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The meaning in loss protocol: A clinical trial of online grief therapy

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ABSTRACT

For a minority of the bereaved, the loss of a significant other can trigger an overwhelming emotional reaction and impaired functioning across life domains, known as prolonged grief disorder (PGD). Hence, ongoing efforts have been made to refine existing treatments to increase their efficacy and to accommodate the idiosyncrasies of grief reactions. This study presents the results of an open clinical trial of the feasibility and effectiveness of the Meaning in Loss (MIL) protocol in an online format. The brief intervention of 12 to 16 sessions combines constructivist and narrative strategies to explore and work through impediments to meaning reconstruction in loss. The sample included 25 participants diagnosed with PGD who were treated by six therapists. Baseline and post-therapy comparisons showed a significant improvement in all clinical measures (grief symptomatology, depression and general distress) and an increase of meaning making regarding the loss. Meaning making was found to be a prospective mediator of symptomatic improvement in grief across the course of therapy. These findings suggest the effectiveness of the MIL protocol in decreasing grief specific and associated symptomatology and argue for the relevance of further controlled evaluations of its efficacy. Moreover, results confirm previous findings that meaning making is a relevant factor in the evolution of grief reactions, including in the context of psychotherapy.

Prolonged Grief Disorder (PGD) is a severe and debilitating condition that may affect approximately 7–10% of mourners following the death of a loved one (Lundorff et al., 2017). PGD has been identified as the extreme end of a continuum from adaptive adjustment to persistent and prolonged maladjustment to a significant loss (Holland et al., 2009), diagnosable as a functionally impairing condition lasting for at least six months, characterized by preoccupation with the loss alongside a wide range of distressing physical, cognitive, and emotional symptoms (World Health Organization, 2020).

PGD symptoms may include intense longing and yearning for the deceased, intrusive memories, avoidance of reminders of the death, pervasive sadness, emotional blunting, anger, or guilt over the loss, and a sense of emptiness and meaninglessness (Killikelly & Maercker, 2017; Shear et al., 2011). Mourners with prolonged grief responses encounter longstanding challenges to cope and adapt in the aftermath of loss, prompting some to seek professional assistance. In recent years, research on PGD has burgeoned (Koukopoulos & Neimeyer, 2023), culminating in its inclusion in both the International Classification of Diseases, 11th revision (ICD-11, WHO, 2018) and the Text Revision of the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM 5-TR, APA, 2022). Consequently, the development of effective psychological interventions tailored to mourners in such circumstances is critical.

Meta-analyses and narrative reviews of the existing treatments suggest that grief interventions hold promise for more severely affected mourners, though not necessarily for grievers who may be experiencing an adaptive grief response (Neimeyer et al., 2023). Currier et al. (2008) conducted a meta-analysis involving 61 grief treatment trials and found that specific interventions were more effective, albeit at a small to moderate level, compared to control conditions (e.g., waitlist, control group, therapy placebo) or psychotherapies for other conditions, particularly for "indicated" samples demonstrating clinical levels of distress

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associated with grief. A further meta-analysis by Wittouck et al. (2011) included 14 studies and confirmed that grief-targeted interventions were more effective in diminishing PGD manifestations than control conditions. These conclusions were reinforced and extended in a further systematic review of 31 randomized controlled trials by Johannsen et al. (2019) corroborating the efficacy of psychotherapy for PGD. These findings underscore the value of evidence-based interventions in addressing PGD, though they have traditionally relied on a corpus of studies of in-person therapy, typically described only in very general terms.

An emerging trend in PGD treatment, however, is the use of telehealth interventions, not only as brief individual psychotherapy but also as self-help or group interventions. The COVID-19 pandemic accelerated this trend, given the widespread use of online resources to mitigate public health restrictions on social contact. In the area of grief therapy, brief telehealth treatments based on cognitive-behavior therapy (e.g., Kersting et al., 2013), exposure and behavioral activation (Eisma et al., 2015), or a self-guided intervention (Reitsma et al., 2023) have shown promising results.

Wagner et al.' (2020) recent meta-analysis of seven web-based CBT interventions for PGD documented their efficacy, particularly for posttraumatic symptomatology, perhaps reflecting their common inclusion of exposure-based techniques. For example, Wagner et al.'s (2006) 5-week telehealth protocol for PGD, combining exposure to bereavement cues, cognitive reappraisal, and integration and restoration activities, demonstrated efficacy in treating PGD at a follow-up of 1.5 years (Wagner et al., 2007), showing the potential of telehealth interventions. A further meta-analysis (Zuelke et al., 2021) of internet and mobile-based interventions for PGD found low to moderate effects and concluded that more research is needed to determine the long-term effectiveness of such interventions.

