Meaning and Mourning: The Search for Significance in Tragic Loss

Robert A. Neimeyer*

〈Abstract〉

The death of a significant person, especially when it comes tragically or prematurely, can shake the foundations of our assumptive and relational world and lead to anguished attempts to find meaning in the loss and in our lives in its aftermath. In this chapter I summarize what is known about complicated grief following difficult losses, review one program of research focused on this attempt at meaning reconstruction, describe recently developed measures of meaning in mourning, and discuss several therapeutic techniques for helping clients make sense of the death and rework their attachment relationship to the deceased. I conclude by illustrating some of this work in my therapy with a couple who had lost not one but two children to tragic accidents, as they tried to adapt to a compound traumatic bereavement.

Key Words: mourning, meaning, tragic loss, grief therapy, death

* Robert A. Neimeyer, PhD, Department of Psychology, University of Memphis, Memphis TN, USA, 38152, neimeyer@memphis.edu

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I. Introduction

When Geraard and Carolien requested a consultation with me during a brief visit to their native Belgium, it was immediately clear they were in a great deal of pain. Four years before their family of six was devastated when their oldest son, Simon, 20, was killed in a vehicular accident one evening when he was headed out to eat with his friends, and a truck ran through a red light and slammed into their car. Drawing together in the crisis, the parents and three surviving children—Victor, 18, and twin sisters Sofie and Heidi, 16—gradually found their footing in a world that had been shattered by the tragic death, somehow moving through the raw anguish to affirm love and life despite the enormity of the loss. As Geraard explained, “After Simon died, you could call it a learning process [that] has been so intense. One thing is what happened, of course, what the loss is, and the other is, what’s the meaning of the loss has been. It’s gigantic. It goes beyond comprehension.” Just how sweeping the meaning of the loss was became clearer as our couples therapy session went forward, as both spouses spoke movingly of how each had changed as they gradually integrated the reality of their son’s death. Geraard in particular spoke of how he had become more willing to give his surviving children the freedom to make their own choices, and to trust his wife’s intuitions of how to lead the family in healing directions. Remarking on the strengthened bond among family members that followed the tragedy, Carolien noted that “the leading thread through our lives is being together and doing things together: the nice thing and the hard thing.” Then, the strong thread of connection that had bound them together through the
nightmare of Simon’s death seemed at risk of breaking as a second unthinkable tragedy befell them, in the form of Sophie’s death just 18 months before, when she drowned in the ocean while on a school holiday in a distant country.

After this second loss, Geraard explained, the couple’s coping process “was completely different… I had the feeling that in the loss of Simon, we had words… where we said “we,” “We were going to do this,” the focus was on “we.” But now we have our own separate process… It’s a part of the survival.” Carolien agreed: “You can almost see the wall go up [between us], because you can’t handle all that grief from the other one… It’s a tsunami that can’t be taken on top [of your own pain].” Geraard in particular seemed to be drowning in the tidal waves of this second grievous loss, as he fought to find ways to make sense of the story of “how Sofie passed away, how she died, on top of the other things.” Carolien agreed: “If I’m troubled by the way she passed away and I hear Geraard say, ‘I don’t even want to think about that,’ that’s so important that I won’t [approach] that subject to discuss it with him.” As a result, a disquieting silence had settled over their communication, as each of them, and their surviving children, struggled to understand the meaning of a second cruel loss, and the meaning of their lives now as a family and as individuals in light of it.

Contemporary research on bereavement tells us that most people are surprisingly resilient in their bereavement following the death of a loved one, typically maintaining their ability to function after a brief disruption, and returning to their emotional baseline within a few months of the death (Bonanno, 2009). But research also clearly establishes that for a significant
minority of the bereaved—roughly 10%—adaptation following the loss can be much more painful, preoccupying, and prolonged, carrying substantial risks for long-term health and mental health functioning (Neimeyer, 2016a). This condition, known as complicated grief (Shear et al., 2011b) or prolonged grief disorder (Prigerson et al., 2009), is slated for inclusion in the World Health Organization’s International Classification of Diseases (ICD-11), and clearly merits the attention of counselors and psychotherapists, as the most effective treatments for it are psychological rather than pharmacological (Currier, Neimeyer, & Berman, 2008; Shear et al., 2014).

In this article I review one line of research on bereavement adaptation grounded in the proposition that a central process in grieving is the attempt to reaffirm or reconstruct a world of meaning that has been challenged by loss (Neimeyer, 2006a). Sketching briefly the symptoms of complicated grief and established risk factors for this debilitating condition, I summarize the evidence linking a struggle for meaning with bereavement complications, and successful meaning making with more positive adaptation over time. I then describe several validated measures of meaning making in loss developed by our team for use in clinical and research settings, and suggest some of the many clinical procedures coherent with a meaning reconstruction model that can add scope and specificity to grief counseling and therapy. Finally, I conclude by returning to the case of Geraard and Carolien to illustrate the application of some of these strategies in an actual session of therapy.
II. Symptoms and Risk Factors for Complicated Grief

