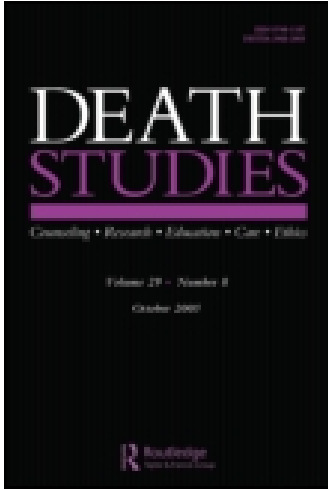


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DOES GRIEF COUNSELING WORK?

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DOES GRIEF COUNSELING WORK?

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Most bereavement caregivers accept as a truism that their interventions are helpful. However, an examination of the bereavement intervention literature suggests that the scientific basis for accepting the efficacy of grief counseling may be quite weak. This article summarizes the findings of four recent qualitative and quantitative reviews of the bereavement intervention literature. It then discusses three possible explanations for these surprising findings and concludes with recommendations for both researchers and clinicians in thanatology that could help to focus efforts to answer the questions of when and for whom grief counseling is helpful.

It is a part of the assumptive world of most bereavement caregivers that their interventions work. Most practitioners believe that what they do is helpful and necessary, and that it does no harm. Moreover, most grief counselors would probably argue that most mourners would benefit from the services they offer. Understandably, caregivers in the helping professions want to believe that their work is valuable and their competence is recognized. These assumptions notwithstanding, several recent literature reviews and meta-analyses of bereavement intervention studies have suggested that these services may be surprisingly ineffective. Just as Wortman and Silver's seminal article challenged the field to reconsider and expand its "mythology" about the normal trajectory of

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bereavement (Wortman & Silver, 1989; also see Wortman & Silver, 2001, for an update), there may be similar unquestioned assumptions about assisting the bereaved that require more careful scrutiny by caregivers. In part, this may reflect a significant gap that exists between researchers who study interventions for the bereaved, and the majority of caregivers who provide direct services to them (Jordan, 2000; Neimeyer, 2000; Silverman, 2000).

We have several goals for this article. First, we will review these challenging studies and summarize their conclusions for the reader. Then we will offer several possible interpretations of these findings and their implications for future research in thanatology and for caregivers who are on the “front lines” of providing support. Lastly, we hope to promote more relevant research and thoughtful clinical practice in the field of grief counseling. We hope that this article will be both provocative and stimulating, encouraging the reader to think more deeply about the implications of the research literature for their own work, and about the importance of bridging the gap that often divides those who study and those who practice.

Research on Interventions for the Bereaved

Recent years have seen a growing number of studies of the effectiveness of services for people seeking help with grief-related problems. A review of all bereavement-related intervention outcome studies is beyond the scope of this article. Instead, we will discuss and summarize several recent qualitative and quantitative reviews of the literature on the effectiveness of individual and group interventions for bereavement-related problems, primarily for adults. For those who may be unfamiliar with this topic, a qualitative (or narrative) literature review involves a scholarly analysis of the existing literature, from which the reviewer draws reasoned conclusions about the state of knowledge in a given area of inquiry. In contrast, a quantitative review (or meta-analysis) is a statistical technique (or group of techniques) that allows objective data from many different studies to be combined to produce a numerical answer to the question, “How effective is a particular type of treatment?” (Hedges & Olkin, 1985). The resulting measure, commonly referred to as the *effect size* of a treatment, is a standardized way of assessing to what degree people who receive the treatment do better on outcome measures

than people in control groups who do not receive the treatment (Kazdin, 1998; Wampold, 2001). The general effect size for many psychotherapeutic treatments for a broad range of problems is on the order of .8 (Wampold, 2001), which is commonly considered a large effect in the social sciences (Cohen, 1988). An effect size of .8 indicates that approximately 79% of people who receive the treatment are better off after treatment than those who do not receive treatment. This is the rough standard against which we might compare the effectiveness of grief counseling. Accordingly, we will summarize below four recent major literature reviews and/or meta-analyses of grief counseling.