These findings encourage the development and testing of theoretically grounded and empirically informed interventions for mourners with prolonged and disabling grief. While numerous protocols have demonstrated effectiveness, many tend to adapt a cognitive-behavior rationale, incorporating techniques designed for PGD (e.g., Wagner et al., 2006) or integrating CBT with other approaches (Shear et al., 2022). However, scholars have pointed out that a major challenge in grief is the meaningful integration of the loss into the person's life story (Elinger et al., 2023; Neimeyer, 2019, 2023). Thus, developing interventions centered on the narrative retelling and meaning-making of the loss experience may be beneficial in fostering such integration, improving PGD treatment, and promoting the well-being of mourners.

The meaning in Loss protocol

The meaning reconstruction perspective (Neimeyer, 2001, 2019, 2023) is anchored in the concept that humans require meaning in their lives in order to find a sense of identity and purpose (e.g., Bruner, 2004; Kelly, 1955). Self-narratives permit the diachronic structuring of events, linking the lived past, the present, and the prospective future in a cohesive form (Angus & McLeod, 2004), which assists people in dealing with life stressors (Neimeyer, 1995). Loss can cause discontinuity, incoherence, or dissociation in mourners' self-narratives in extreme cases (Neimeyer, 2019). This disturbance is frequently connected with difficulty in understanding the loss and its influence on the life of the mourner, who may need assistance to "make sense" of an unwelcome life transition.

Mourners may become stuck or fixated on the experience of loss, unable to integrate it into their life narratives and move on with their lives or be caught in "silent stories" (Neimeyer, 2016), expressed in continual ruminative, repetitive, but unsuccessful processing of the loss rather than progressive meaning-making activity. From the standpoint of meaning reconstruction, the difficulties in integrating the loss into autobiographical memories (i.e., life story and self-narratives) are central to PGD (Neimeyer, 2006).

According to Gillies and Neimeyer (2006), mourners may reconstruct meaning through three processes: sense-making, benefit-finding, and identity change. Sense-making refers to the need to explain the loss, either by assimilating it to existing global meanings or by changing such meanings and beliefs to accommodate the loss (Park, 2010). Benefit finding acknowledges the possibility of post-loss growth and the perception of gains deriving from the event (e.g., Tedeschi & Calhoun, 2008). Finally, identity change relates to the emergence of a new vision of the self in the aftermath of grief, simultaneously strengthened and softened by it (Pals & McAdams, 2004).

A large body of research suggests that impediments to meaning-making of the loss contemporaneously and prospectively predict the severity of intense and prolonged grief symptoms, whereas success in reaffirming or reconstructing meaning predicts less intense symptomatology and personal growth (Coleman & Neimeyer, 2010). For instance, Rozalski

et al. (2017) confirmed that the ability to find meaning in the loss fully mediated adaptation to the violent death (e.g., suicide, homicide, accidents) of a significant person. Similarly, Milman et al. (2017, 2019) discovered that the ability to make sense of loss in the first year of bereavement mediated the impact of a number of risk factors (e.g., violent death loss, spousal bereavement, low social support) on the intensity of prolonged grief symptomatology in the second year.

Recently, the ability to restore meanings challenged by the stresses of the COVID-19 pandemic has been found to mediate the impact of direct COVID-related stressors such as personal disease diagnosis and the death of people in the family or social network on associated depression and anxiety (Breen et al., 2022; Negri et al., 2023). In the case of indirect COVID-19 stressors like job loss or child care, conservation or reconstruction fully accounted for their impact on ensuing psychopathology (Milman et al., 2020).

These and other studies (see Neimeyer, 2019) support the need for continued development and evaluation of meaning-oriented protocols in grief therapy, which have already shown promise in open trials (Elinger et al., 2021; Lichtenthal et al., 2019; Neimeyer and Young-Eisendrath, 2015; Saindon et al., 2014). The incorporation of the loss into autobiographical memory through narrative retelling of events, within a framework of sensitivity to attachment issues with the deceased and the implications of the loss for one's personal identity, is a common feature of these treatments (Neimeyer, 2023).

Present study

This paper reports the findings of an open clinical trial for bereaved individuals conducted in telehealth format using the Meaning In Loss (MIL) protocol (for more information, see Alves et al., 2018; Neimeyer & Alves, 2016). The primary goal of this protocol is to assist mourners in integrating their loss experience through the reconstruction of meaning by combining a variety of strategies based on a constructivist-narrative framework (Alves et al., 2018). Nonetheless, this protocol acknowledges the contribution of different frameworks, such as humanistic, cognitive, and experiential, by weaving together contemporary theories of grieving with an innate respect for the subjectivity of each client.

The current study had three goals: (1) to assess the feasibility of implementing the MIL protocol in telehealth format; (2) to test the hypothesis that the intervention would be characterized by reduced PGD symptomatology, depression, and general distress as well as increased meaning-making over the course of treatment of a sample of clients meeting PGD criteria; and (3) to investigate the hypothesis that meaning-making would predict the reduction of PGD symptoms over time.

