank, E., Kupfer, D. J., Wagner, E. F., McEachran, A. B., Cornes, C. (1991). Efficacy of interpersonal psychotherapy as a maintenance treatment of recurrent depression. *Archives of General Psychiatry, 48*, 1053-1059.
- Freud, S. (1957). Mourning and melancholia. In J. Strachey (Ed. and Trans.), *Standard edition of the complete works of Sigmund Freud*. London: Hogarth Press. (Original work published 1917).
- Gallagher, D., Nies, G., Thompson, L. W. (1982). Reliability of the Beck Depression Inventory with older adults. *Journal of Consulting and Clinical Psychology, 50*, 152-153.
- Gamino, L. A., Hogan, N. S., & Sewell, K. W. (2002). Feeling the absence: A content analysis from the Scott and White grief study. *Death Studies, 26*, 793-813.

- Gamino, L.A., & Sewell, K.W. (2004). Meaning constructs as predictors of bereavement adjustment: A report from the Scott & White Grief Study. *Death Studies, 28*, 397-421.
- Gilbert, K. R. (2002). Taking a narrative approach to grief research: Finding meaning in stories. *Death Studies, 26*, 223-239.
- Giles, D. C. (2002). *Advanced research methods in psychology*. New York: Routledge.
- Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago: Aldine.
- Hamilton, M. (1960). A rating scale for depression. *Journal of Neurology, Neurosurgery, and Psychiatry, 23*, 56-62.
- Hartmann, D. P. (1977). Consideration in the choice of interobserver reliability estimates. *Journal of Applied Behavioral Analysis, 10*, 103-116.
- Hogan, N., & DeSantis, L. (1994). Things that help and hinder adolescent sibling bereavement. *Western Journal of Nursing Research, 16*, 132-153.
- Horowitz, M. (1976). *Stress response syndromes*. Northvale, New Jersey: Aronson.
- Horowitz, M. J., Adler, N., & Kegeles, S. (1988). A scale for measuring the occurrence of positive states of mind: A preliminary report. *Psychosomatic Medicine, 50*, 477-483.
- Horowitz, M. J., Siegel, B., Holen, A., Bonanno, G. A., Milbrath, C., Stinson, C. H. (1997). Diagnostic criteria for complicated grief disorder. *American Journal of Psychiatry, 154*, 904-910.

- Horowitz, M. J., Wilner, N., & Alvarez, W. (1979). Impact of Events Scale: A measure of subjective stress. *Psychosomatic Medicine, 41*, 209-218.
- Kessler, R.C., Price, R. H., & Wortman, C. B. (1985). Social factors in psychopathology: Stress, social support, and coping processes. *Annual Review of Psychology, 36*, 531-572.
- Kaunonen, M., Tarkka, M., Paunonen, M., & Laippala, P. (1999). Grief and social support after the death of a spouse. *Journal of Advanced Nursing, 30* (6), 1304-1311.
- Lerner, J.S. & Keltner, D. (2000). Beyond valence: Toward a model of emotion-specific influences on judgment and choice. *Cognition and Emotion, 14*, 473-493.
- Lerner, J. S., & Keltner, D. (2001). Fear, anger, and risk. *Journal of Personality & Social Psychology, 81*(1), 146-159.
- Lepore, S. J., Silver, R. C., Wortman, C. B., & Wayment, H.A. (1996). Social constraints, intrusive thoughts, and depressive symptoms among bereaved mothers. *Journal of Personality and Social Psychology, 70*, 271-282.
- Lindemann, E. (1944). Symptomatology and management of acute grief. *American Journal of Psychiatry, 101*, 141-148.
- Mackay, H. C., Barkham, M., Stiles, W. B., & Goldfried, M. R. (2002). Patterns of client emotion in helpful sessions of cognitive-behavioral and psychodynamic-interpersonal therapy. *Journal of Counseling Psychology, 49*(3), 376-380.
- Maercker, A., Bonanno, G. A., Znoj, H., Horowitz, M. J. (1998). Prediction of complicated grief by positive and negative themes in narratives. *Journal of Clinical Psychology, 54*, 1117-1136.

