

Running Head: THE EFFECTIVENESS OF A COGNITIVE NARRATIVE  
INTERVENTION FOR COMPLICATED GRIEF

The Effectiveness of a Cognitive Narrative Intervention for Complicated Grief in  
Widowhood

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### Abstract

The implementation of bereavement interventions is frequently requested, and its effectiveness has been controversial. The aim of this study is to evaluate the effectiveness of a cognitive narrative intervention for complicated grief (CG) for controlling post-traumatic and depressive issues. The study is a randomised controlled trial and uses the Socio Demographic Questionnaire (SDQ), the Inventory of Complicated Grief (ICG), the Beck Depression Inventory (BDI) and the Impact of Events Scale - Revised (IES-R). There were three phases in the study: (1) The SDQ and CG evaluations were applied to bereaved elders ( $n=82$ ). The bereaved elders with the 40 highest ICG values ( $\geq 25$ ) were randomly allocated into two groups: the intervention group ( $n=20$ ) and control group ( $n=20$ ); (2) Participants were evaluated using the BDI and IES-R and the IG gave informed consent to participate in an intervention with four weekly 60 *min* sessions addressing recall, emotional and cognitive subjectivation, metaphorisation and projection. (3) Two months later, the ICG, BDI and IES-R assessments were repeated. Outcome measures showed a statistically significant reduction of CG, depressive and traumatic symptoms compared to the controls. Very high effect sizes for the ICG, BDI and IES-R reflect the effectiveness of the intervention along the longitudinal profile. These results reinforce the importance of brief interventions that combine a reduced number of sessions with lower costs, which is reflected in an increased adherence to the program along with high effectiveness.

Keywords: randomised trial, cognitive narrative intervention, widowhood, complicated grief.

## The Effectiveness of a Cognitive Narrative Intervention for Complicated Grief in Widowhood

Grief is a well-marked event with powerful meaning in individual lives (Bonanno, 2001; Boelen, Keijsers, Hout & Bout, 2007; Wagner, 2006). We discuss healthy grief or uncomplicated grief when the loss turns out to be accepted and the ability to function in everyday life is regained (Stroebe et al., 2007; Boelen & van den Bout, 2008). However, when this process is not experienced in a normative way, the process is referred to as complicated grief (CG). CG is more prolonged and severe than expected (Bonanno et al., 2007; Stroebe et al., 2007; Newson, et al., 2011), affects the individual's functional capacity (Tomita & Kitamura, 2002; Wittouck et al., 2011), and prevents their return to the level of functioning prior to the loss (Prigerson et al., 1995; Newson et al., 2011). Spousal bereavement is the type of loss that most often results in psychological and psychiatric referral and leadings to severe and prolonged feelings of grief and loneliness (Parkes, 1998, 2006; Prigerson et al., 1995). Newson and colleagues (2011) reported that in a sample of elderly patients, 4.8% had CG. The loss of a spouse presents a 2.42-fold increased risk of experiencing CG (95% CI 1.38 to 4.21). However, CG is not yet included in the DSM-4 (Prigerson, Jacobs, Rosenheck & Maciejewski, 1999; Jacobs, Mazure & Prigerson, 2000); despite this, many researchers believe that CG is a diagnostic entity that is distinct from major depressive disorder (MDD) and posttraumatic stress disorder (PTSD) (Golden & Dalgleish, 2010; Zuckoff et al., 2006). Lichtenthal and colleagues (2004) reported that approximately 40% of the general population meet the criteria for CG and not for MDD or PTSD. On the other hand, during a mourning process, in addition to CG, many people experience various symptoms (Kristjanson, Lobb, Aoun, & Monterosso, 2006), such as sadness, loss of interest, and intrusive thoughts; thus, they display symptoms that meet the criteria of other disorders as well, such as MDD (Zisook, Shuchter, Sledge, Paulus, & Judd,