Meta-analyses and Literature Reviews

Allumbaugh and Hoyt (1999) reviewed 35 bereavement intervention studies that included both single-group (pre- and posttest) and two-group (treatment and control) designs. Thus, they did not limit the analysis to studies that included random assignment to treatment/control conditions. Rather, the authors used a method of meta-analysis that corrected for the pre-treatment status of the groups on such variables as levels of distress, and allowing for inclusion of single-group designs, which typically yield larger effect sizes than controlled studies. Overall, Allumbaugh and Hoyt found an effect size for bereavement interventions of .43. They suggested that this relatively small effect may be due to a general ineffectiveness of grief counseling, to the low statistical power of many of the studies, or to one or more intervening variables that masked real effects of the interventions. The authors examined 12 of these potential moderator variables, including categorical variables such as characteristics of the treatment (e.g., level of practitioner training) and treatment modality (e.g., group vs. individual; number of sessions), as well as client characteristics, such as age, gender, time since loss, and relationship to the deceased. They concluded that more highly trained practitioners produced a better result (particularly when compared to non-professional therapists), and individual therapy produced better results than group treatment. However, these two variables were confounded because studies using individual treatment also tended to use professionally trained therapists rather than paraprofessional volunteers.

Allumbaugh and Hoyt (1999) also found that more effective interventions included a greater number of sessions and began closer to the time of death of the loved one, although the mean length of time since death

across the studies was over 2 years. The authors noted that this is a relatively long time after death for an intervention to begin, and may account for the failure to find expected improvement over time in the control groups, because much of the change in functioning may already have been accomplished by two years. Importantly, Allumbaugh and Hoyt also noted that studies using clients who were self-identified and specifically seeking help for their bereavement had much larger effect sizes than studies where participants were recruited by the investigators. Despite this, they found only a marginally significant trend for clients defined as high risk to benefit more from the interventions. They speculated that this unexpected finding might have been a result of the great inconsistency in definitions of high risk from one study to another.

Kato and Mann (1999) provided a combined qualitative and quantitative review of bereavement intervention studies. They used selection criteria that required random assignment to treatment and control groups, similar recruitment procedures for both groups, and initiation of the intervention only after the loss had occurred. Using this stricter set of criteria, the authors reviewed 13 articles, breaking the sample into studies that used individual, family, or group interventions. They noted that three of the four studies using individual therapy interventions produced only slight changes in physical health, and one found improvement in stress reactions of the participants. Kato and Mann further concluded that one family therapy study and six of the eight group studies reviewed found almost no beneficial effects of the interventions. Using meta-analytic computations for combined data from the thirteen studies, the authors reported an overall effect size of .052, .272, and .095 for the reduction of depressive symptoms, somatic symptoms, and all other psychological symptoms, respectively. They also found a global average effect size across all types of outcome variables of .114 and concluded that, "The effect sizes for these studies suggest that psychological interventions for bereavement are not effective interventions" (p. 293).

Kato and Mann (1999) offered three possible explanations for these findings. These included the possibility that psychological interventions for the bereaved are simply not helpful, that they are not powerful enough as delivered in the studies (e.g., too few sessions), and that the positive effects of the interventions have been masked by methodological problems such as small sample sizes, unreliable and invalid measures, and high drop-out rates. Importantly, Kato and Mann also noted that most of the studies failed to analyze the data separately by gender and

by expectedness of the loss, two factors that have sometimes been shown to differentially affect bereavement outcome. Finally, the authors noted that, in the majority of studies, participants in both the treatment and control groups tended to improve. This supports the widely recognized observation that most bereavement is self-limiting without formal intervention (Stroebe, Hansson, Stroebe, & Schut, 2001). This, in turn, would tend to decrease the contrast between control and treatment groups in these bereavement intervention studies. Indeed, it is this tendency for many bereaved individuals to improve with or without professional intervention that may account for the larger apparent effects reported by Allumbaugh and Hoyt (1999), who included studies simply reporting pre–post changes without ensuring that such improvement exceeded that of untreated controls.

Neimeyer (2000) summarized an unpublished meta-analytic study of bereavement interventions performed by Fortner and Neimeyer. The authors searched the literature from 1975 through 1998, including in their research only studies that met acceptable scientific criteria of random assignment to treatment and control groups. They included studies involving both children and adults across all types of losses. To assess the effectiveness of the interventions, they used both a more traditional measure of effect size, Cohen's d (Cohen, 1988), and a more novel measure of "treatment induced deterioration" (p. 544). The latter indicated the percentage of people who, on a statistical basis, would have been better off in the no-treatment condition. They found an overall effect size of .13 across the sample of 23 studies, which closely corresponded to Kato and Mann's (1999) findings for a smaller sample of studies. They also found that approximately 38% of participants would have had a better outcome had they been assigned to the control, rather than the treatment condition. This contrasts with most psychotherapy outcome studies, which showed an average deterioration of only 5% (Neimeyer, 2000). In an attempt to further understand these findings, the authors investigated the differential effectiveness of variables such as length of therapy, credentials of the therapist (professional vs. non-professional), modality of treatment (individual vs. group), and theoretical approach used by the therapist. None of these variables was correlated with effect size. However, Neimeyer and Fortner did find that a greater length of time since the death, younger age of the participant, and higher levels of risk (sudden violent death or evidence of chronic grief) were related to increased effect size for the interventions.