- Marmar, C. R., Horowitz, M. J., Weiss, D. S., Wilner, N. R., Kaltreider, N. B. (1988). A controlled trial of brief psychotherapy and mutual-help group treatment of conjugal bereavement. *American Journal of Psychiatry*, *145*, 203-209.
- Miller, M. D., Frank, E., Cornes, C., Imber, S. D., Anderson, B., Ehrenpreis, L., Malloy, J., Silberman, R., Wolfson, L., Zaltman, J., Reynolds III, C. F. (1994). Applying interpersonal psychotherapy to bereavement-related depression following loss of a spouse in late life. *Journal of Psychotherapy Practice and Research*, *3*, 149-162.
- Neimeyer, R. A. (2000). Searching for the meaning of meaning: Grief therapy and the process of reconstruction. *Death Studies*, *24*, 541-558.
- Neimeyer, R. A. (2001). Reauthoring life narratives: Grief therapy as meaning reconstruction. *Israel Journal of Psychiatry and Related Science*, *38*, 171-183.
- Neimeyer, R.A. (2004). Research on grief and bereavement: Evolution and revolution. *Death Studies*, *28*, 489-4890.
- Neimeyer, R.A., & Hogan, N.S. (2001). Quantitative or Qualitative? Measurement Issues in the Study of Grief. In M. S. Stroebe, Hansson, R. O., Stroebe, W., & Schut, H. (Eds.), *Handbook of bereavement research: Consequences, coping, and care* (pp. 89-118). Washington, DC: American Psychological Association.
- Nelson, M. L., & Friedlander, M. L. (2001). A close look at conflictual supervisory relationships: The trainee's perspective. *Journal of Counseling Psychology*, *48*, 384-395.
- Ott, C. H. (2003). The impact of Complicated Grief on mental and physical health at various points in the bereavement process. *Death Studies*, *27*, 249-272.

- Parkes, C. M. (1965). Bereavement and mental illness. *British Journal of Medical Psychology*, 38, 1-26.
- Pennebaker, J.W. (1989). Confession, inhibition, and disease. In L. Berkowitz (Ed.), *Advances in experimental social psychology* (Vol. 22, pp. 211-244). New York: Academic Press.
- Pennebaker, J.W., Francis, M.E., & Booth, R.J. (2001). *Linguistic Inquiry and Word Count*. Mahwah, NJ: Erlbaum Publishers.
- Pennebaker, J. W., Mayne, T. J., & Francis, M. E. (1997). Linguistic predictors of adaptive bereavement. *Journal of Personality and Social Psychology*, 72, 863-871.
- Pennebaker, J. W., & Seagal, J. D. (1999). Forming a story: The health benefits of narrative. *Journal of Clinical Psychology*, 55, 1243-1254.
- Pennebaker, J. W., Zech, E., & Rime, B. (2001). Disclosing and sharing emotion: Psychological, social, and health consequences. In M. S. Stroebe, Hansson, R. O., Stroebe, W., & H. Schut (Eds.), *Handbook of bereavement research: Consequences, coping, and care* (pp. 517-544). Washington, DC: American Psychological Association.
- Prigerson, H. G., Bierhals, A. J., Kasl, S. V., Reynolds, C. F. III, Shear, M. K., Newsom, J. T., & Jacobs, S. (1996). Complicated grief as a distinct disorder from bereavement-related depression and anxiety: A replication study. *American Journal of Psychiatry*, 153, 84-86.
- Prigerson, H.G., Frank, E., Kasl, S. V., Reynolds III, C. F., Anderson, B., Zubenko, G. S., Houck, P. R., George, C. J. Kupfer, D. J. (1995). Complicated grief and bereavement-related depression as distinct disorders: Preliminary empirical validation in elderly bereaved spouses. *American Journal of Psychiatry*, 152, 22-30.

- Prigerson, H. G., Maciejewski, P. K., Newsom, J., Reynolds, C. F. III, Frank, E., Bierhals, E. J., Miller, M., Fasiczka, A., Doman, J., & Houck, P. R. (1995). The Inventory of Complicated Grief: A scale to measure maladaptive symptoms of loss. *Psychiatry Research, 59*, 65-79.
- Prigerson, H. G., Shear, M. K., Jacobs, S. C., Reynolds, C. F. III., Maciejewski, P. K., Davidson, J. R.T., Rosenheck, R., Pilkonis, P. A., Wortman, C. B., Williams, J. B. W., Widiger, T. A., Frank, E., Kupfer, D. J., Zisook, S. (1999). Consensus criteria for Complicated grief: A preliminary empirical test. *The British Journal of Psychiatry, 174*, 67-73.
- Radloff, L. S. (1977). The CES-D Scale: A self-report depression scale for research in the general population. *Journal of Applied Psychological Measurement, 1*, 385-401.
- Reynolds III, C. F., Frank, E., Perel, J. M., Imber, S. D., Cornes, C., Miller, M. D., Mazumdar, S., Houck, P. R., Dew, M. A., Stack. J. A., Pollock, B. G., & Kupfer, D. J. (1999). Nortriptyline and interpersonal psychotherapy as maintenance therapies for recurrent Major Depression. *JAMA, 281*, 39-45.
- Reynolds III, C. F., Miller, M. D., Pasternak, R. E., Frank, E., Perel, J. M., Cornes, C., Houck, P. R., Mazumdar, S., Dew, M. A., & Kupfer, D. J. (1999). Treatment of bereavement-related major depressive episodes in later life: A controlled study of acute and continuation treatment with nortriptyline and interpersonal psychotherapy. *American Journal of Psychiatry, 156* (2), 202 - 208.
- Richards, T. A., Acree, M., & Folkman, S. (1999). Spiritual aspects of loss among partners of men with AIDS: Postbereavement follow-up. *Death Studies, 23*, 105-127.