1994) or PTSD (Schut, De Keijser, Van Den Bout, & Dijkhuis, 1991). Simon and colleagues (2007) found that in addition to CG, 55% of complicated grievers presented with MDD symptoms, and 49% met the criteria for PTSD. Silva (2010) concluded that 70.9% of psychiatric outpatients have both CG and MDD, 73.6% have both CG and PTSD, and 69% show triple comorbidity. As a result, bereaved elders with CG are likely to meet the criteria for MDD and/or PTSD; therefore, intervention in this area is clinically relevant and should at a minimum address this triple group of comorbid symptoms. Researchers and clinicians would benefit from short-term interventions (Kang & Yoo, 2007; Kato & Mann, 1999; Jané-Llopis et al., 2003; Jané-Llopis & Barry, 2010) that are validated and acceptable for patients (Munõz, 2001). It has been stated that the best treatment for CG may have not been developed yet (O' Conner et al., 2003; Wittouck et al., 2011) and that there is no well-defined protocol for psychological interventions in this area (Stroebe et al., 2006). Taking this into account, the use of narratives has demonstrated positive results in interventions with the bereaved (Parkes, 2006; Currier et al., 2008); the expression of emotions (Stroebe et al., 2005) and thoughts has therapeutic effects (Pennebaker et al., 1988); and the creative use of metaphors promotes meaning reconstruction (Gonçalves, 1994, 2002b). Careful use of sensorial memories with patients at risk for PTSD (Rocha, 2004) would enable the construction of a better-adapted bereavement narrative.

The current study, performed in Portugal, aimed to evaluate the effectiveness of cognitive narrative intervention in reducing the total values of complicated grief, depressive and traumatic symptoms in bereaved participants by examining differences between two groups: the IG (intervention group) and controls (control group, without intervention, waiting list).

## Method

### *Study design*

This study, approved by an institutional review board, is a longitudinal randomised controlled clinical trial. Repeated measures, including robustness tests of intervention and bias control (Nezu & Nezu, 2008), were used. The variables considered are the following: (a) complicated grief, depressive and traumatic symptoms (dependent variables) and (b) cognitive narrative intervention (independent variable). There are three sequential phases: (1) assessment of the total value of the Inventory of Complicated Grief of bereaved elders and data collection for the sociodemographic questionnaire. Forty of these, with the highest ICG levels (equal to or greater than 25, considering the cutoff value for this instrument (Prigerson et al., 1995; Frade et al., 2010)), consented to participate and have been randomly allocated into either the intervention group ( $n=20$ ) or the waiting list group ( $n=20$ ). (2) Participants ( $N=40$ ) were then assessed with the BDI and IES-R, and those participants in the intervention group began a program based on cognitive narrative therapy (CNT). (3) Finally, two months after the intervention, we repeated the evaluation with the ICG, BDI and IES-R on members of both groups.

### *Intervention: manualised cognitive narrative program for complicated grief in widowhood*

#### Treatment conditions

To achieve our objective, it is important to consider the robustness of the treatment based on an intervention manual (Nezu & Nezu, 2008; Jané-Llopis & Barry, 2010). The manual should be descriptive and allow the investigator to make adjustments. Our attention focuses on the *Manual of cognitive narrative psychotherapy: manual of brief therapy* (Gonçalves, 2002a). It was necessary to shorten the number of sessions due to time constraints, while still