Method

Participants

Twenty-five participants enrolled in the open clinical trial; 18 completed psychotherapy, and 7 discontinued prior to completion (the mean number of sessions completed was 8). The inclusion criteria were (1) PGD diagnosis and (2) availability for telehealth intervention, while the exclusion criteria were (1) high risk of self-harm and/or suicide, (2) having any condition or disorder that interfered with telehealth intervention (e.g., debilitating social anxiety, psychotic symptoms), and (3) ongoing psychotherapy. The Prolonged Grief Disorder-13 (PG13; Delalibera et al., 2012) and the Inventory of Complicated Grief (ICG; Frade et al., 2009) were used to assess PGD. Participants needed to score above the ICG cutoff of 30 points and meet the PG13 criteria for PGD to be included.

Table 1 details the sample demographics. Participants identified themselves mainly as women (92%), and all were Caucasian. Participants' ages were between 18 and 63, with a mean of 39.4 years (SD = 12.2). Time since the loss ranged from 6 months to 7 years, with a mean of 20.3 months (SD = 18.8). In all cases, the deceased had a close relationship with the participants, with the deceased being their parent ($n = 11$), spouse or partner ($n = 8$), offspring ($n = 4$), or sibling ($n = 2$). The majority of the losses were due to medical issues (either predicted or unforeseen) ($n = 14$); violent and/or unexpected causes of loss were less frequent but not uncommon ($n = 8$). Three clients listed the cause of death as "natural," referring to a medical issue linked to old age.

Procedure

The study was disseminated through social media and health partners (e.g., hospitals, clinics, etc.) after it were approved by the ethics committee of the affiliated university. The first phase of the project included the development of a website to promote the study and inform potential participants about the clinical trial and the inclusion criteria. Those interested in participating were invited to contact the principal researcher using the website's "contact us" section. Following the initial contact, a researcher (either the

Table 1. Demographic characteristics of the sample.

Variable	Category	*N* (%)	M (SD)
Gender	Male	2 (8)	
	Female	23 (92)	
	Non-binary, other	0 (0)	
Age	–	–	39.4 (12.2)
Marital status	Single	5 (20)	
	In a relationship	2 (8)	
	Married/consensual union	9 (36)	
	Divorced	1 (4)	
	Widowed	8 (32)	
Education	Less than 12 years	1 (3)	
	12 years	8 (32)	
	More than 12 years	16 (64)	
Occupation	Unemployed	1 (3)	
	Student	2 (8)	
	Part-time job/ internship	3 (12)	
	Full-time job	16 (64)	
	Retired	2 (8)	
	Sick leave	1 (4)	
Type of loss	Natural causes	3 (12)	
	Non-oncological disease	7 (28)	
	Oncological disease	4 (16)	
	Accident	3 (12)	
	Acute health problem	3 (12)	
	Suicide	3 (12)	
	Homicide	2 (8)	
Relationship of deceased to participant	Parent	11 (44)	
	Sibling	2 (8)	
	Companion/Husband/ Wife	8 (32)	
	Offspring	4 (16)	
Time since loss in months	–	–	20.3 (18.8)

first or second author) conducted a preliminary screening through email, assessing the conditions to proceed with telehealth consultation (e.g., a private space for the sessions, wi-fi coverage to ensure a video call), the temporal criterion for prolonged grief disorder (at least 6 months since the loss), and ensuring that participants were not engaged in psychotherapy. Participants who did not meet these criteria did not advance to the clinical assessment.

Prior to the assessment interview, participants gave informed consent and completed self-report questionnaires. The questionnaires permitted diagnosis of PGD (through the PG-13) and its severity (through the ICG) along with the assessment of depression, general distress, and meaning-making. The clinical assessment was done by a researcher on a video call after ensuring that participants understood the conditions mentioned in the informed consent. The clinical interview mainly assessed other disorders that could prevent intervention completion.

Sessions were held over Skype. The initial 12 sessions were delivered weekly, with optional further sessions delivered biweekly up to a maximum of four sessions. The ICG (Prigerson et al., 1995), Beck Depression Inventory-II (BDI-II; Beck et al., 1996), Outcome Questionnaire 45.2 (OQ45.2; Lambert et al., 1996), and the Integration of Stressful Life Experiences Scale (ISLES; Holland et al., 2010) were administered at the onset of each session. The Working Alliance Inventory-Short Revised (WAI-SR; Hatcher & Gillaspy, 2006) assessed the client's perception of the quality of the therapeutic relationship at the end of each session.

Measures

Prolonged grief disorder 13 (PG-13)

The PG-13 (Prigerson et al., 2009; Portuguese version: Delalibera et al., 2012) is a self-report questionnaire that identifies the presence of prolonged grief by assessing the frequency of four grief-related symptoms in the past month and the severity of seven current grief-related symptoms using a 5-point Likert scale. Additional items evaluate symptom duration and functional impairment. Scores range from 11 to 55, with high scores representing elevated PGD symptoms (Prigerson et al., 2009). The Portuguese adaptation showed good internal consistency (Cronbach α =.93).

Inventory of complicated grief (ICG)

The ICG (Prigerson et al., 1995; Portuguese version: Frade et al., 2009) assesses complicated grief symptoms through a self-report questionnaire of 19 items using a 5-point Likert scale ranging from 0 (never) to 4 (always). The total score varies from 0 to 76 points. The clinical cutoff score for the Portuguese population is 30 (Sousa, 2011). Internal consistency for the Portuguese adaptation was high (Cronbach α = .91).