Schut, Stroebe, van den Bout, and Terheggen (2001) have published the most recent review of bereavement intervention research. These authors offered a general methodological critique of existing research, noting such common problems as a lack of control groups and random assignment of participants, low initial participation rates, and high levels of non-adherence to and attrition from intervention protocols. They also questioned whether there is a sufficient number of methodologically comparable and rigorous studies to use meta-analytic techniques at this point in time. Accordingly, Schut and his associates limited their review to a qualitative summary of three categories of studies: primary, secondary, and tertiary interventions after loss.

With regard to interventions designed to prevent the development of problems in the general population of bereaved persons (primary prevention), Schut et al. (2001) reviewed 16 studies involving either children and/or adults. They concluded that "primary preventive interventions receive hardly any empirical support for their effectiveness" (p. 720), although they noted that there is somewhat more support for the efficacy of interventions with children than with adults.

The authors also evaluated seven studies that focused on bereaved persons who were defined as being at high risk for developing bereavement related-problems (secondary prevention). These included populations who had experienced the sudden, traumatic death of a loved one, those who were in a high-risk category (e.g., bereaved parents), and those who showed high levels of symptomatic distress on pre-intervention measures or clinical assessment. Schut and his colleagues concluded that although there is more evidence of intervention efficacy for this population, the effects are still quite modest in comparison to traditional psychotherapy outcome studies. They also emphasized the importance of doing gender specific analyses, because several of the studies showed differential effectiveness of the interventions for men and women. Importantly, they also found that studies that specifically screened for high levels of distress (rather than simply selecting on the basis of membership in a high-risk category, such as bereaved mothers) tended to show better results for the intervention.

Finally, Schut and his colleagues examined interventions for people who had already developed a complicated mourning response (tertiary prevention). This group included seven studies in which the participants were already suffering from clinical levels of depression, anxiety, and other bereavement-induced disorders at the time of entry into the study.

Participants also tended to be self-referred for help (as opposed to being recruited to participate), and the interventions were typically delivered a longer time after the death than in secondary and primary prevention interventions. Despite some methodological limitations of the research, Schut's group found that this type of tertiary intervention was generally successful, as indicated by reductions in levels of psychiatric symptoms and grief-related distress when compared with control group participants.

Schut et al. (2001) concluded their review by stating that "the general pattern emerging from this review is that the more complicated the grief process appears to be, the better the chances of interventions leading to positive results" (p. 731). They suggest that this finding may be a result of the fact that many primary and secondary interventions involve outreach recruitment of participants, rather than help seeking on the part of the bereaved. This may result in participants in tertiary studies who are both more distressed (and therefore have greater room to improve) and are more motivated to accept and make good use of psychotherapeutic help. In addition, Schut and his group noted that the most successful interventions tended to be delivered later in the bereavement process. It is possible that this apparent time effect also reflects the presence of greater complication, insofar as the most recent criteria for the diagnosis of complicated grief require marked symptomatology that persists for six months or more following loss (Neimeyer, Prigerson & Davies, 2002; Prigerson & Jacobs, 2001).

Tentative Conclusions about Bereavement Interventions

What conclusions can be drawn about the effectiveness of bereavement related interventions from this brief summary of recent qualitative and meta-analytic reviews of the literature? In general, it appears that the scientifically demonstrated efficacy of formal interventions for the bereaved is distressingly low, far below that of most other types of psychotherapeutic interventions. This is a conclusion that runs counter to the professional experience of many clinicians in the field, including us. Upsetting as they may be, however, these findings deserve careful consideration by practitioners in the field, lest we miss a valuable opportunity to improve the practice of grief counseling. We believe the data provide important information for bereavement researchers and

practitioners alike, and, in that spirit, we would like to offer several possible interpretations of the studies and then conclude with some recommendations for future research and the practice of bereavement care. More specifically, we would like to offer three possible and interrelated explanations for the general findings that grief counseling has very low efficacy: grief counseling may not be needed by most mourners; grief counseling may not work in the form that it is typically delivered in research studies, and the positive effects of grief counseling may be masked by methodological issues in the design and implementation of the studies.