remaining consistent with the methodology of CNT. The program was reduced to four individual weekly sessions lasting approximately 60 *min* each. The first session involved **recalling**; the objective of this session is to evoke the most significant episode of loss and to make clear the meaning of the deceased. Patients described the importance of the deceased and their journey through life together, and they were then asked to evoke memories from a specific episode related to the loss. The second session addressed **emotional and cognitive subjectivation**. Patients described the episode and structured their experience with sense of authorship, coherence and diversity of cognitive and emotional content, in contrast with the previous session. Initially, emotions were activated, and the second step was the exploration of the cognitive components, followed by the realisation of associations between thoughts and emotions. The third session involved **methaphorisation**, in which the objective was for the patient to explore different meanings for the chosen episode and to choose a metaphor/title unifier. For example, *“If it was a movie or a book, what title would you give?”* Frequent use of specific interview skills was suggested, such as paraphrasing, silence and reflection of meaning, as well as techniques eliciting metaphors from the perspective of another. For example, *“If your husband was here, what would you think he would say?”* Finally, during the fourth session, **projection** took place; the patients built and experimented with other possible organisations of the episode, generating meaningful future projections. The therapist invited the patients to build up and reconstruct several narratives. The metaphors in the projection envision circumstances more positively, providing an alternative to a root metaphor. This can be discussed as follows *“Does this narrative represent a more adaptative functioning?”*

At the beginning of each session, a summary of the previous meeting was presented, and at the end of each session, there was an exploration and summarisation of the patients’ reactions.

It is important to note that the sensorial objectivation phase described in CNT manuals was not performed due to increased risk of traumatic recall (Rocha, 2004), resulting from activation of sensory experiences with intense traumatic emotions (Gonçalves, 1994, 2002a, 2002b).

#### Therapists and treatment reliability

Treatments were conducted by the first author of this work, who had undergone training and continued supervision in CNT. The treatment was manualised and described in a detailed session-by-session protocol to increase treatment reliability. Therapy sessions were monitored; at the end of each session, as well as for each patient, the psychologist conducted a self-assessment. Some sessions were monitored by supervisors to ensure that the therapist adhered to the protocol.

#### *Sample*

##### Sample selection

Bereaved elders were recruited from three nursing homes in northern Portugal. Those who fulfilled the inclusion standards were eligible; spousal loss over 6 months ago and age over 60 years were the criteria. Individuals with current substance abuse or dependence, psychotic symptoms, severe depression with a risk of suicide, presence of dementia, severe hearing difficulties, or current psychotherapy or psychotropic medication use were excluded. The study was disclosed in detail, and informed consent was requested from eligible participants.

A total of 82 bereaved elderly were eligible and were administered the Inventory of Complicated Grief. Cases with higher scores were flagged. Twenty-nine did not have CG, and they were excluded as a result; 53 participants had CG. Thirteen of the 53 cases displayed borderline symptoms of CG, and they were also excluded. Upon completion of the selection process, 40 participants were chosen (see Figure 1).

## Participants

The selected sample contained 40 participants ( $N=40$ ). These participants were randomly allocated into two groups: an intervention group and a control group, each with 20 participants (see Figure 1). Both groups' participants underwent the same sampling and assessment procedures. Table 1 describes participant characteristics for each group. The participants in the IG and control group were homogenous in that they displayed similarities in sociodemographic characteristics. There were no significant differences between groups in all characteristics, suggesting that randomisation was successful.

## Analysis of attrition rates in the sample

The values of attrition rates for IG considered were the following: (a) number of initial participants ( $n=20$ ), (b) number of participants in the intervention ( $n=20$ ), (c) number of participants who completed the intervention ( $n=20$ ) and (d) number of participants who completed the last evaluation ( $n=19$ ) (see Figure 1). There was attrition of one participant in the IG due to his own death. Thus, there was no abandonment during the four sessions of the intervention program or the subsequent evaluation (adhesion=95%, attrition rate=5%). Regarding the controls, of the 20 participants initially contacted, none of the cases had been lost at the final evaluation (see Figure 1). Given that all of the research was conducted in institutions, issues with session scheduling did not arise; however, there is a clear indication of good acceptability, and there is no bias related to missing cases in either group.