Viewed in psychiatric, diagnostic terms, complicated grief (CG), also known as prolonged grief disorder, refers to a severe response to the death of a loved one characterized by marked separation distress and preoccupation with the loss to an extent that one experiences significant impairment in social, familial or occupational functioning for a year or more following bereavement (Maercker, Neimeyer, & Similoa, 2016). Additional symptoms include a continuing struggle to accept the reality of the death, avoidance of “triggers” that remind the mourner of the loss, a sense of purposelessness, and disruptions of one’s relationships with others (see Table 1). Viewed in psychological terms, complications in grieving exist on a continuum ranging from mild, limited and transitory to severe, pervasive and disabling, with research demonstrating that a CG diagnosis constitutes the most extreme end of this dimension (Holland, Neimeyer, Boelen, & Prigerson, 2009). Common to both of these conceptualizations is the recognition that complications in grieving can be significant and distinguishable from depression following bereavement by the prominence of preoccupying anxiety over separation (Maercker et al., 2016), which along with traumatic distress constitutes the core of CG symptomatology (Holland & Neimeyer, 2011).
<Table 1> Diagnostic Features of Complicated Grief

1. Duration of bereavement of at least 1 year
2. Marked and persistent separation distress, reflected in intense feelings of loneliness, yearning for or preoccupation with the person who has died
3. At least 5 of the following 9 symptoms experienced nearly daily to a disabling degree:
   - Diminished sense of self (e.g., as if a part of oneself has died)
   - Difficulty accepting the loss on emotional as well as intellectual levels
   - Avoidance of reminders of the reality of the loss
   - Inability to trust others or to feel that others understand
   - Bitterness or anger over the death
   - Difficulty “moving on,” or embracing new friends and interests
   - Numbness or inability to feel
   - Sensing that life or the future is without purpose
   - Feeling stunned, dazed, or shocked by the death
4. Significant impairment in social, occupational, or family functioning

Adapted from (Prigerson et al., 2009) and (Shear et al., 2011a)

If, as research indicates (Galatzer-Levy & Bonanno, 2012), most bereaved people ultimately cope adaptively with their loss, what mourners are at heightened risk of a more complicated and debilitating trajectory through bereavement? A growing body of research has addressed this question, pointing to the particular vulnerability of some populations, such as parents who have lost children, 30% of whom may screen positive for CG (Keesee, Currier, & Neimeyer, 2008), or those whose loved ones died by suicide (Survivors_of_Suicide_Loss_Task_Force, 2015) or homicide, for whom the incidence of CG may approach 50% (McDevitt-Murphy, Neimeyer, Burke, & Williams, 2012). Beyond highlighting the documented suffering of such groups, several studies have also begun to identify a variety of prospective risk factors that predict more intense post-loss
grieving, bearing on (a) the circumstances of the death, (b) the background of the bereaved, (c) their relationship to the deceased, (d) their styles of coping with the loss, and (e) the broader social and institutional systems in which they are engaged. <Table 2> summarizes these risk factors, derived from a recent review of the bereavement literature (Neimeyer & Burke, 2017).

<Table 2> Empirically Established Risk Factors for Intense Grief
(from Neimeyer & Burke, 2017)

| Factor | Summary of findings |
|--------|---------------------|
| **Circumstances of the Death** | |
| Cause of death | Sudden, violent and traumatic deaths (as by suicide, homicide, genocide and fatal accident) are associated with more intense and complicated grief. |
| Peri-event variables | Viewing the body following a violent death, and poorer quality of death in hospital care lead to worse bereavement outcomes. |
| **Background of the Bereaved** | |
| Gender | Women tend to be more susceptible to CG than men, and this is especially true for female caregivers and mothers. |
| Demographic disadvantage | Fewer economic resources and lower levels of education are associated more anguished anticipatory grief before a death, and more intense grief after the loss. |
| **Relationship to the Deceased** | |
| Kinship | In general, grief over the death of immediate, first-degree relatives is greater than for the loss of relationships to extended family or non-family bonds, with bereaved parents and spouses reporting the greatest distress. |
| Factor                        | Summary of findings                                                                                                                                                                                                 |
|------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Marital dependency          | Within bereaved spouses or partners, those who are more psychologically dependent on their partners report greater anticipatory grief in palliative care, as well as more grief and despair following the death. |
| Caregiver burden            | Family caregivers to someone with a progressive, debilitating illness (e.g., cancer, dementia) experience greater post-loss grief, with the length and intensity of caregiving predicting level of bereavement distress.           |
| Coping Style                |                                                                                                                                                                                                                     |
| Attachment style            | Mourners with more insecure styles of attachment, especially of an anxious type, display more preoccupying and prolonged grief.                                                                                   |
| Meaning making              | An early struggle to find meaning in a pending loss is a risk factor for difficult anticipatory grief, as well as a warning sign for post-loss adaptation. In bereavement, difficulty in making sense of the loss forecasts protracted complication. |
| Social Systemic and Institutional Factors |                                                                                                                                                                                                                     |
| Social support              | Lower perceived support within the family or social network predicts greater distress, perhaps especially for grievers whose practical and instrumental needs are unmet. Poor family communication and perceived criticism also are associated with worse bereavement adaptation. |
| Institutional factors       | Lack of informational and emotional support for families in care settings (hospitals, emergency departments, hospices) can complicate adjustment of mourners following the death.                                      |

In any given case, of course, the bereaved may contend with none, one, or multiple risk factors, with the probability of intense, preoccupying and protracted grieving increasing with the number of factors involved. For
example, Geraard struggled with the sudden death of his daughter, which precipitated a crisis of meaning triggered by the traumatic circumstances under which she died. Moreover, this trauma was compounded by the absence of institutional support as he was forced to identify her body in the morgue when it was repatriated to Belgium. Ultimately, the only recognizable feature that he could rely on was the memorial tattoo on Sophie’s wrist that she had gotten for her deceased brother Simon, as little care had been taken in the shipping, resulting in her body being badly decomposed. Thus, he met criteria for no less than 5 of the identified risk factors in <Table 2>, making it fully understandable why he would be dealing with intense complications in his bereavement 18 months after the death of his child.