Formal Intervention May Not Be Needed Much of the Time

One likely explanation for the failure to find significant effects is that most uncomplicated grief is probably naturally self-limiting. Most longitudinal studies of bereavement show naturally occurring declines in bereavement symptoms (Ott & Lueger, 2002; Raphael, Minkov, & Dobson, 2001; Stroebe et al., 2001). With the help of family and friends, apparently most mourners are able to work through and integrate their losses relatively well. This self-healing trend is also evidenced by the fact that control participants in many studies tend to improve without any intervention (a fact that would tend to wash out differences between control and treatment groups). Likewise, Schut et al. (2001), and Allumbaugh and Hoyt (1999) noted that studies showing the greatest efficacy involved designs where mourners sought help for self-identified bereavement-related distress, rather than being recruited into the study simply because they were bereaved. This suggests that most mourners who seek out professional care in non-research settings may be more distressed and not following the more expected trajectory of "healing with time." It is also plausible that persons who seek out grief counseling on their own are more motivated to deal with the loss than the general population of mourners, although we are aware of no research studies that have specifically examined that proposition.

Neimeyer's (2000) calculation that 38% of participants would have done better had they not received the intervention also raises the sobering possibility that some services may be actively detrimental for some mourners. As an example, Murphy and her colleagues (Murphy et al., 1998) found that men who participated in a carefully designed group intervention for parents bereaved by the violent death of their children

actually worsened on symptoms of PTSD. Moreover, this unexpected outcome occurred even though the group was based on reasonable clinical principles that balanced supportive discussion with coping skills training in each session. Likewise, Farberow (1992) found that participants in a suicide survivor support group worsened on certain types of emotional responses after participation. Researchers and clinicians alike should be very alert to the possibility that for some, interventions may do more harm than good (Jordan, 2000). It may be that people with more avoidant (Bonanno, 1999) and/or instrumental (Martin & Doka, 1999) coping styles are more likely to respond poorly to traditional bereavement interventions that emphasize emotion-focused, rather than problem-focused, coping styles. This is buttressed by studies showing that men may use and respond to bereavement support services differently than women (Mastrogianis & Lumley, 2002).

Of course, by observing that most mourners may not need formal bereavement intervention, we are not suggesting that all people who do not seek services will necessarily do well after the death of a loved one. On the contrary, one of the most important trends in these reviews is the recognition that there are subgroups of mourners who are at elevated risk for dysfunction and who respond well to formal intervention. For example, the research associated with the proposed new diagnostic category of traumatic or complicated grief (Prigerson & Jacobs, 2001) strongly suggests that this disorder is neither self-limiting nor benign in its mental health and medical consequences (Ott, 2003). Moreover, we simply do not know what percentage of at-risk and high-distress mourners actually seek treatment. There may be a group of bereaved persons who are not likely to improve simply with time and informal support, yet who are also unwilling or unable to access professional services. This “hermit” group of mourners is of particular concern, and may require alternative service modalities, including extra outreach (please see recommendations below).

Grief Counseling as Delivered in Research Studies May Be Ineffective

Most studies represented in the reviews offered 8–12 sessions of intervention, whether group or individual. These sessions were generally held on a weekly basis, meaning that on average the participants had contact for about three months with the caregivers/researchers. It is possible that the dosage (how many sessions) and timing (when they were delivered)

of treatment were simply too “weak” to produce measurable effects. Several studies have suggested that for some people, mourning may be a longer process than commonly believed, particularly after certain types of traumatic loss (Lehman, Wortman, & Williams, 1987; Murphy, Johnson, & Lohan, 2003). There is evidence that certain aspects of the experience may worsen rather than improve in the second and third years (Wortman, 2001). Thus, a research intervention consisting of only a few sessions may be considerably below the “therapeutic dosage” level needed to produce a measurable effect.