## *Assessment*

A brief SDQ was delivered to collect data from the bereaved elders; this included information regarding personal identification, a history of the couple's relationship and contextualisation of the loss from the bereaved's perspective. These data were utilised to



screen eligibility criteria, control homogeneity between the IG and control group and (in the case of the IG) to contextualize the loss. The dependent variables were operationalised with three measurement instruments in their Portuguese versions: the ICG, a 19-item measure of CG (Frade et al., 2010); the BDI, which has 21 groups of statements reflecting the severity of depressive symptoms (Serra & Abreu, 1973); and the IES-R, a 22-item measure of traumatic symptomatology (Castanheira et al., 2006). These instruments have adequate psychometric properties in terms of reliability (Cronbach's Alpha: ICG, .91; BDI, .89; IES-R, .94). The ICG, the BDI and the IES-R were administered at pretreatment and again at two month follow-up. In addition to these instruments, a brief questionnaire was used to evaluate the acceptability of the intervention by the IG.

### *Data analysis*

Before proceeding to the data analysis, participants' names were replaced with numbers to protect anonymity and confidentiality. We used the IBM SPSS Statistics software (version 19) for statistical analysis and effect size calculator. Four steps were followed. (1) Each dependent variable was analysed and compared between groups at first assessment phase (T1) and at the second assessment phase (T2) using *t* test analysis. Subsequently, we calculated the effect sizes of the intervention, using the Hedges conservative procedure adjusted to the number of cases. (2) After evaluating the instruments' cutoff values and flagging those cases with a decrease in symptoms (better evolution) on the longitudinal profile, a nonparametric chi-square test was used to compare frequencies and prevalences between groups. (3) With the consideration that the previous effect-size analysis only includes between-groups effects, we also applied a multivariate general linear model (GLM) of repeated measures for CG, depressive and traumatic symptoms. This was performed in order to undertake an analysis of evolution over the longitudinal profile (the influence of time

factors and the interactions (time x groups) in the intervention program. (4) Finally, we presented the descriptive values of the patient's acceptability with the intervention program.

## Results

### *Comparison between IG and controls outcomes in the first and second phases*

There are two essential conditions with which outcomes can be compared when addressing the effectiveness of an intervention; at T1, there should not be statistically significant differences between groups, while at T2, there should be significant differences between groups (APA, 2002). We calculated the mean of the ICG, BDI and IES-R scores at T1 and T2 and compared the differences using the *t* test for independent groups. As seen in Table 2, at baseline, there is no significant difference between groups on the ICG. However, at T2, there is a significant difference between groups for complicated grief ( $p < .01$ ). The IG had a lower mean ( $M=25.32$ ;  $SD=6.46$ ) when compared to the controls ( $M=39.80$ ;  $SD=5.31$ ). Among the baseline BDI scores (see Table 2), we noted non-significant differences between groups, which is expected, considering the randomisation procedures; in T2, however, there are very significant differences between the groups. At T1 for the IES-R, we found a significant difference between the groups; nevertheless, at T2, we observed a very positive difference in traumatic stress outcome, with a significance level of  $p < .01$ . The IG had a lower mean ( $M=15$ ;  $SD=7.45$ ) compared to the controls ( $M=42.80$ ;  $SD=7.73$ ). Due to problems with the baseline assessment, this statistical procedure did not sufficiently clarify the intervention effects on traumatic stress; this issue will be addressed later, using a repeated measures analysis.

### *Effect Sizes*

Regarding the effect size analysis of the cognitive narrative program's second evaluation control intervention (see Table 2), we can say that the value of the ICG, the BDI and the IES-

R is considerably high (ES values  $>.08$ ) for small samples. Of all the variables, the IES-R showed the highest ES value ( $g=3.59$ ). We found a positive effect that falls within the confidence interval (95% CI for ICG, 1.58-3.23; BDI, 0.86-2.29; IES R, 2.57-4.60), due to the IG demonstrating better results during the second evaluation compared to the controls.