III. Loss and the Reconstruction of Meaning

Viewed through a constructivist lens, human beings are characterized by a effort to understand, anticipate, and to some extent control the events that constitute their lives, and in this sense to find meaning in them (Kelly, 1955; Neimeyer, 2009). Difficulties arise however, when events invalidate the meaning system on which we rely, challenging and sometimes shattering our assumptions about how life is or should be (Janoff-Bulman & Berger, 2000). The death of loved ones, especially when these deaths are premature and traumatic, frequently disrupt our life stories in ways that are both profound and pervasive, launching an anguished and often complicated search for meaning in the loss that yields no easy answers. As people are able to make sense of the loss or find
some compensatory “benefits” or life lessons in it, however, they gradually integrate the event, adapt, and perhaps even grow through the experience (Neimeyer, 2001).

A great deal of evidence now supports the outlines of this meaning reconstruction model. For example, in groups as diverse as bereaved young adults (Holland, Currier, & Neimeyer, 2006), parents who have lost children (Keesee et al., 2008), and older widows and widowers (Coleman & Neimeyer, 2010) an inability to make sense of the loss strongly predicts intense and complicated grief, whereas greater meaning making about the loss over time is associated with alleviation of this same symptomatology (Holland, Currier, Coleman, & Neimeyer, 2010). Moreover, in the context of palliative care, a struggle to find significance in the pending death of a loved one is the strongest predictor of anguished anticipatory grief in family members (Burke et al., 2015), and this same pre-loss search for meaning also functions as a leading risk factor of intensity of post-loss grief in the months that follow the death (Burke, Neimeyer, Bottomley, & Smigelsky, 2017). Conversely, finding meaning in the death of a spouse in the early months of bereavement prospectively predicts greater well-being as much as four years beyond the death (Coleman & Neimeyer, 2010).

Beyond its role as a predictor of adaptive bereavement, meaning making seems to serve as a mediator of various adverse factors influencing bereavement adjustment. For example, research has demonstrated (Currier, Holland, & Neimeyer, 2006) and replicated (Rozalski, Holland, & Neimeyer, 2016) the finding that the struggle to find meaning in the loss accounts for essentially all of the greater impact of violent death (suicide, homicide, fatal accident) relative to natural death losses (through sudden or gradual illness). Moreover, the finding that “negative religious coping” or
spiritual struggle following a loss is associated with more complicated grief symptomatology seems to be accounted for principally by the mediating role of meaning making, suggesting that a crisis of faith following tragic loss challenges the mourner’s world of meaning, which then predicts more intense and disruptive grief responses (Lichtenthal, Burke, & Neimeyer, 2011). In a related vein, recent research also suggests that the traumatic impact of highly “central” losses that typically predict quite adverse psychological outcomes are moderated and often nullified for mourners who are able to integrate them into their meaning systems (Bellet, Neimeyer, & Berman, 2017).

IV. Measuring Meaning Making in Mourning

Like other pioneering investigators of meaning making in the wake of loss (Davis & Nolen-Hoeksema, 2001; Davis, Nolen-Hoeksema, & Larson, 1998), our team initially adopted simple self-ratings of the degree of sense-making or benefit-finding in bereavement as the basic metric in our research, often supplemented by brief free-response narratives that prompted participants to describe their meaning-making in their own words (Currier et al., 2006; Holland et al., 2006; Neimeyer, Baldwin, & Gillies, 2006). Although this straightforward method yielded meaningful results, we soon began to construct and validate a range of meaning-oriented measures that permitted a more sophisticated assessment of meaning making as a multidimensional process for use in both research and clinical settings. In this section I will briefly describe each of these instruments, referring the reader to the original publications for details of their
psychometric properties. <Table 3> provides a summary of these measures.

| Title of Measure | Authors | Items | Focus | Subscales |
|------------------|---------|-------|-------|-----------|
| Integration of Stressful Life Experiences Scale (ISLES) | Holland, Currier, Coleman & Neimeyer (2010) | 16 | Extent of meaning made of loss | Comprehensibility, Footing in the World |
| Integration of Stressful Life Experiences Scale Short Form (ISLES-SF) | Holland, Currier & Neimeyer (2014) | 6 | Extent of meaning made of loss | Comprehensibility, Footing in the World |
| Grief and Meaning Reconstruction Inventory (GMRI) | Gillies, Neimeyer & Milman (2015) | 29 | Thematic content of meaning made of loss | Continuing Bonds, Personal Growth, Sense of Peace, Emptiness & Meaninglessness, Valuing Life |
| Inventory of Complicated Spiritual Grief (ICSG) | Burke, Neimeyer, Holland, Dennard, Oliver & Shear (2014) | 18 | Struggle for spiritual meaning in loss | Insecurity with God, Disruptions in Religious Practice |
| Meaning in Loss Codebook (MLC) | Gillies, Neimeyer, & Milman (2014) | NA | Coding of meaning themes in loss narratives | 30 distinct categories of meanings made |