Beck depression inventory-II (BDI-II)

The BDI-II (Beck et al., 1996; Portuguese version: Coelho et al., 2002) assesses depressive symptoms through a self-report questionnaire of 21 items using a 4-point Likert scale, ranging from 0 to 3, and the total score ranges between 0 and 63 points. Higher BDI-II values correspond to greater depressive symptomatology. Internal consistency for the Portuguese adaptation was high (Cronbach α = .89).

Outcome questionnaire-45.2 (OQ-45.2)

The OQ-45.2 (Lambert et al., 1996; Portuguese version: Machado & Fassnacht, 2015) assesses the impact of symptoms on well-being through a

self-report questionnaire of 45 items using a 5-point Likert scale from 0 (never) to 4 (always). Total scores range from 0 to 180, with higher values indicating more psychological distress. The scale has three subscales: *symptom distress*, measuring subjective psychological discomfort, *interpersonal relations*, measuring problems in interpersonal functioning and *social roles*, measuring impairment in diverse social contexts such as work or home. Internal consistency for the Portuguese adaptation was high (Cronbach α =.89).

The integration of stressful life experiences scale (ISLES)

The ISLES (Holland et al., 2010) assesses the meaningful integration of stressful life experiences through a self-report questionnaire of 16 items with a Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). The scale includes items about the ability to make sense of the stressful experience, retention of significant goals, and impact of the loss on one's sense of self, organized into two subscales: *Comprehensibility* (5 items) and *Footing into the World* (11 items). Higher scores on the ISLES indicate a greater ability to integrate the loss, and lower values suggest incomprehension and disorientation in the face of the loss (Holland et al., 2010). Internal consistency for the original study was high (Cronbach α =.89). The use of the ISLES, not adapted to Portugal by the time of the trial, required a cross-translation made by two bi-lingual researchers and was supervised by one of the authors of the scale (the last author of this study).

Working alliance inventory-short revised (WAI-SR)

The WAI-SR (Hatcher & Gillaspy, 2006; Portuguese version: Ramos, 2008) assesses the quality of the therapeutic alliance through a self-report questionnaire of 12 items using a 5-point Likert scale from 1 (rarely) to 5 (always). The WAI-SR assesses three aspects of the working alliance: (1) agreement on the tasks of therapy; (2) agreement on the goals of therapy; and (3) development of an affective bond. Each aspect is assessed by four items. Internal consistency for the Portuguese adaptation was high (Cronbach α = .89).

Therapy and therapists

The MIL protocol is divided into five phases and includes 12–16 sessions. Each phase includes a set of techniques designed to foster an evolving and flexible exploration of the loss story, both for the client and the therapist. A description of the phases is presented below and in Table 2. For a comprehensive account of each phase, see Alves et al. (2018) and Neimeyer et al. (2022). Despite the consistent structure of the protocol, it allows for tailoring the intervention according to clients' specific needs, which is reflected in the possibility of having four extra sessions allowing therapists to manage the duration of each phase and at the client's request in difficult cases. Regardless of the reason, the need for additional sessions was always discussed and agreed between therapists, clients and supervisors. In short, additional sessions were parsimoniously used when a given phase of the protocol took more time than expected, or due to clients' needs (e.g. to discuss in further detail the impact of

Table 2. Summary of the MIL protocol phases.

Phase	Session/Technique	Description
Reopening the story	1 & 2. Introducing the Deceased, Goal setting	Describing the deceased person's unique bond with the client with its defining features. Setting therapy goals according to the client's current needs and difficulties.
Processing the event story of the loss	3. Loss Time Line	Retelling the loss event in the context of the client's larger life story, with a focus on emotionally regulated integration of its traumatic details, where indicated.
	4. Meaning Reconstruction Interview	Exploring different dimensions and implications of the loss using entry, experiencing, explanation, and elaboration questions.
	5. Directed Journaling	Writing about the sense made of the loss and possible benefits or life lessons found in it in response to prompting questions.
Accessing the back story of the relationship	6. Hello Again Letter	Reopening the dialogue with the deceased with a letter prompted by questions about what the client wants to share and ask the departed.
	7. Letter from the deceased	Writing a letter back as if from the loved one in response to the above correspondence, which typically reaffirms love and support in moving forward with life.
	8. Life Imprint	Exploring and sharing the lasting impact of the deceased on the client's life and values.
Consolidation	9. Exploring sources of meaning	Articulating the unique experience of the client within contemporary models of grief. Exploring spiritual and/or artistic means of expression.
	10. Virtual Dream Stories	Writing a symbolic story about one's loss to place it in perspective and consider its implications for the future.
Termination	11. Preparation of Ending Ritual	Planning a ritual of remembrance, release, or reinvention.
	12. Ending ritual and review	Exploring the ending ritual chosen by the client and the impact of therapy, the most significant therapeutic work, and the main changes in the grief process.