*Comparing the frequency and prevalence of CG, MDD and PTSD in groups and their positive evolution*

In order to calculate the frequencies and prevalences of CG, MDD and PTSD for each group and for each phase (T1 and T2), a ICG cutoff point of  $\geq 25$  was used, as well as  $> 12$  for the BDI and  $> 35$  for the IES-R. For the analysis of the positive evolution of the IG and controls, we used the chi-square test implemented using the crosstabs procedure, which allowed us to quantify the number of cases that progressed positively along the longitudinal profile of each group. As seen in Table 3, we found that at T1, all participants had CG. This was one of the initial criteria for participation (see Figure 1). At T2, a decrease in prevalence of CG in the IG (94.7%) is evident, with five participants maintaining CG; they represented 26.3% of the group. The controls, at T2, displayed had a reduced prevalence of CG of (80%), that correspondings to the positive evolution of 16 participants; 95% of participants still had CG. As shown in Table 3, depression prevalences in both intervention and control participants were similar at T1. At T2, the IG showed a positive evolution for 16 cases (84.2%), while the controls had a positive evolution for 15 cases (75%). There is a stay of 19 cases with MDD (95%) in the controls, in contrast with the number of MDD cases in the IG ( $n=8$ ; 42.1%). In the first evaluation, using the IES-R, the IG contained eight participants with PTSD, while the control group had 14 participants (see Table 3). Thus, although complicated grief was the main clinical focus problem, we noted the presence of PTSD in some participants. Despite these disparate differences between the IG and controls at T1, we

see that at T2, the IG had a positive development of 100%, as it had no participants with PTSD. In turn, the controls showed a positive evolution of eight cases. By calculating the value of the Pearson chi squared, at T1, we did not find significant differences between groups in frequency and prevalence of CG, MDD or PTSD, and we also found are significant differences between the groups at T2.

*Multivariate repeated measures (time effect and interception effect)*

Using Mauchly's test of sphericity, we obtained a value less than .05; thus, we can be confident that the data from the GLM do not meet the assumption of sphericity (Bryman & Cramer, 2003). Examining Table 4, we concluded that the intervention program had a very positive effect on time effectiveness ( $p < .01$ ) for the ICG, the BDI and the IES-R. There was also a positive effect on interception (time x groups) ( $p < .05$ ) for the BDI and a very positive effect on interception for the ICG and IES-R ( $p < .01$ ).

*Intervention group acceptability of the cognitive narrative program*

Intervention group participants responded to questions regarding the acceptability of the intervention program. The response options ranged from zero to ten. Table 5 shows that we obtained very satisfactory answers, with an average variation (approximated) of eight to ten, indicating that the program was important for the participants. We emphasise that the participants see this intervention as an opportunity to clarify their thoughts and emotions. The IG felt that they received more support and that it is important to receive such help when solving problems, leading to a better and more adaptive life.

## Discussion

This study was part of a wider project that included the results of other studies in the area of bereavement. In particular, this randomised controlled trial evaluated the effectiveness of a four-session cognitive narrative intervention reducing complicated grief, depressive and traumatic symptoms in bereaved participants and examined differences between the two groups. The objective was achieved, as there was a large and consistent decrease of symptoms along the longitudinal profile; additionally, there was an expected time effect and a significant interaction (time x groups). The interception is, in this case, the main effect. At T2, there were significant differences between groups for the outcome variables ( $p < .01$ ), with the IG displaying lower mean values on the ICG, the BDI and the IES-R compared to the controls. These results reinforce the general idea that most people can improve if they discuss their life events, narrating the episodes and constructing meaning for their emotions and thoughts (Gonçalves, 2002a, 2002b; Neimeyer, 2000; Pennebaker et al., 1988).