The first such measure we developed was the *Integration of Stressful Life Experiences Scale* or ISLES, which assesses the extent to which survivors of highly distressing life events or losses are able to integrate
them into their overall framework of meaning (Holland et al., 2010). The scale includes 16 items (e.g., Since this event happened, I don’t know where to go next in my life) to which the respondent indicates agreement or disagreement on a 5-point scale. The items factor into two subscales entitled Comprehensibility and Footing in the World, with the latter referring to a sense of feeling secure or grounded in a meaningful world. A 6-item short form of the ISLES subsequently was developed and validated to retain the same factor structure and incremental validity in predicting complicated grief symptomatology (Holland, Currier, & Neimeyer, 2014).

Complementing the ISLES, we also developed the Grief and Meaning Reconstruction Inventory or GMRI to assess not so much the extent of meaning making about a loss, as the thematic content of meanings made (Gillies, Neimeyer, & Milman, 2015). Grounded in a qualitative study of the narratives of a diverse group of adults grieving the loss of several types of relationships to various causes of death, the GMRI consists of 29 items (e.g., Memories of my loved one bring me a sense of peace and solace) rated for degree of agreement on a 5-point scale. Items are grouped into 5 interpretable subscales, measuring Continuing Bonds, Personal Growth, Sense of Peace, Emptiness and Meaninglessness, and Valuing Life. The GMRI therefore offers a convenient way to assess specific sources of meaning in a given mourner’s adaptation to the loss, as well as points of vulnerability.

One frequent observation in both our clinical practice and research is the extent to which mourners seek meaning in the death of loved ones in spiritual terms, sometimes succeeding and sometimes struggling to do so. Spiritual coping and crisis were most evident when the deaths were
inherently tragic, as in the deaths of children (Lichtenthal et al., 2011; Lichtenthal, Currier, Neimeyer, & Keesee, 2010) or through the homicide of a loved one (Burke, Neimeyer, McDevitt-Murphy, Ippolito, & Roberts, 2011). This therefore suggested the need for a bereavement-specific measure of spiritual coping with loss, beyond the generic scales on which the field had depended to that time. Conducting a close content analysis of both written narratives and focus group feedback by spiritually inclined mourners (Burke, Neimeyer, Young, & Piazza-Bonin, 2014), we developed and validated the Inventory of Complicated Spiritual Grief or ICSG (Burke, et al., 2014), which contains 18 items (e.g., My trust in God has been shaken) that are rated for agreement on a 5point scale. The ICSG factors into two subscales, which measure Insecurity with God and Disruptions in Religious Practice, reflecting a spiritual struggle in the mourner’s relationship to the divine and to the faith community. Perturbations in grievers’ religious meaning systems as measured by the ICSG predict post-loss levels of complicated grief even after the circumstances of the death and generic measures of spiritual coping have been taken into account (Burke, et al., 2014). However, it should be noted that the ICSG was constructed to assess the experience of Christian mourners, and therefore may neglect the spiritual issues of other groups, such as the concern sometimes voiced by believers in reincarnation that the death of their loved one represented karmic retribution for wrongdoing in a past life.

Beyond the development and validation of self-report questionnaires, we also have constructed the Meaning in Loss Codebook, or MLC, a reliable coding system for identifying a set of 30 themes that can be observed in mourners’ attempts to make sense of their loss (Gillies, Neimeyer, &
Milman, 2014). Encompassing both positive (e.g., \textit{Compassion, Acceptance, Affirmation of the Deceased}) and negative categories (e.g., \textit{Negative Affect, Regret, Lost Identity}), the MLC is being used to code survivor accounts and relate these to different levels of prolonged grief symptomatology (Breen, Karangoda, Kaine, Howting, & Aoun, 2017), as well as exchanges in online support groups for those bereaved by suicide (Pritchard & Buckle, 2017).

Finally, our group is continuing to develop new measures of previously neglected processes, such as social validation or invalidation of the meaning of a given loss (in collaboration with Benjamin Bellet and Jason Holland) and a multifactorial measure of coping strategies used by the bereaved (in collaboration with Elizabeth Crunk and Laurie Burke). We hope this next generation of scales will permit investigators and clinicians to conduct a nuanced assessment of the status of mourners’ meaning systems as well as facilitate research on meaning reconstruction processes in grief therapy. It is to the topic of treatment we now turn.

V. Treatment Approaches

As an approach to grief therapy, a meaning reconstruction model encourages clinicians to attend to two key dimensions of a client’s attempts to grapple with the significance of the loss and integrate it into their ongoing self-narrative (Neimeyer & Thompson, 2014). The first of these concerns \textit{processing the event story of the death}, in an effort to make sense of it and its implications for the mourner’s life, whereas the second focuses on \textit{accessing the back story of the relationship} to the
deceased, in order to restore a sense of attachment security and resolve “unfinished business” with him or her. A large repertory of techniques of grief therapy address these two objectives, drawing on both psychotherapeutic (Neimeyer, 2012f, 2016c) and expressive arts (Thompson & Neimeyer, 2014) modalities. Here I will mention a representative selection, giving precedence to those that are commonly incorporated in a meaning reconstruction approach to treatment. In the case of working on both the event story and the back story, I will first give more detailed attention to a single, central technique, and then mention several others that supplement and extend it in helpful directions.

