

Comparative Effects of Induced After-Death Communication and Traditional Counselling on Grief



Janice Miner Holden
University of North Texas



Noelle R. St. Germain-Sehr
William & Mary School of Education

Ana Reyes
University of North Texas

Sahar Loseu
University of North Texas

Michael K. Schmit
Texas A&M University–Commerce

Amber Laird
University of North Texas

Leslie Weintraub
University of North Texas

Amanda M. St. Germain-Sehr
Texas Woman's University

Eric Price
California State University, Fullerton

Sarah Blalock
Texas State University

Cynthia Bevly
University of North Texas

Cody Lankford
University of North Texas

Judith Mandalise
University of North Texas

Using a true experimental pre/post-test research design, we compared the effects on grief symptoms of two approaches to grief counselling: traditional grief counselling (TGC) and Induced After-Death Communication (IADC). The participants were 41 bereaved adult volunteers who were predominantly female, older and white. The participants completed a pre-test and a 90-minute counselling session. One week later, they completed a 90-minute session with the same counsellor and modality and a post-test. On the six Hogan Grief Reaction Checklist subscales, IADC clients improved significantly more overall with a large effect. Follow-up analysis of covariances (ANCOVA) and ANCOVA of the continuing presence subscale of the Ongoing Attachment Inventory revealed that IADC clients improved significantly more on one scale and nonsignificantly on six subscales, two with medium, four with small, and one with no effect. The results suggest that IADC may be an effective treatment for bereaved clients who both do and do not meet the criteria for prolonged grief disorder. Limitations and directions for future research are discussed.

When a loved one dies, it is normal to experience both distress and growth from grief. The bereaved sometimes pursue grief counselling, seeking relief from the distressing symptoms and/or seeking personal growth (Worden, 2018).

A meta-analysis of research on the effectiveness of grief counselling showed little to no effect, and even detriment (Jordan & Neimeyer, 2003). However, this study has been criticized on methodological grounds (see, for example, Larson & Hoyt, 2007). In response, Schut (2010) identified particular populations of clients for whom grief counselling is more likely to be effective, and in a recent review Hall (2014, p.11) concluded:

there is sufficient evidence to show that intervention is not effective for the bereaved in general, but is effective for those at high risk or for those who are already experiencing complications in their grief ... the more complicated the grief process, the better the chances of bereavement interventions leading to positive results.

In contemporary parlance, complicated grief is termed Prolonged Grief Disorder (American Psychiatric Association, 2022).

In this article we present a study in which we compared the effects on grief symptoms of two grief counselling approaches—traditional grief counselling (TGC) and Induced After-Death Communication (IADC)—among bereaved adults, most of whom did not meet the criteria for Prolonged Grief Disorder. In the remainder of this

section we summarize the research on after-death communication (ADC) and IADC that provided the rationale for our study.

In his classic text on grief counselling, J. William Worden (2018, p. 26) acknowledged that bereavement sometimes includes the experience of “hallucinations [of the deceased] ... both ... visual ... and ... auditory [as a] normal, ... frequent experience of the bereaved [that] many ... find ... comforting”. Indeed, both within and outside the scope of bereavement, people have reported a phenomenon we refer to with the descriptive, non-pathologizing term ADC, in which a living person perceives the presence of a physically deceased person or animal (Holden, 2017). Until recently, most ADC has been unfacilitated; that is, the ADC occurred to the experiencer suddenly, without warning and without having been explicitly sought. A recent systematic review of all research on unfacilitated ADC — a total of 35 studies published from 1894 through 2006 and involving a total of over 50,000 people from 24 countries — yielded the first empirically-based data about this phenomenon (Streit-Horn, 2011). Most of these data are summarized in Holden (2017), and many of them have been confirmed by a recent multinational investigation of over 1,000 ADC experiencers (Elsaesser et al., 2020). Among consistent findings are that ADC is common, that most ADC experiencers appear to be mentally healthy (Knight, 2011; Streit-Horn, 2011), and that they overwhelmingly report having benefitted psychospiritually from the experience, including reduction of distress and enhancement of personal growth (Elsaesser et al., 2020; Holden et al., 2018; Knight, 2011; Streit-Horn, 2011).

ADC also can be facilitated. In 2005, psychologist Allan Botkin published a book about his discovery of IADC (Botkin, 2005). Different from existing grief counselling approaches in which counsellors utilize such techniques as guided imagery, empty chair, or eye movement desensitization and reprocessing (EMDR), IADC involves two or three sessions totalling 3 hours in which bilateral stimulation—sequential alternate stimulation of both sides of the body and brain through a sensory modality such as vision, hearing, and/or touch—is used to facilitate processing of the core sadness—the most emotionally painful aspect of the grief. Botkin found that at the point that core sadness was substantially decreased, either spontaneously or following a prompt to focus on what one would most want to say to the person whose loss they were grieving, about 75% of patients reported ADC and then evidenced substantial relief from grief symptoms.