PGD in occupational or familial contexts). No additional strategies or techniques were implemented in these sessions.

The first phase, *Reopening the story*, enables the client to introduce the therapist to the departed in detail, revealing unique qualities of the person who died and the relationship they shared (Hedtke, 2012). Practicing a person-first approach rather than a problem-first approach reverses the common silencing of the loss story in the social world and helps therapists to know the distinctive character of the client's loss. Most importantly, it honors the deceased by inviting their symbolic presence in therapy and in client's life, laying the groundwork for subsequent interventions. Finally, casting clients as narrators gives them agency in shaping the therapy agenda, leading to the identification of the clients' burdens and the definition of the key therapeutic aims.

The second phase entails *processing the event story of the loss*, which includes one of the main goals of the protocol. The unique structure of restorative retelling (Neimeyer & Rynearson, 2022) maintains the emphasis on narration, prompting an in-depth exploration of specific aspects of the loss story (e.g., dealing with events previously unknown to anyone), but also of the stories of the clients' relationship with the deceased and their fuller life story. To construct a tellable story, the external narrative of the loss is gradually voiced and woven together with the internal narrative of the client's emotional and bodily reactions and the reflexive, meaning-oriented narrative of the client's sense-making (Neimeyer & Rynearson, 2022). Particular procedures (e.g., mindful breathing, body grounding, or distant visualization) ensure that retelling does not trigger re-traumatization but rather integration of the loss, drawing on the secure therapeutic relationship (Neimeyer, 2019).

The meaning reconstruction interview, a systematic yet open inquiry into the consequences of the death for clients' lives, priorities, and ideas about how to deal with the loss, is used to extend this work. As therapy progresses, it focuses on reopening symbolic communication with the deceased and finding new ways of "continuing something that has no [physical] continuation," as a client put it. *Accessing the back story of the relationship*, the third phase, is focused on nurturing constructive continuing bonds between the client and the departed and settling unfinished business (Holland et al., 2020). These bonds are framed by their past relationship and clients' current needs. Some clients may need the closure of their relationship, but most clients want to maintain some sort of bond with the deceased that is not associated with extreme suffering, intrusive imagery, or a relentless void (Neimeyer & Rynearson, 2022).

This phase accommodates techniques promoting the establishment of such continued (or renewed) bonds (Klass & Steffen, 2018) through correspondence with the deceased (Neimeyer, 2012), which includes a Hello Again Letter (inspired by White, 1989) and its exploration through the deceased's life imprint on the clients. Such work promotes emotional disclosure and letting go of lingering issues with the deceased, while the Response Letter from them frequently grants encouragement to continue living or amnesty for guilt.

The next phase, *Consolidation,* expands on the connections made in the preceding phase, anchoring them in clients' daily lives and outside of the therapy session. Writing a symbolic Virtual Dream Story (Neimeyer et al., 2011) is often used to enhance self-distancing from the loss, mirroring personal themes in an imaginary context that may promote a hopeful perspective. Another goal in this phase is to view clients' unique experience of loss through the lens of contemporary models of grief (Neimeyer & Harris, 2022), fostering a better understanding of their ongoing reactions, difficulties, and needs.

Termination, the final phase, is marked by a closing ritual indicating the end of therapy. The closing ritual represents therapy's function in fostering adaptation to loss and articulating the changes that clients identify in their lives. This creative ritual can take any shape agreed upon by the client and therapist, such as rituals of remembrance, release, or reinvention (Martin, 2022). These can include concrete actions (e.g., visiting the cemetery for the first time, distributing the ashes of the deceased), symbolic actions (e.g., donating the deceased person's clothes to charity or performing acts of kindness in their honor), or an artistic creation that the client executes (e.g., a poem, a song, a scrapbook or blog with photos of the deceased, a drawing, a story), which is shared with the therapist and often with relevant others. This phase also includes relapse prevention, drawing on the mechanisms and strategies that fostered and can sustain clients' changes (e.g., self-compassionately acknowledging rather than avoiding emotions, use of writing for well-being), and exploring potential difficulties after therapy ends.

Homework assignments were used at therapists' discretion, and mainly included but were not limited to asking clients to identify the Chapters of their Lives (Neimeyer, 2014) for restorative retelling of the event of the loss in their life story (Phase 2, *Processing the event story of the loss*), write letters to and from the deceased (Neimeyer, 2012) (Phase 3, *Accessing the*

back story of the relationship) and to plan the closing ritual of therapy (Phase 5, *Termination*).

Seven therapists, five women and two men, delivered the therapy protocol. All had prior experience with adult psychotherapy, but only one with the MIL protocol. To ensure that therapists had the necessary involvement and expertise in the protocol, they received 36 hours of training from the last author, who has extensive experience in meaning-focused grief therapy (Neimeyer, 2023). The training was delivered online in the form of 12 three-hour group sessions. Therapists were also able to discuss their cases with more experienced therapists (first, second, and last authors) through individual or group supervision. Supervision also was used to ensure the fidelity and adherence of the therapists to the protocol.