1. Processing the event story

1) Narrative retelling

At a very basic level, most people who struggle with complicating loss feel a great press to “tell the story,” to find someone willing to hear what others cannot, and who can join them in making sense of the death without withdrawing into awkward silence or offering trite and superficial advice regarding the questions it poses. But especially when the death was traumatic—as by suicide, homicide, or fatal accident—mourners typically only relate a highly “edited” or censored story to others, in an effort to mitigate the stigma, protect the listener, and perhaps avoid the horrific details and haunting implications it comprises. Unfortunately, the result is often a “silent story” that lives continuously in the mourner’s own ruminations (Neimeyer, 2006b), as he or she struggles alone with the issues of remorse, re-enactment of the scene of the dying, and often
fantasies of revenge when other parties are judged to be at fault for the
deaht of the loved one.

In response to this common reaction to violent death, Rynearson and his
colleagues have developed a protocol for restorative retelling, a clinical
protocol in which a trained mental health professional supports a bereaved
client in closely reviewing and relating the story of the death under
conditions of high safety but low avoidance (Rynearson, 2006; Rynearson
& Salloum, 2011). Related to prolonged exposure treatments for traumatic
life events, the procedure involves first grounding the client or family in
personal, relational or community sources of resilience. These can include
an appreciative discussion of their relationships as a family prior to the
tragedy, their preferred means of self-soothing, their ways of coping with
other major adversities, or their religious or philosophic beliefs, all of
which can be drawn on as sources of stabilization as they steer toward a
detailed engagement with the story of the dying, as imagined,
reconstructed, or witnessed. Then, across the course of multiple sessions,
therapists support the client in individual, family or group settings in
slowly “unpacking” the story, sometimes assisted by drawings they make
to externalize and illustrate the scene of the dying and integrate its painful
reality (Correa, 2016).

In my own adaptation of this method, I have found that “braiding
together” three narrative strands of the event story helps clients find a
more substantial and coherent “through line” as they strive to share an
anguishing account that makes sense of the dying and makes sense of the
clients themselves in its aftermath (Neimeyer, 2012e). The first of these
strands is the external narrative, the basic plot of the story, of what
happened and when. Helping the client find words for the troubling details
of each of the successive scenes, while assisting them with self-regulation in doing so, validates the account and ultimately promotes more mastery of it. Such work progresses slowly and patiently, encouraging the client with questions such as, “When did you first learn of the death? Who told you, and where were you at the time?” “When you arrived at the hospital, what did you see? Who else was present? Do you recall any particular images or conversations that were important, or that have stayed with you?” The key is to listen deeply and responsively to the story, opening it to a more detailed reading, as the client begins to “fill in the blanks” of critical scenes and exchanges and link them into a sequential account.

The second narrative strand concerns the internal narrative, the story of what was happening inside the clients as critical aspects of the event were unfolding around them. Here, the therapist attends to significant signals of emotion (a tear, a clenched jaw) or an evocative scene (being notified of the death, encountering the loved one’s body), asking questions like “What were you thinking or feeling at just that moment?” or “What’s happening for you now, as the tears start to come?” Naming and claiming these reactions validates them, and allows clients to acknowledge the intimate impact of the story, while working with the therapist to “breath through” the hard parts, distance a bit in imagery from the difficult scene, and imagine vividly how they would prefer to have been present for the loved one, even if unable to stop the death. Here the goal is to develop a more informed and self-compassionate stance toward one’s own suffering in the presence of a frightening or traumatic account.

Finally, the third strand woven through the retelling focuses on the reflexive narrative, that is, the meaning oriented story, which is often suggested by clients’ implicit questions and interpretations of the events
being related. In tracing this thread, it is critical that the therapist not push prematurely for meaning making, but instead to “lead from one step behind” by following clients’ often nonverbal or co-verbal signals of puzzlement (a furrowed brow, a questioning intonation in the voice) or insight (a sudden look of concentration accompanied by silence, a culturally appropriate vocalization like “hmm” or “huh”). Following these with open queries (“What occurs to you just now?” “What strikes you about that?”) can sharpen the problem clients’ attempts to understand what was happening, or the provisional answers that they are beginning to formulate. In particularly critical or ambiguous circumstances, the therapist might gently probe, “What sense did you make of what was happening when the doctor was called suddenly?” or “What did you see in your partner’s eyes as they met your own on the other side of your child’s hospital bed?” The goal of such work is to trace, and create space for clients’ efforts to make fuller sense of the event story, in concert with the sense-making of significant others.