Therefore, encouraging patients to face their personal stories and to work creatively through their loss is important for the treatment of complicated grief (Boelen et al., 2007; Greenberg, 2002). CNT is innovative in the sense that the use of metaphors rich in meaning for metaphorisation and projection allows the patient to reflect on their situation and focus of concern and, afterwards, to deconstruct the metaphors carrying negative meaning and project alternative and additional adaptive metaphors onto the future (Gonçalves, 2002b). The results of these sessions are encouraging. The effectiveness of this intervention is stronger than previously conducted interventions in mourning (Allumbaugh & Hoyt, 1999; Kato & Mann, 1999; Shear et al., 2005; Boelen et al., 2007; Wittouck et al., 2011; Neimeyer, 2000; Currier et al., 2008), shown by the very high effect-size values obtained for the ICG, BDI and IES-R. This intensifies the assumption that interventions aimed at treatment (tertiary prevention) are the most effective (Boelen et al., 2007; Houwen et al., 2010; Stroebe et al., 2005, 2007;

Rosner et al., 2010; Wittouck et al., 2011). This intervention also had a high acceptability of among participants, and, so, we can reflect suggesting that high adherence to such programs may be related to lower perceived of social support. In this intervention, the bereaved felt supported throughout the mourning process. This may be related to gender, as most of the participants were women; women usually share the perception that help is useful, which translates into greater adherence (Stroebe et al., 2007). This study reinforces the importance of promoting brief interventions, combining a smaller number of sessions (Kang & Yoo, 2007; Jané-Llopis & Barry, 2010) with lower cost; this would result in increased adherence to intervention programs (Munõz, 2001; Kato & Mann, 1999). This also can educate the population that the sample represents, as well as the staff in nursing homes, about the importance of grief work; it is important to pay attention to the importance of changing thoughts and emotions, the benefits of seeking help, as well as to recognise that mourning does not pass with the “cure of time”. The characteristic symptoms of complicated grief do not resolve spontaneously, necessitating intervention (Prigerson et al., 1995; Wittouck et al., 2011).

This study has some caveats. First, complicated grief is not currently recognised as a diagnostic entity in the DSM (Piper et al., 2001; Wittouck et al., 2011; Newson et al., 2011; Gana & K’Delant, 2011), which raises some reservations about treating a “pathology” that still is not officially recognised. Second, the questionnaire responses, especially the IG responses to questions regarding satisfaction with the intervention program, may be contaminated by social desirability; responses were given orally and were noted by the investigator, who was also the therapist in the intervention program (Jané-Llopis & Barry, 2010). Third, this study is not representative of the population because the sample size is relatively small. The predominance of female participants limits the generalisation of the results to men, and therefore, it is necessary to replicate the study in different contexts for

generalisation of the results (APA, 2002; Jané-Llopis & Barry, 2010) using, for example, a larger number of male participants. Randomised controlled trials should be replicated using larger samples (Boelen et al., 2007; Bennett et al., 2011), as well as long-term monitoring of critical outcome measures (Kang & Yoo, 2007; Houwen et al., 2010; Jané-Llopis & Barry, 2010).

For future direction of research in this area, we suggest the comparison of the efficacy of different therapeutic approaches, such as cognitive behavioural therapy (CBT) and CNT, as there is growing evidence that the preferred treatment for CG is CBT (Boelen et al., 2006; Maccallum & Bryant, 2011; Bennett et al., 2011). Moreover, it is important use more than one trained therapist and perform randomisation of the participants in order to consider the possible effects of the therapist on the outcome. Another indication for further research is that although the controls did not participate in the intervention, placement on a waiting list should ideally lead to the opportunity to receive an intervention, such as IG, immediately after the last set of answers to questionnaires (after T2). This is important to ensure the well-being of the participants, as evaluation without intervention proved harmful. In the controls, there was an increase in the average total score on the IES-R in T2. It is advisable, then, to be cautious with the sensory memories due to the risk of activating traumatic symptoms (Rocha, 2004). In this study, certain scales were used as instruments of measurement; in the future, we suggest that these measures be supplemented by a more detailed clinical assessment in order to conduct a more rigorous identification of the symptoms. Additional research is required to confirm the utility of this intervention.

We conclude that this investigation, with a reduced number of sessions and high effectiveness, paves the way for future investigations; the same protocol could be followed, for instance, in other areas of intervention.