Data analysis

Descriptive analyses were first performed to characterize the sample. To compare the scores of the measures (ICG, BDI-II, OQ45.2, and ISLES) and compute Cohen's d values to describe effect sizes for the magnitude of change over time, paired samples *t*-tests were performed in a within-subject analysis comparing the scores of the mentioned measures before and after the treatment.

To analyze the association between the ICG and the predictor variables, which comprised session, ISLES (lag-1), and ICG (lag-1), the data analysis used a two-level hierarchical linear model (HLM; Raudenbush & Bryk, 2002). HLM allows for the analysis of hierarchical data, where observations are nested within groups or clusters. Moreover, the HLM considers the data's within-subject correlation as well as any between-subject variance in the intercept.

Specifically, we considered the equation: $\text{icgij} = \beta_0 + \beta_1 * \text{session ij} + \beta_2 * \text{isles(lag } -1)\text{ij} + \beta_3 * \text{icg(lag } -1)\text{ij} + u_i + e_{ij}$, where the icgij is the observed value of the ICG for individual i at time j; sessionij is the session for individual i at time j, centered at session 0; isles(lag −1)ij is the value of the independent variable ISLES for individual i at time j-1.; icg(lag −1)ij is the value of the ICG for individual i at time j-1. Additionally, β_0 is the intercept, representing the expected value of ICG when all predictors are equal to zero, and β_1, β_2 and β_3 are the fixed effects coefficients, representing the expected change in ICG associated with a one-unit change in the corresponding predictor, holding all other predictors constant. Finally, u_i is the random effect for individual i, which captures the between-subject variability in the intercept, and e_{ij} is the residual error term, representing the unexplained variation in ICG at time j for individual i, after accounting for the effects of the predictors and the random intercept.

The model assumes that the residual errors are normally distributed with mean zero and constant variance and that the random intercepts are normally distributed with mean zero and variance τ^2. The model also assumes that the residuals are uncorrelated across time for a given individual but that they may be correlated across individuals within a cluster. Additional analyses were conducted to examine potential interactions and nonlinear relationships between the predictors and the dependent variable, but none were found to be significant. The *lmer* function from the *lme4* package in R (version 3.1.2, R Core Team, 2020) was used to fit the models.

Results

This section presents the main results of the study, organized into three subsections: (1) the feasibility of the protocol in telehealth format; (2) the results of the paired t-test analysis of the clinical measures, testing the protocol effectiveness; and (3) the prediction of changes in PGD symptoms by meaning-making.

Feasibility of the protocol

One objective of this study was to assess the feasibility of providing telehealth grief therapy using the MIL protocol. The dropout rate of the trial was 28%, within the range of dropout reported by meta-analysts such as Swift and Greenberg (2014), who found attrition rates ranging from 8.8% to 30.5% in general psychotherapy. The authors also reported an average dropout rate of 24.9% in bereavement, comparable to the current study's rate. Another meta-analysis (Wagner et al., 2020) found attrition rates in web-based interventions for bereavement ranging from 10% to 58%, bolstering the acceptability of our protocol in telehealth format. The therapeutic alliance reported by the clients, as measured by the WAI-SR, ranged from 3.59 (in the first session) to 4.42 (in session 16), with a mean of 4.04 for all sessions of the completers, indicating a high-quality therapeutic alliance comparable to that reported by psychotherapy outpatients, which showed a mean of 3.8 in the study of Munder et al. (2010).

At the end of the study, therapists and clients provided informal feedback on the protocol's telehealth implementation. The qualitative data collected were organized into broad categories to describe the

strengths and caveats identified by therapists and clients. Clients identified several strengths, including the sense of security that came with participating from their own homes, which facilitated the expression of their deepest emotions. They also emphasized the ability to "bring" and "involve" their deceased loved ones in sessions and felt a high level of attentiveness from the therapists, further enhancing the protocol's appeal. For their part, therapists commended the protocol's flexibility and the multitude of clinical strategies it offered, which respected individual clients' pace and needs. Furthermore, therapists underscored the protocol's focus on the clients' personal experiences rather than only on general symptoms of grief as a significant strength.

As main obstacles, both clients and therapists referred to technical problems with the audio or video channels of Skype as the main downside of the telehealth format, although these were usually solved and did not endanger therapy participation. Clients also reported occasional difficulties in dealing with the emotional intensity of some techniques. Therapists referred to difficulties in addressing clients' problems not related to grief (e.g., relationship issues) and in maintaining compliance with therapy scheduling and homework assignments.

Preliminary clinical effectiveness

To evaluate the possible impact of the intervention on client outcomes, paired *t*-tests were calculated for each clinical measure. Table 3 presents the pre-therapy (assessment session) and post-therapy (last session) scores of the measures, the results of the paired *t*-test comparing the two, and the effect size for each measure used.

Table 3. Results of paired t-tests of clinical measures.