Likewise, the timing of interventions in the bereavement trajectory may be important, with many interventions being delivered too early or too late in the grieving process to be effective. Allumbaugh and Hoyt (1999) found that interventions delivered closer in time to the loss seemed to produce greater effect sizes. However, their mean time since the death across all reviewed studies was two years, suggesting that “earlier” after the loss may still have been a relatively long time post-death when compared with programs that begin shortly after the loss. The Kato and Mann (1999) review, which primarily had duration times of 3–12 months post-loss (and tighter methodological selection criteria for inclusion of studies), did not find significant effects for time since the loss. In addition, Neimeyer (2000) actually found that interventions that occurred sooner after the death had significantly smaller effect sizes. Similarly, in their qualitative review, Schut et al. (2001) reached a similar conclusion that interventions offered too soon in the mourning process may be less effective, or even counter productive. It is difficult to reconcile these somewhat contradictory findings, unless we consider the possibility that the optimal timing of bereavement interventions may be curvilinear. That is, there may be a critical window of time, neither too soon nor too long after a loss, when mourners are most responsive to and able to use formal support services. One possibility is that services may be most effective when delivered in a 6–18 month period following the loss. This may be the time when complicated grief is both diagnosable and prognostic of later difficulties (Ott, 2003; Prigerson & Jacobs, 2001), but before problematic patterns of adjustment have become entrenched or triggered “empathic failure” in the mourner’s family or community (Neimeyer & Jordan, 2002). This speculation obviously requires further empirical validation before clinical practices are adjusted to reflect this concept.

A third possibility is that the types of support needed early in the mourning trajectory may be different from those required later in the process. For example, young widows and widowers who are early in their grief may need support with grieving and the adjustment to single parenting. One to two years after the loss, however, their focus may shift toward finding a new partner and establishing a blended family, concerns that are substantially different from those of early grievers. In any study that mixes mourners who are at different points in their mourning process, a generic intervention may be effective for only some of the participants, making detection of significant effects more difficult. We are aware of no study that has attempted to customize the type of intervention to particular points in the bereavement trajectory, although this would be a valuable contribution.

Finally, the membership composition of the group therapies used in most intervention studies could also limit their effectiveness. Greater identification and support among group members (especially early in the group) has been associated empirically with more favorable outcome (Geron, Ginzburg, & Solomon, 2003; Yalom, 1995), suggesting that clients who do not identify with the other group members may be at risk for negative effects (Neimeyer, Harter & Alexander, 1991). Because support and therapy groups provided to the bereaved rarely prescreen prospective members to ensure their homogeneity on relevant variables (e.g., ethnicity, gender, or level of distress), it is likely that some members might perceive themselves as “outliers,” at risk of feeling alienated from the group. Likewise, the presence of people in the group with markedly different levels of difficulty (e.g., including one or two persons with extremely traumatic losses or complicated grief reactions in a group of mourners with more normative experiences) could lower group cohesion, lead to a preoccupation with (or resentment of) needy members, or frighten more typical grievers with the prospect of their own deterioration. It is even possible that the apparently greater efficacy of interventions for at-risk mourners reflects their greater homogeneity and its implications for greater between-member identification and supportive sense of universality in group interventions, rather than their direct responsiveness to treatment because of their distress. (However, this would not explain the apparently greater effectiveness of treatments employing individual modalities for at risk individuals.) This possibility could be more carefully evaluated in future studies by examining outcomes for complicated grievers in heterogeneous versus homogeneous

groups or could be controlled by ensuring sufficient commonality of membership through advance screening of members to minimize the potential problem of group outliers.

To summarize, the duration, timing, precision, and group composition of services in typical outcome studies may be out of synchrony with some mourners participating in the research, thus minimizing the overall positive impact of the interventions and making it appear that grief counseling has little efficacy. In fact, interventions of greater “strength” or more customized design might well demonstrate greater effects.

Methodological Problems May Mask True Benefits

Although recent studies have shown improved methodological sophistication, the general quality of research on bereavement interventions leaves much to be desired. The designs of many studies suffer from the common problems found in many psychotherapy intervention studies (see Schut et al., 2001, for a review). These include the lack of appropriate control groups and random assignment to treatment conditions, small sample size (and consequent low statistical power), and lack of a theoretical foundation for and adherence to a clear treatment protocol. An additional problem is the failure to choose psychometrically sound outcome measures that pertain to the grieving process, despite the recent development of such measures (Neimeyer & Hogan, 2001). Most studies have used narrowly defined and simplistic criteria to assess the impact of the intervention, such as psychiatric symptom checklists or global measures of functioning. Many models of bereavement suggest that simplistic formulations of recovery are likely to be of little help in conceptualizing or measuring outcomes in bereavement. For example, Rubin and Malkinson (2001) have proposed a two-track model of bereavement outcome that examines both the return to functioning of the mourner and the ongoing and evolving internal relationship to the deceased (an issue unique to loss-related phenomena). It is possible that many bereavement intervention studies fail to find an effect because they are measuring the wrong outcomes and need to focus on variables that are specific to bereavement.