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Table 1

*Sociodemographic characteristics of IG (n=20) and controls (n=20) and significant values of the differences between groups determined using the t test or chi-squared test*

Characteristics	Intervention Group				Control Group				p
	n	%	M	SD	n	%	M	SD	
Sex									.50
Female	17	85			18	90			
Male	3	15			2	10			
Educational level			3.20	1.24			2.80	1.61	.38
Time since loss (years)			8.06	7.25			12.35	11.98	.18
Importance of the deceased			9.30	1.84			9.75	0.91	.33
Other losses	12	60			15	75			.50
Perceived difficulty of the situation			9.0	1.28			8.53	2.00	.49
Nursing home status									.50
In patients	13	65			14	70			
Out patients	7	35			6	30			
Cause of death									.12
Place of death									.80
Hospital	8	40			9	45			
Nursing home	3	15			4	20			
Home	9	45			7	35			
Type of death									.50
Expected	8	40			5	25			
Unexpected	12	60			15	75			

*Note.* Tests of significance according to the variable type, continuous or categorical, t test or chi-squared test, respectively.

\*  $p < .05$ . \*\*  $p < .01$ .



Table 2

*Complicated grief (ICG), depressive symptoms (BDI) and traumatic symptoms (IES-R): comparison between the IG and controls at T1 and T2*

Outcome variable	Intervention		Control		<i>df</i>	<i>t</i>	<i>p</i>	<i>Hedges's g</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>				
ICG T1	37.60	8.50	42.50	8.32	37.98	1.84	<i>n.s</i>	
ICG T2	25.32	6.46	39.80	5.31	34.90	7.63	.00**	2.41
BDI T1	19.65	7.21	23.25	6.88	37.92	1.62	<i>n.s</i>	
BDI T2	12.26	5.34	21.00	5.53	36.99	5.02	.00**	1.57
IES R T1	33.70	10.75	41.25	8.75	36.51	2.44	.02*	
IES R T2	15.00	7.45	42.80	7.73	36.99	11.44	.00**	3.59

\*  $p < .05$ . \*\*  $p < .01$ .

Table 3

*Frequency and prevalence of CG, MDD and PTSD in the IG and controls at T1 and T2*

	Intervention		Control		$\chi^2(1)$
	<i>n</i>	%	<i>n</i>	%	
With complicated grief T1	20	100	20	100	<i>a</i>
With complicated grief T2	5	26.3	19	95	.00*
Positive Evolution	18	94.7	16	80	.17
With depression T1	17	85	18	90	.63
With depression T2	8	42.1	19	95	.00*
Positive Evolution	16	84.2	15	75	.48
With Trauma T1	8	40	14	70	.06
With Trauma T2	0	0	18	90	.00*
Positive Evolution	19	100	8	40	.00*

*Note.* T1 = 1st evaluation; T2 = 2nd evaluation

a. No statistics are computed because complicated grief in T1 is a constant

\* Pearson chi squared for  $\chi^2 < .05$ .

Table 4

*GLM repeated measures for complicated grief (ICG), depressive symptoms (BDI) and traumatic symptoms (IES R)*

	Time	<i>df</i>	<i>F</i>	<i>p</i>
Time ICG	Before and after intervention	1	35.89	.00**
Time x groups ICG	Before and after intervention	1	14.48	.001**
Time BDI	Before and after intervention	1	17.71	.00**
Time x groups BDI	Before and after intervention	1	4.67	.037*
Time IES R	Before and after intervention	1	31.69	.00**
Time x groups IES R	Before and after intervention	1	44.86	.00**

\* $p < .05$ . \*\* $p < .01$ .