	Pretest		Post-test					Cohen's
Measure	M	SD	M	SD	*t*	*df*	*p*	*d*
ICG	47.89	8.23	31.06	13.87	7.038	17	<.001	1.310
BDI-II	31.00	10.36	18.00	11.33	5.853	16	<.001	1.193
OQ-45.2	93.22	19.12	65.06	24.39	7.493	17	<.001	1.231
ISLES	34.59	10.38	41.59	10.54	−2.702	16	.016	−.669

Notes: ICG: Inventory of Complicated Grief; BDI-II: Beck Depression Inventory-II; OQ-45.2: Outcome Questionnaire-45.2; ISLES: Integration of Stressful Life Events Scale.

The differences in complicated grief (measured by the ICG), depression (measured by the BDI-II), and general distress (measured by the OQ-45.2) from pre-test to post-test were in the expected direction: clients had significantly fewer PGD and depression symptoms and less general distress at the end of therapy, with large effect sizes in the range of $d = 1.2–1.3$. Clients also evidenced an improved ability to attribute meaning to loss, as measured by the ISLES, with a moderate effect size.

The effects of meaning-making on PGD symptoms throughout treatment

The third goal of this study, to investigate the hypothesis that meaning-making would predict the reduction of PGD symptoms over time, was tested by the HLM with ISLES scores predicting changes in ICG. Table 4 presents the results of the HLM predicting changes in ICG scores over the course of treatment. The predictors in the model were session number, ISLES (lag −1), and ICG (lag-1), with a random intercept for each participant. On average, there was a positive relationship between session and ICG after controlling for the other variables in the model. Furthermore, ISLES (lag-1) was a significant predictor of ICG. This indicates that, on average, there was a positive relationship between ISLES at time t-1 and ICG at time t, after controlling for the other variables in the model. Finally, ICG (lag −1) was also a significant predictor of ICG, indicating that, on average, there was a positive relationship between ICG at time t-1 and ICG at time t, after controlling for the other variables in the model. The model also revealed significant between-participant variability in the intercept, indicating a variation in the initial level of ICG scores across participants. Overall, the model accounted for a significant amount of variance in ICG, $R^2 = .47$, $F(3, 838) = 234.69$, $p < .001$.

Discussion

This study investigated the feasibility and preliminary effectiveness of a protocol designed to treat PGD, building on previous research indicating that a meaning-focused approach is promising in brief psychotherapy for grief (e.g., Elinger et al., 2021; Lichtenthal et al., 2019; Neimeyer

Table 4. Hierarchical Linear Model predicting CGI.

Predictor	b	SE	*t*	*p*
Intercept	3.72	0.39	9.57	<.001
Session	0.19	0.05	3.89	<.001
$ISLES_{(lag-1)}$	0.11	0.04	2.73	.007
$ICG_{(lag-1)}$	0.59	0.02	24.84	<.001
Random intercept (participant)	–	–	6.59	<.001

& Young-Eisendrath, 2015) and that fostering meaning-making is an important goal in grief therapy. The MIL protocol combines a contemporary theory-guided conceptualization of grief with a set of techniques designed to allow emotional expression, narrative integration of the loss, and reconstruction of a continuing bond with the deceased that seems to be feasible and effective to treat PGD.

The findings of the study confirm the viability of applying the protocol in a telehealth environment, contributing to the increasing usage and sophistication of web-based therapies (McDonald et al., 2020). Our study found similar dropout rates to individual on-site therapy, further supporting the viability of this modality (Langarizadeh et al., 2017). Furthermore, clients' ratings of the therapeutic alliance showed an upward trend consistent with prior research on bereavement therapies (Hiemeyer et al., 2022). Informal feedback from both clients and therapists supported the notion that the protocol could be used in this format, with clients emphasizing the safety of doing therapy at home and the ability to talk freely about the person they've lost. In fact, the MIL protocol encourages clients to actively seek a new way of relating to the deceased in ways that were facilitated by being in their homes, often surrounded by photos or objects that reminded them of the deceased, allowing for a more dynamic exploration of past and present bonds than when therapy takes place in the therapist's consulting room. Clients also mentioned feeling heard by the therapist and being able to express their deepest feelings, which indicates that it was possible to accommodate the telehealth format to encourage and support non-verbal and emotional expression (García et al., 2021).

The difference in CGI, BDI-II, and OQ45.2 pre-post scores suggests that the MIL protocol was effective in reducing not only PGD symptoms but also depression and general distress. The effect sizes for these symptomatic improvements were large ($d = 1.2–1.3$), fully three times the magnitude of the average within-group pre-post effect size (d =.38) that characterized 24 intervention groups of grief therapies in the meta-analysis of Currier et al. (2008). The present results compare favorably for within-group analyses of change over time for similar outcomes displayed by onsite delivery of metacognitive grief therapy (Wenn et al., 2019).