As a mnemonic guideline for restorative retelling, I emphasize the importance of bracing, pacing and facing (Neimeyer, 2016b). Bracing entails giving clients the necessary support within sessions (e.g., by regulating upsurges of strong emotion through mindful breathing or visual distancing from the scene being related) and between sessions (e.g., by establishing conditions of privacy for journaling their reflections on the story told and rituals for re-engaging the social world once the interval of journaling is completed). Pacing refers to deciding how to punctuate the story into “chapters” that correspond to clients’ windows of tolerance (usually 15 to 60 minutes, followed by at least 15 minutes of processing), and also how to slow the pace of the retelling to “stay with” difficult
details and allow new insights to emerge. And *facing* involves the core goal of mastering the traumatic story of dying by confronting rather than avoiding it, and doing so with the respectful witnessing of the therapist (and in family or group settings, other clients). Open trials of restorative retelling (Saindon et al., 2014) and randomized controlled trials of similar “revisiting” procedures (Shear et al., 2014) support its effectiveness as a key procedure for processing and integrating the event story of the death.

2) **Other procedures**

In addition to restorative retelling procedures for articulating and integrating the event story of the loss, several other techniques can enhance meaning making about the death and its implications for clients’ lives. One of these is *Chapters of Our Lives* (Neimeyer, 2014), which encourages clients to draft the “Table of Contents” of the book of their lives, just as if it were a novel, a biography, adventure story or love story, and then reflect aloud or in writing on several facilitative questions about it. In doing so, clients include the loss in a larger framework of meaning that organizes the plot of their autobiographies, identify crucial turning points, recognize themes of recurrent struggle and resilience, and consider how the same events might be viewed differently from the perspectives of other authors or readers, and how they might be further transformed in hopeful directions.

Another narrative method is *directed journaling* (Lichtenthal & Neimeyer, 2012), which goes beyond the common admonition for the diarist to pour out his or her deepest emotions relevant to a difficult life event, and instead to strive to find meaning in the challenging
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circumstances associated with the loss. For example, sense-making instructions may prompt the client with questions like, “Are there ways in which this loss has influenced the direction of your life story? How, across time, have you dealt with this?” or “What philosophic or spiritual beliefs contributed to your adjustment to this loss? How were they affected by it in turn?” Alternatively, benefit-finding instructions encourage the reader to engage questions like, “In your view, have you found any unsought gifts in grief? If so, what?” or “What lessons about living or loving has this person or this loss taught you?” Importantly, this meaning-oriented journaling encourages a “self-distancing” perspective that complements the “self-immersive” perspective of more emotion-focused journaling, reinforcing “big-picture” appraisals of the loss and how to adapt to it. A randomized controlled trial suggests that both forms of meaning-making writing produce surprisingly enduring changes in symptoms of grief, even when practiced over a single week of journaling (Lichtenthal & Cruess, 2010).

Finally, analogical listening (Neimeyer, 2012a) represents a means of deeply orienting to clients’ emotional symptoms of grief, and how they hold these “felt senses” in their bodies (Gendlin, 1996). Beginning with closed eyes and slow, rhythmic breathing, therapists instruct clients to direct their attention inward and down, into their abdomens, scanning for signals of how and where they hold significant feelings related to the loss, often in surprisingly specific places such as the pit of their stomach, their heart, or their throat. Speaking slowly and evocatively, the therapist asks questions such as, “If that feeling had a shape, what might it be? If it had a color or colors, how would you describe them? Is there movement associated with the image, and if so, of what kind?” Later prompts might
invite the client to ask the shape whether it has something to tell them or teach them, perhaps after externalizing it in a colored image on art paper (Thompson, 2014) or even dialoging with it as a symbolic presence in an empty chair in the session (Neimeyer & Hooghe, 2017). As clients find words for ineffable experiences and explore their relationship to this symbol of their grief, they typically discover meaning and orientation in an internal narrative of loss they previously merely avoided as a source of pain.

2. Accessing the back story

1) Imaginal conversations

Just as restorative retelling is a flexible and powerful technique for integrating the event story of the death, imaginal conversations are versatile and effective means for accessing and transforming the back story of the relationship to the deceased. These typically involve invoking the deceased as an ally in the therapy (Rynearson, 2012), often by imagining them healed of their physical and psychological suffering, fully ready to hear what their bereaved loved ones have to tell them, and able to offer a response of a compassionate, caring and constructive kind (Jordan, 2012). The goal of such work is to reaffirm secure attachment with the deceased in a symbolic form that does not require their physical presence, or alternatively to address “unfinished business” in a relationship marked by disappointment, misunderstanding, betrayal or abuse. In pursuing this agenda, the therapist operates on the assumption that we need the dead in order to grieve them well, viewing the continuing bond with the deceased
as a source of both distress and potential resilience if brought directly into the therapy in a vividly experiential way.