On a related point, the apparently disappointing outcome that characterizes existing intervention studies could derive in part from their orientation to the pathogenic rather than the salutogenic consequences

of profound loss. That is, by focusing preemptively on outcomes defined in terms of depression, anxiety, or grief symptomatology, investigators may fail to observe equally important positive consequences of bereavement that have been well documented (Frantz, Farrell, & Trolley, 2001; Neimeyer, Prigerson, & Davies, 2002). As contemporary theories of posttraumatic growth (Tedeschi, Park, & Calhoun, 1998) and meaning reconstruction (Neimeyer, 2001) emphasize, personal development defined in terms of enhanced empathy for the suffering of others, a revised sense of life priorities, and deepened existential or spiritual attunement seems to occur because of residual pain and distress rather than only when it is ameliorated. For this reason, measures that assess meaningful growth as well as bereavement symptomatology (e.g., Hogan, Greenfield & Schmidt, 2001) are worth considering in future studies, as well as in clinical practice.

Finally, many studies have failed to investigate a number of interactional or moderator variables that may be masking the positive benefits derived by subsets of participants in intervention studies. A number of these intervening variables have been previously mentioned, including differential responses to an intervention based on gender, risk status, circumstances of the death, and time since the death. The reviews cited in this article suggest that women, high-risk mourners, sudden traumatic loss survivors, and mourners further along in the grieving process generally respond better to the studied interventions than men, low-risk mourners, and expected death and recent loss survivors. Investigations that fail to analyze data for these groups separately are more likely to have “washouts,” wherein real intervention effects for some groups are masked by the apparent lack of impact for the entire subject pool. These are precisely the results that Murphy et al. (1998) and Murray, Terry, Vance, Battistutta, and Connolly (2000) obtained in their carefully designed intervention studies.

Recommendations for the Future

We believe there are trends noted in these four reviews that have important implications for the conduct of grief counseling. Hence, we would like to conclude this article with a discussion of some of the implications for both researchers and clinicians in thanatology and to offer a set of specific recommendations for future research and practice.

Recommendations for Research

There is a continuing need for improvement in the quality of research designs in grief counseling interventions. Although recent reports show an awareness of the principles of good research design (Murphy et al., 1998; Murray et al., 2000; Schut, Stroebe, van den Bout, & de Keijser, 1997), the majority of studies still demonstrate poor internal validity, making it difficult to draw confident conclusions from the research. In addition to the basic principles common to the design of all intervention studies (Kazdin, 1998), there are some specific issues that need improvement in bereavement intervention studies. As previously discussed, a broad range of outcome measures needs to be used not just symptom-oriented tools. These measures should be sensitive to changes in domains that are likely to be pathognomic indicators specific to bereavement, such as yearning for the deceased, feelings of guilt and remorse, shattering of the mourner's assumptive world, and so on, that are unremitting, long term in duration, and disruptive of functioning. As previously mentioned, we also make a plea for the use of measures that assess the positive outcomes that may accrue to mourners after the loss of a loved one.

Likewise, data need to be analyzed taking into account the moderator variables that appear to be influential in determining the effectiveness of an intervention. At a minimum, these include gender, time since the death, risk status of the mourner (including both membership in a high-risk category and elevated distress levels at the start of the intervention), and pre-existing personality and functioning of the mourner. We also strongly support the incorporation of mixed qualitative and quantitative designs in bereavement intervention research (Jordan, 2000; Neimeyer & Hogan, 2001). Well-conceived qualitative data can tap into many of the bereavement specific issues that are frequently missed in the use of standardized self-report measures. Studies that use qualitative methods to explore which aspects of interventions are most helpful to the bereaved would be particularly useful in designing and improving interventions.

Secondly, we would encourage bereavement intervention researchers to concentrate their intervention studies on high-risk mourners. We believe there is now sufficient evidence to conclude that generic interventions, targeted toward the general population of the bereaved, are likely to be unnecessary and largely unproductive. Instead, interventions that are tailored to the problems of mourners in high-risk categories (e.g.,

bereaved mothers, suicide survivors, etc.), or showing unremitting or increasing levels of distress after a reasonable period of time are likely to be more beneficial. Jacobs and Prigerson (2000) have offered a review of interventions that show promise in treating individuals meeting criteria for the proposed disorder now being called *complicated grief*. Along with this, there is a great need for researchers to focus on the development of screening measures that have good predictive validity for identifying persons at risk for complicated mourning responses. New measures such as the Inventory of Complicated Grief (Prigerson & Jacobs, 2001) and the Grief Evaluation Measure (Jordan, Baker, Rosenthal, Matteis, & Ware, 2003) show promise in this regard.