Table 5

*Program acceptability as judged by the participants*

	<i>n</i>	<i>M</i>	<i>SD</i>
Importance of intervention	19	9.84	.50
Help me decide better	19	8.11	1.56
To clarify thoughts and emotions	19	7.74	1.56
Additional support	19	9.32	.82
To live a better life	19	7.79	1.47
Importance of seeking help	19	9.16	.96

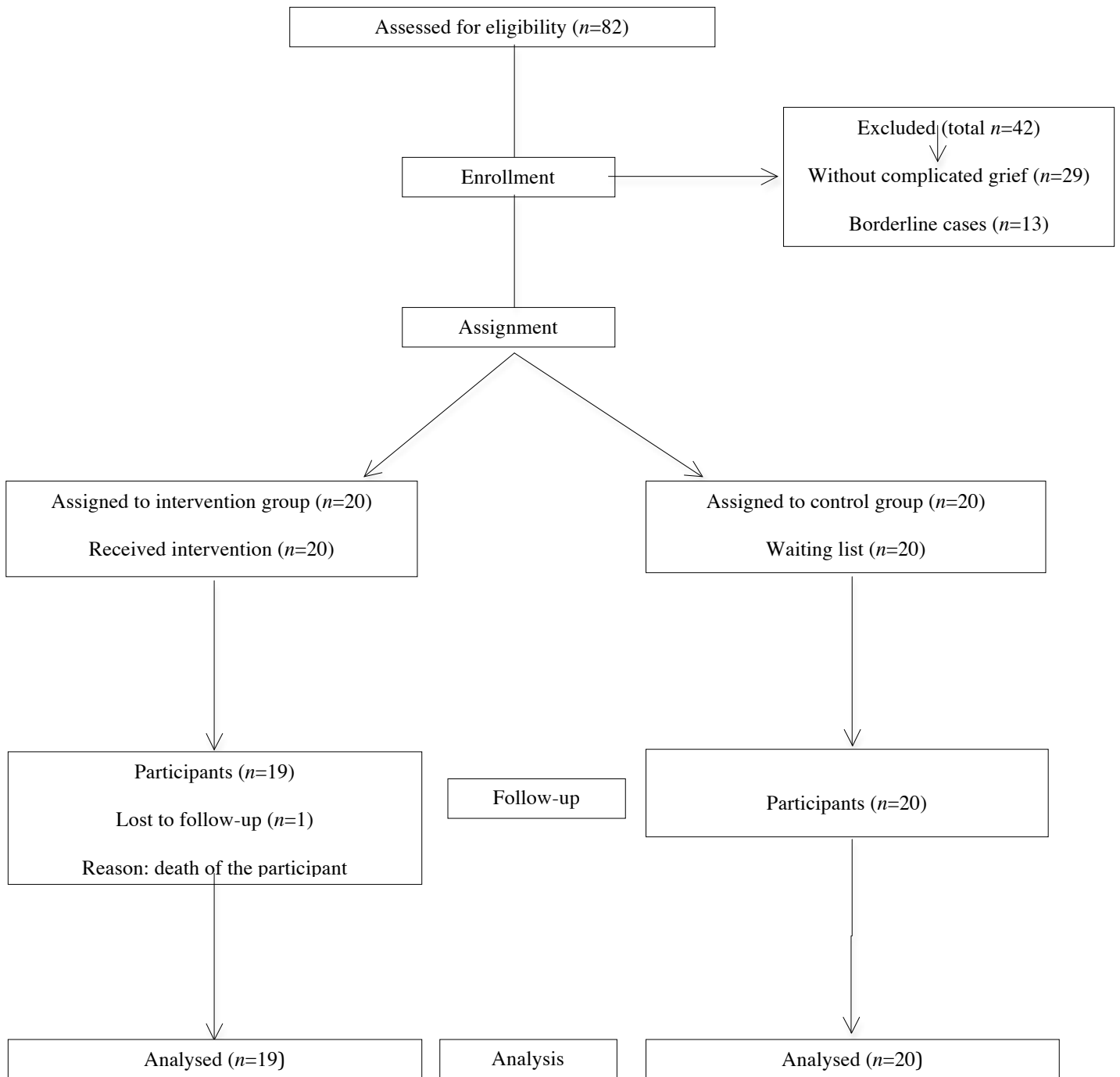


Figure 1. Flow of participants through each stage of an experiment