- Richards, T. A., & Folkman, S. (1997). Spiritual aspects of loss at the time of a partner's death from AIDS. *Death Studies, 21*, 515-540.
- Rosenblatt, P.C., & Wallace, B. R. (2005). Narratives of grieving African-Americans about racism in the lives of deceased family members. *Death Studies, 29*, 217-235.
- Scolari (1997). *QSR NUD*IST 4: Software for qualitative data analysis* [computer software]. Thousand Oaks, CA: Sage Publications Software.
- Shear, M. K., Frank, E., Foa, E., Cherry, C., Reynolds III, C. F., Bilt, J. B., & Masters, S. (2001). Complicated Grief Treatment: A pilot study. *American Journal of Psychiatry, 158*, 1506-1508.
- Shear, K., Frank, E., Houck, P.R., & Reynolds III, C. F. (2005). Treatment of Complicated Grief. *JAMA, 293*, 2601-2608.
- Shucder, S. R., & Zisook, S. (1986). Treatment of spousal bereavement: A multidimensional approach. *Psychiatric Annals, 16*, 295-305.
- Shucder, S. R., & Zisook, S. (1993). The course of normal grief. In M. S. Stroebe, W. Stroebe, & R.O. Hansson (Eds.), *Handbook of bereavement: Theory, research, and intervention* (pp. 23-43). Cambridge: Cambridge University Press
- Strauss, A. & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. London: Sage.
- Stroebe, M. S., Hansson, R. O., Stroebe, W., Schut, H. (2001). Introduction: Concepts and issues in contemporary research on bereavement. In M. S. Stroebe, Hansson, R. O., Stroebe, W., & Schut, H. (Eds.), *Handbook of bereavement research: Consequences, coping, and care* (pp. 3-22). Washington, DC: American Psychological Association.

- Stroebe, M. S., Schut, H., & Finkenauer, C. (2001). The traumatization of grief? A conceptual framework for understanding the trauma-bereavement interface. *Israel Journal Psychiatry Related Sciences*, *38*, 185-201.
- Stroebe, W., Stroebe, M.S., Abakoumkin, G., & Schut, H. (1996). The role of loneliness and social support in adjustment to loss: A test of attachment versus stress theory. *Journal of Personality and Social Psychology*, *70*, 1241-1249.
- Stylianou, S.K., & Vachon, M.L.S. (1993). The role of social support in bereavement. In M. S. Stroebe, Stroebe, W., & Hansson, R. O. (Eds.), *Handbook of bereavement: Theory, research, and intervention* (pp. 397-410). New York, NY: Cambridge University Press.
- Sundin, E. C., & Horowitz, M. J. (2002). Impact of Event Scale: Psychometric Properties. *British Journal of Psychiatry*, *180*, 205-209.
- Van Baarsen, B. (2002). Theories on coping with loss: The impact of social support and self-esteem on adjustment to emotional and social loneliness following a partner's death in later life. *Journal of Gerontology*, *57*, 33-42. .
- Van Minnen, A., Wessel, I., Dijkstra, T., & Roelofs, K. (2002). Changes in PTSD patients' narratives during prolonged exposure therapy: A replication and extension. *Journal of Complicated Stress*, *15*, 255-258.
- Windholz, M. J., Marmar, C. R., & Horowitz, M. J. (1985). A review of the research on conjugal bereavement: Impact on health and efficacy of intervention. *Comprehensive Psychiatry*, *26*, 433-447.
- Wolpe, J. (1958). *Psychotherapy by Reciprocal Inhibition*. Stanford, CA: Stanford University Press.

- Worden, J. W. (1982). *Grief counseling and grief therapy: A handbook for the mental health practitioner*. Springer: New York.
- Wortman, C. B., & Lehman, D.R. (1985). Reactions to victims of life crises: Support attempts that fail. In I.G. Sarason & B.R. Sarason (Eds.), *Social Support: Theory, research, and applications* (pp. 463-489). Dordrecht, The Netherlands: Martinus Nijhoff.
- Wortman, C.B., & Silver, R.C. (1989). The myths of coping with loss. *Journal of Consulting and Clinical Psychology*, 57, 349-357.
- Wortman, C.B., & Silver, R.C. (2001). The myths of coping with loss revisited. . In M. S. Stroebe, Hansson, R. O., Stroebe, W., & Schut, H. (Eds.), *Handbook of bereavement research: Consequences, coping, and care* (pp. 405-429). Washington, DC: American Psychological Association.
- Zilberg, N. J., Weiss, D. S., & Horowitz, M. J. (1982). Impact of Event Scale: A cross-validation study and some empirical evidence supporting a conceptual model of stress response syndromes. *Journal of Consulting and Clinical Psychology*, 50, 407-414.
- Zisook, S., & DeVaul, R. (1985). Unresolved grief. *The American Journal of Psychoanalysis*, 5 (4), 370-379.
- Zisook, S. & Schuchter, S. (2001). Treatment of the depressions of bereavement. *American Behavioral Scientist*, 44, 782-797.