Thirdly, we believe there is a need for researchers to spell out in more detail the theoretical foundation for and the operational implementation of their interventions. Most reports in the literature provide only a cursory description of how the treatment procedures were developed, how they were linked to previous research in the field, and how they were delivered during the intervention. The recent work of Murphy (Murphy et al., 1998) and Sandler (Sandler et al., in press) and their associates are good examples of research interventions that have a solid theoretical foundation and a detailed accounting (through an available manual) of the procedures used in the intervention. This attention to detail in future studies will facilitate the accumulation of knowledge and replication of interventions for both research and clinical purposes.

Fourth, at the risk of contradicting ourselves with regard to the call for more sophisticated research designs, we would also like to suggest more effectiveness-oriented, as well as efficacy-focused, research within bereavement care programs. Although randomized, controlled studies of treatment interventions are still considered the “gold standard” of research design, we believe that there is much to be learned from studying the effectiveness of common interventions as actually delivered in “real world” clinical settings (Borkovec & Castonguay, 1998; Seligman, 1995). As noted previously, there is a distinct possibility that most research-based interventions are too weak and poorly timed to show efficacy, whereas many interventions delivered in clinical settings might prove more effective. For example, many agencies and organizations offer bereavement support groups with varying structures and leadership formats, from open-ended, peer-facilitated groups such as the Compassionate Friends to time-limited psychoeducational groups run by professionals. While less credible from a strict validity standpoint, a

large-scale study focused on the effectiveness of these groups (perhaps when compared with a sample of mourners who do not attend groups) would offer a wealth of information about the relative usefulness of different styles of group interventions for different types of mourners and loss situations.

Lastly, we make a plea for bereavement intervention researchers to pay close attention to the trends in the very large body of studies on psychotherapy outcome research (Nathan & Gorman, 2002; Wampold, 2001). Although there is still debate about this point, there is convincing evidence that the non-specific, relational, and contextual aspects of psychotherapy are probably the most important “active ingredient” in the treatment process, rather than specific techniques or procedures (see Deegear & Lawson, 2003, and Wampold, 2001, for recent reviews). In the current era of managed care, the prevailing model of psychotherapy is based on an analogy with medical treatment, wherein an expert diagnoses and then treats a relatively passive patient for specific disease or injury. We believe this model is likely to have only limited use when thinking about the provision of assistance for bereaved individuals, even those with specific patterns of dysfunctional bereavement response such as complicated grief (Prigerson & Jacobs, 2001). Wofelt (2003) proposes instead that we conceptualize this work as a form of “companioning.” We feel that this term is compatible with a conceptualization of grief counseling as a specialized and concentrated form of skillful social support, rather than the administration of a highly technical and diagnosis-specific medical procedure. This suggestion is compatible with studies indicating that the relational aspects of any psychotherapeutic encounter provide a context for the inspiration of hope and the learning of new coping skills that is crucial to all successful psychosocial interventions (Frank & Frank, 1991).

Note that we are not suggesting that there is no role for the use of well-defined techniques in grief counseling (such as eye movement desensitization and reprocessing (EMDR), journaling, guided visualization, etc.). Rather, we believe that the common and probably most important factor in all bereavement interventions is the encounter with compassionate and empathically attuned caregivers who provide mourners with a healing experience of being understood and supported in their journey of loss. If this assumption is correct, then bereavement intervention researchers should build on the large body of studies from psychotherapy outcome research that identify crucial aspects of the therapeutic

relationship (Norcross, 2002). In a parallel fashion, we encourage thanatology researchers to begin to delineate those aspects of the therapeutic relationship in grief counseling (whether individual or group) that provide this crucial interpersonal matrix for healing after a loss. We are unaware of any studies in grief counseling that have examined this important dimension, and we strongly encourage the field to begin looking at this aspect of intervention.