A particularly potent form of Imaginal conversations is *chair work*, which facilitates a dialogue between clients and their deceased significant others who are symbolically placed in an empty chair across from them (Neimeyer, 2012b). Extending the rich tradition of chair work in emotion-focused therapy (Greenberg, 2010), the technique can be introduced when a client expresses a need for connection to the loved one, or to deal with unresolved relational issues (e.g., anger, guilt, pursuit of forgiveness) with the one who has died. The therapist might begin by taking a position at right angles to the client and positioning a third, empty chair opposite the client, as the client is then asked to close his or her eyes and visualize the deceased in the chair, describing how he or she might be dressed and seated after accepting an invitation to participate in the session to resume a conversation that was interrupted by death. Instructing the client to open his or her eyes, the therapist then encourages direct disclosure of feelings and questions to the deceased, as the therapist gently repeats or asks the client to repeat especially poignant phrases, or to say more about a particular emotion or need. At a natural pause point in the conversation, the therapist then asks the client to take the deceased person’s seat and respond, as the therapist again reflects, summarizes and prompts the “deceased” toward greater honesty and directness. Choreographing this iteration from one position to the other through multiple rounds typically evokes significant emotion, clarity and insight, re-establishing firmer bridges between the client and deceased when the relationship is basically good, and firmer boundaries between them when it is not. Controlled research on therapies that make central use of Imaginal
conversations attest to their benefits beyond more generic forms of counseling (Shear, Frank, Houch, & Reynolds, 2005), suggesting their utility as a mainstay intervention for complicated grief.

2) Other procedures

In a similar vein to imaginal conversations, correspondence with the deceased can help reopen a sense of contact and communication between the client and the loved one, perhaps prompted by “conversation starters” like, “The one thing I have wanted to ask you is…” or “What I need you to know about me is…”, as the client deepens into a heartfelt expression regarding the role of the other in his or her life, or petitions advice or direction on how to cope with life now (Neimeyer, 2012c). Following this “hello again” letter (White, 1989), the client can be encouraged to draft a “response letter” as if from the deceased to address the client’s earlier correspondence. Such letters are typically completed at home, but brought in and read aloud in therapy to give them the quality of spoken dialogues, and to permit the therapist’s collaboration in teasing out their meanings and implications for future actions and choices.

Several other techniques can also help the client retain and reconstruct rather than relinquish the bond with the deceased. These include personally decorated memory boxes to hold special mementos of the deceased, which can be opened to foster remembrance or closed to symbolically contain the loss (Potash & Handel, 2012), and opening the family photo album to stimulate rich recollections in therapy regarding the relationship to the deceased (Gamino, 2012). A further tool along these lines is the life imprint, which invites reflection and journaling about the ongoing impact
of the deceased on the client’s sense of self, ranging from his or her gestures and mannerisms through choices of vocation and avocations to core beliefs, values and life projects (Neimeyer, 2012d). These can then be developed further in therapy by considering which imprints might be extended and how, and which might be released in a ritual of reinvention. We will conclude by considering the application of some of these techniques in the therapy with Geraard and Carolien with which this article opened, as well as in the intense individual session with Geraard that followed.

VI. On the Edge

Geraard had asked that his wife accompany him as a support figure in their initial joint session, even though both agreed that the therapy had been at his request. Both, however, eagerly accepted my invitation to “introduce” me to all members of the family, living and dead, producing photos of Simon, Victor, Heidi and Sofie, using the images to comment on the special qualities of each child, and, at my appreciative questioning, about the strong bonds between them. Because the explicit focus of the consultation was on Sofie’s tragic death 18 months before, they also shared several images of her that were incorporated into a memorial booklet given out at her funeral. Some of these included Sofie’s artwork—impressively mature for an artist just beginning university—alongside a black-and-white photo of her as a newborn with her twin sister, of the whole family together in better years, and of Sofie squealing with delight on the threshold of adulthood as she received a kiss from both parents,
one on each cheek. As the back story of family relationships unfolded, it encompassed the several years the family had spent living “close to nature” in Scandinavia, with “no relatives in the neighborhood,” reinforcing their closeness as a nuclear family, and enfolding them in a “culture of care” that typified their adoptive country.

However, the photos in the memorial booklet also included a foreboding, if artistic image: one staged by Sofie that depicted her at the bottom of a long staircase, as if she had fallen, looking back, with several of her paintings scattered on the descending stairs. The most visible of these depicted a close-up of her face underwater, hair wafting out in all directions, and bubbles coming from her mouth as she directly met the eyes of the viewer. In light of her tragic death by drowning, the image carried an ominous meaning, and set the stage for my subsequent individual session with Geraard, in which he asked my help in dealing with his ruminative reliving of the event of her dying, as he imagined it happening on a remote beach in a foreign land.

Prior to our second session, Geraard requested a brief consultation with me, in which he asked that we meet privately in the session to follow—so that he would not feel the need to “protect” his wife or vice versa—but if possible to position her to view the session at a distance. To accommodate this in the medical center in which we were meeting, we were able to arrange for her to view the video-recorded session as it was broadcast live into another room, while she was accompanied by the family therapist who had worked with the couple prior to my consultation, and who would see them again following it. Geraard also expressed his considerable fear that a detailed discussion of the event story of the death, though critically important to relate, would precipitate him into the unspeakable angst and
despair that had already nearly swallowed him following Simon’s death 4 years before. In 20 minutes of careful listening and discussion, I reassured him that we would work within his “window of tolerance” for the feelings that might be triggered, and that at all points I would collaborate closely with him to see whether another step in the retelling was feasible and advisable at that time. We agreed, and adjourned to the room where the session would be held.