These preliminary findings imply that the MIL protocol can lessen the initial symptoms of PGD, such as acute yearning, intrusive memories, or uncomfortable emotions (anger, guilt, etc.). The protocol focuses on examining and integrating the client's experiences, which appears to facilitate emotional processing of the challenging and painful events related to loss, creating a more positive and rewarding way of coping with it. Furthermore, improvements in PGD symptoms were associated with improvements in the management of sadness and overall distress, indicating that the procedure had a significant impact on other aspects of the clients' lives, such as mood, interpersonal connections, and social functioning. These results are in line with previous studies of CBT for grief, in which significant improvements were found in measures of depression, anxiety, or trauma symptomatology (e.g. Eisma et al., 2015; Wagner et al., 2006).

Moreover, even after correcting for the passage of time and the influence of the ICG in the previous session, meaning-making appeared to be a prospective predictor of session-by-session improvement in ICG scores. These findings are consistent with a growing body of research suggesting that meaning-making mediates the evolution of severe and dysfunctional grief in a variety of samples of mourners and types of loss (Breen et al., 2022, 2023; Coleman & Neimeyer, 2010; Currier et al., 2006; Milman et al., 2017, 2019), and this study extends this work to suggest its role as an evidence-based mechanism of change in grief therapy. In fact, the MIL protocol is based on the premise that meaning-making processes are critical in loss adaptation. Meaning is thought to be a multidimensional phenomenon encompassing various existential levels, ranging from a person's most abstract and general beliefs about life through the significance of the deceased's relationship and the comprehensibility of the loss to the 'felt sense' of how people experience their grief and other embodied emotions (Neimeyer, 2006). If a mourner struggles with a deep sense of meaninglessness after loss, such experiences seem to be disorganized and devoid of significance, appearing as symptoms of rumination, avoidance, etc.

By placing meaning-making at the core of treatment, the MIL protocol fosters the development of a reconstructed perspective, integrating the relationship with the deceased and the loss into the client's evolving meaning system. For example, by beginning therapy with a person-first rather than problem-first focus through inviting the client to "introduce" the therapist to the deceased through a focus on their special characteristics and illustrative stories, this approach implicitly conveys the message that grief is "about" something, and most commonly *someone* significant; rather than simply about managing unwanted symptoms, thoughts and behaviors. As successive phases of the therapy encourage clients to engage in an emotionally regulated and restorative retelling of the loss story and its integration into their larger biography, they commonly discover that bereavement, however

painful, prompts "relearning the world" in its wake (Attig, 2011), deepening their engagement with significant lessons and experiences. Likewise, the opportunity to review and revise their continuing bond with the deceased rather than stoically relinquish it and move on opens the immediate and ongoing prospect of retaining and refining much of what the relationship meant to the bereaved, and still means, as they carry a more secure attachment with them in a way that does not require the person's physical presence (Neimeyer, 2023). In life review, evocative writing and ritualization, meaning-focused therapy thereby assists clients in finding greater comprehensibility and coherence in their loss experience, which in turn predicts greater mastery of prolonged grief in successive sessions.[1]

Limitations and implications

Despite the relevant findings, this study had several limitations. The lack of a control condition to compare with the intervention group, either a waitlist or a support-only intervention, is a significant restriction. As a result, it is impossible to say with certainty that the significant clinical changes observed were caused by the protocol and not by the passage of time or common factors such as therapist attentiveness to clients' experiences. Nonetheless, the observed changes are consistent with the clients' overall improvement in various aspects of their lives, which appears less likely to occur spontaneously given the intransigent nature of prolonged grief disorder, as required by its diagnosis and demonstrated in longitudinal research (Djelantik et al., 2022). Furthermore, the prospective prediction of symptomatic improvement by enhancement of meaning-making strengthens the case that the alterations were due, at least in part, to constructive shifts in the sense and significance found in the loss because of the meaning-focused therapy protocol.

Other limitations include sample size and characteristics. The sample size was appropriate for a pilot study, but it lacked diversity, given that most clients identified as female and middle-class, as is typical of most psychotherapy studies. Furthermore, limited sample size may compromise the power of the analysis. To enhance the generalizability of our findings, future research should include larger samples of both clients and therapists. Moreover, future studies should investigate the impact of therapist effects on these models, which would be feasible with larger samples. Another weakness was the dependence on self-reported assessments, which did not provide external confirmation of symptom alleviation. Finally, informal feedback about the MIL protocol was not gathered using regulated and systematic means, such as questionnaires or interviews with independent clinicians, preventing clients' opinions from being quantified. Furthermore, the therapists asked the clients their viewpoints of the therapy upon completion of the treatment, and their responses may have been influenced by social desirability factors.

Notwithstanding its limitations, this study is the first to demonstrate the feasibility and effectiveness of a protocol based on the MIL approach to PGD in an open trial design, arguing strongly for larger controlled studies (Rounsaville et al., 2001). Its positive results should encourage further exploration of the protocol's applications in supporting people with prolonged maladaptive grieving responses, using more robust study designs and comparison with other treatments targeting PGD.

Note

1. Readers interested in training or certification in grief therapy as meaning reconstruction are encouraged to consult the extensive online and onsite training programs of the Portland Institute for Loss and Transition, available at: https://www.portlandinstitute.org/.

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