Recommendations for Practice

Our suggestions for clinicians generally mirror the comments for researchers, with perhaps a more circumscribed strength of recommendation, because we believe that recommendations for changes in clinical practice require a higher degree of empirical validation than simple suggestions for promising areas of further research. Perhaps the first request is that grief counselors adopt a more critical attitude toward their methods. On the basis of the trends observed in these summaries, we feel that it should no longer be taken for granted that grief counseling is necessary and necessarily helpful for all or most mourners. Indeed, perhaps the central finding of these reviews is that grief counseling does not appear to be very effective, most probably because many of the people who receive it would do just as well (and perhaps in some cases better) without it. The assumption that grief counseling is “naturally” beneficial for everyone fails to recognize the possibility of harmful effects of bereavement interventions for some individuals. This readiness to encourage all individuals to receive treatment needs to be replaced with an effort to customize interventions to the particular gender, personality, background, resources, and perceived needs of individual mourners. Although the empirical basis for this customization is in its infancy, we encourage clinicians to work toward this goal in their daily practice. Again, there is a growing body of research from the general psychotherapy outcome literature that offers empirically based guidelines for the customization of intervention modalities and styles that may serve as a useful starting point for grief counselors (Beutler, 2000). For example, clients who view their problems in terms of distinct symptomatology have been shown to respond well to behavioral or cognitive therapy, whereas those who view their difficulties in more psychological terms seem to favor insight-oriented group therapy (Winter, 1990).

A corollary of this is that clinicians should not assume that “one size fits all” in terms of the types of interventions required by mourners. It is a truism that grief is unique to each individual (Neimeyer, Keesee, & Fortner, 2000), yet this wisdom is rarely reflected in the design and delivery of services for the bereaved. Although some interventions may be customized to the extent that they target specific kinship losses (e.g., death of a child) or cause of death (e.g., homicide survivors), it is rare that the content or process of an intervention is tailored to address the specific problems of the targeted group, although steps are being made in this direction (Rynearson, 2001). Moreover, our impression is that there is typically very little formal assessment done with persons seeking bereavement support. More attention paid to the personality structure, previous loss, trauma and psychiatric history, coping style, and support resources available would help clinicians make more informed judgments about the types of services that are likely to be beneficial for a given individual.

The reviews cited in this article offer a rather confusing picture for the clinician seeking guidance about the timing of interventions, although there seems to be some evidence that services delivered later in the bereavement trajectory are more effective. This finding may be related to the finding that higher risk mourners also respond better to interventions. Schut et al. (2001) noted that the studies classified as tertiary interventions (which by definition presume the development of a diagnosable disorder) showed the greatest efficacy for their treatments. These authors pointed out that it might take some time for a mourner to develop full-blown complications after a loss, which might account for the observation that later interventions appeared to be more powerful. As we have previously observed, another possibility is that the relationship between the timing of the intervention and efficacy is actually curvilinear, suggesting that providing assistance too early or too late in the bereavement trajectory may reduce its effectiveness. Our own clinical experience suggests that the optimal time period may be somewhere between 6 to 18 months after the death, but this is an issue that must be empirically evaluated. In the meantime, clinicians would probably do well to have early contact with newly bereaved clients to establish a relationship and provide psychoeducation, but they should be cautious about pushing mourners into treatment too early in the process. Likewise, the research suggests that arbitrary cutoffs of one year for bereavement care, as found in many hospice programs, may be poorly thought

out. Rather, a program of less frequent but longer-term contact with bereavement caregivers (e.g., 12 sessions beginning at 4–6 months post-loss and spread over 12 months rather than 12 weeks) may be more effective.

Just as we suggested to researchers, we also believe that clinicians and program administrators should concentrate their efforts on identifying and engaging high-risk mourners. On the basis of the available literature (Parkes, 2002; Stroebe & Schut, 2001), this would include men who lose spouses (particularly older and isolated males), mothers who lose children, and survivors of sudden and/or violent traumatizing losses, such as suicide, terrorist attacks, warfare, homicide, and accidental death. Likewise, individuals with previous psychiatric histories (including depression, substance abuse, post-traumatic stress disorder, and psychotic disorders), low self-esteem or coping self-efficacy, high levels of dependency on the deceased, and abuse/trauma histories are likely at elevated risk. Finally, individuals manifesting high-distress grief (e.g., high levels of depressive, anxiety, anger, or rumination symptoms, or who meet diagnostic criteria for complicated grief) early in their bereavement experience are also likely to benefit more from intervention. Bereavement support programs, hospices, and nursing homes that have contact with individuals facing a loss are in an excellent position to identify and perform outreach to these high-risk categories of mourners.

We hope that this “review of reviews” proves to be both provocative and stimulating to our colleagues in thanatological research and practice. With the incorporation of research findings into the practice of grief counseling, and the thoughtful researching of new interventions and services developed in the clinical setting, we envision an improved and more exacting answer to the question “Does grief counseling work?” in the years to come.

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