After I sketched the restorative retelling procedure we would follow—a slow-motion review of the event story of the death, braiding the external, internal, and reflexive narratives, Geraard immediately grasped its significance for him, that “retelling the story, piece by piece, [would be], if not a way of controlling it, at least a way of managing it.” As what he called a “foreword” or prologue to the story, he began by framing the many uncanny and unplanned “links” between the deaths of his son and daughter: the announcement of the death by a midnight knock on the door like in a Hollywood movie, the convergence of dates linking Simon’s death and the repatriation Sofie’s body, the identical dates of their cremation, and more. The most troubling of these links, however, arose with the repatriation of his daughter’s corpse, which had “not been cared for properly,” and so was badly deteriorated when he was required to identify her in the morgue. Unable to recognize even her face, he could only confirm her identity in a single detail: The tattoo of Simon’s name that Sofie had inked into the skin of her wrist. Visualizing this scene once more, Geraard’s horror and anger rose up in a great wave of pain, leading us to pause the story and “breathe down” theanguishing emotion before resuming the retelling.

With these eerie parallels, not only did Sofie’s death “re-open the
wounds” that were beginning to heal from Simon’s, but it also posed a kind of crisis of meaning. As Geraard asked after summarizing the similarities in the two events: “There is no such thing as coincidence… but what does it all mean?” Worryingly, a friend had suggested a sinister answer: “that Simon had something to do with the death of Sofie.” Thus, for this broken-hearted father, reviewing the story was also a way of searching for an explanation that was less dark than the one that had been offered.

Recognizing the depth of pain that engaging the retelling could evoke, I paused at this point to ask Geraard, “What would be the pro’s and the con’s, advantages and disadvantages, of re-opening even a little bit the story of that loss, those experiences, those images, those feelings, as opposed to leaving it closed?” Geraard’s answer was decisive: “I feel that there is an absolute necessity for me to somehow to find ways to tell the story. Because somehow it is a necessity to integrate what happened to Sofie into my life.” We therefore sought a safe way to go “over the edge” of the cliff, in a jointly constructed metaphor, allowing us to explore these depths, but also to be securely anchored by ropes to solid ground. Like two technical climbers, Geraard suggested, I could spot for him, anchor him, and help him find his way down and back into the world of the living.

In response to my question of where the retelling would need to begin, he noted simply that “the story would start where the story ended, on that beach” in the foreign land. As I asked him to describe the scene as he imagined it, he said he could do so clearly, as he “had a lot of pictures,” pictures taken by his daughter, allowing him to envision the “long, solitary beach” of her dying through her own eyes. Reconstructing the scene in his
mind’s eye, Geraard described the “miles and miles of beach, nobody there, hardly anybody, distant from civilization,” and, by implication, distant from help. Ironically, he added with a sigh, “when she drowned, the sea was very calm.” Further setting the scene, he tearfully described how, “before dinner, the youngsters went bathing in the sea…” They were going to wash their hair with bio-degradable shampoo, because they cared for nature. And then somehow suddenly they were pulled into the water. They were pulled like hands clawing at their feet.” Factual description blended with expressed emotion and further challenges to Geraard’s assumptive world, as the young people’s “care for nature” was cruelly reciprocated by a deadly undertow that dragged them beneath the waves.

As Geraard’s narration continued, he depicted the screaming of friends for help, and the hurried arrival of a lifeguard, who saved another girl but could not find his daughter. Moving slowly through the successive scenes, he gradually pieced together the sequence of events, fleshing out “the picture he had drawn in his mind” with interviews he had conducted with survivors. At one point, however, he had held back in the interviews, fearing what he would hear from the other girl who was sucked down by the undertow, and narrowly saved by the lifeguard’s intervention. In his own heart and mind, Geraard had lived out the terrifying realization that his daughter surely knew she was dying, but he did not dare to hear a chilling confirmation of this from Sofie’s surviving friend.

As Geraard bravely confronted and took in this catalogue of horrors, narrating them, sequencing them, and voicing and validating the associated emotions, we periodically paused to consider whether to take further steps in the retelling, or whether the chapter we had told to that point was enough for a single session. Tacking between his internal and reflexive
narrative, he reassured me that although he could feel the tension in his shoulders, stomach and legs, he “was at the edge, and it was okay,” as he was “exploring the limit.” Acknowledging that I had experienced some of the same tension in me during the retelling, I shared with evident emotion that I felt he had taken me along with him, to which he responded, with equally clear emotion, “Thank you for that. Thank you for that coming along.”

As we drew nearer the end of the session, we shifted from direct narration to processing its significance. Noting that this was only the fourth time in the year and a half of his bereavement that he had shared any part of the story of Sophie’s dying with someone outside the family, Geraard now realized that doing so was possible, and that he could trust his bodily sensations to be guides as to how to find the tolerable edge of the story, and gradually explore it further with trusted others, including his wife and therapist. Reflecting on my role in the retelling, he added, “I think the value of the therapist is to... create an environment where that story or part of that story can be told, without judging and without trying to find solutions.” Seeing the emotion in my own eyes, and hearing it in my voice, he emphasized, was vital, in no way alarming, but instead “it was the sign of connectivity.” I closed with my own tearful acknowledgement of the sad privilege of coming to know all of his family, living and dead, in his the process of witnessing a compelling story of love and grief. As the session ended, Geraard and I spontaneously reached out to shake hands, and simultaneously shifted into a strong mutual embrace, having joined one another in a profoundly existential project to begin rebuilding a world of meaning that had been shattered by unspeakable loss.
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