In 2013, a pre/post outcome analysis of 71 of Botkin's patients yielded significant improvement in grief

symptoms (Hannah, Botkin, Marrone, & Streit-Horn, 2013). Of 16 IADC therapists Botkin had trained, 15 completed his survey, indicating that their observed outcomes with a total of 211 of their patients/clients were virtually identical to his own (Botkin & Hannah, 2013). Like Botkin, these therapists observed that IADC helped clients substantially more than did the therapists' traditional therapeutic approaches for treating grief. Although both of these studies were conducted with assessment instruments that lacked established psychometrics and without comparison groups, results were strong enough to substantiate the pursuit of further research.

Thus, we undertook a study to assess the effects on grief of IADC compared with TGC based on Worden's (2009) approach. Our primary research question was: After controlling for pre-test scores, is there a statistically significant difference in grief-related post-test scores between persons receiving either IADC or TGC for grief?

Method

We used a true experimental pre/post-test research design to determine the effect of two different grief counselling approaches on seven grief-related variables. Because the G*Power 3.1 statistical power analysis program cannot compute an a priori power analysis for the multivariate analysis of covariance (MANCOVA) statistic, we instead utilized the multivariate analysis of variance, repeated measures, between factors platform to estimate the minimum number of study participants required ($N = 42$), given a statistical power level of .80, an α level of .05, and a medium effect size ($f = .25$; Faul, Erdfelder, Lang, & Buchner, 2007).

Participants

Participants were adult volunteers residing in a large U.S. southwestern metropolitan area who reported experiencing grief related to the loss of a loved one who had died at least 1 year prior and who were fluent in English, were available during the specified sequential Saturdays during which the study was scheduled, and passed our screening for mental health concerns. Of 162 volunteers who initially indicated interest in participating in the study, 121 completed the screening process via the qualifying survey. Several of these potential participants were screened out for not fulfilling one or more of our screening criteria—most being unavailable at the scheduled study time. Of the remaining 56 participants, 30 were randomly assigned to IADC and 26 to TGC. Of these, four IADC participants and 11 TGC participants did not complete the study. A total of 41 participants did: 26 IADC and 15 TGC.

Participants were predominantly older (78% at least 50 years old), white (90%), educated (63% with at least a bachelor's degree), and self-identified as religious or spiritual (93%), with most reporting moderate to liberal religious/spiritual beliefs (90%). Most participants were reportedly grieving the death of a relative (63%) or spouse/partner (32%), and a majority indicated a definite belief in life after death (66%). Regarding ADC, prior to participation in the study, 56% of participants

reported having a sense of their deceased loved one's presence, 27% indicated uncertainty in this regard, and 17% indicated no sense of the deceased person's presence since their death. At the start of the study, 15% met the criteria for Prolonged Grief Disorder.

Interventions

Traditional Grief Counselling

In this study, TGC practitioners followed principles and techniques described by Worden (2018). Principles included helping the survivor actualize the loss, identify and express feelings, find ways to live without the deceased, find meaning in the loss, find ways to remember the deceased, provide time to grieve, interpret normal grief-related behaviour, accept one's unique ways of grieving, and examine defences and coping styles (Worden, 2018, pp. 93–107). In pursuit of these principles, techniques included basic counselling skills and might include the use of evocative language, symbols, writing, drawing, role-playing, cognitive restructuring, creation of a memory book, guided imagery, and use of metaphor (Worden, 2018, pp. 107–110).

At the outset of the first session, counsellors would establish a therapeutic alliance by inviting clients to describe the deceased and the client's relationship to them, and using reflective listening and open-ended follow-up questions in response to whatever clients disclosed. As they listened, counsellors would assess the extent to which clients were progressing in the four tasks of grief. For the remainder of the first session and the majority of the second, counsellors would address any task(s) in which clients acknowledged they were struggling by pursuing one or more of the aforementioned principles using one or more of the aforementioned techniques. At the end of the second session, counsellors summarized with clients any insights and/or strategies they had found helpful in coping with their grief.

Induced After-Death Communication

The IADC counsellor began Phase 1 at the start of the first session by using predominantly reflective listening and open-ended questions to explore in depth the client's descriptions of the deceased and their relationship with them. When the client indicated that they had expressed what they wished to on those topics, the counsellor would explain the bilateral stimulation technique: repeated right–left stimulation of the client's body—using the modality that the client chose (tapping the backs of the hands or using eye movement).

In Phase 2, the counsellor asked the client to identify the worst aspect of their grief, to scale its intensity from 1 (low) to 10 (high), and to stay with that worst aspect during 20–30 seconds of bilateral stimulation, usually with the client's eyes closed. Following that "set" the client would open their eyes and describe what they'd experienced, to which the counsellor would reflectively listen. As long as the client showed intense emotion, the counsellor would repeat with another set. When the client appeared to have diminished emotional reaction and scaled their intensity at three or lower, the counsellor would implement another set. If the client

did not spontaneously report an ADC, the counsellor would ask the client, “If you could say one thing to your deceased loved one, what would it be?” and then ask the client to stay with that message during one or more additional sets of bilateral stimulation.

In Phase 3, the client and counsellor would process whatever had come up from the entire session. If a client had an ADC in the first session, the second session was typically spent processing whatever had arisen for the client over the intervening week; if not, and/or if the client wished, the bilateral stimulation process would be repeated.

Instruments

To assess grief symptoms, we used the six scales of the Hogan Grief Reaction Checklist (HGRC; Hogan, Greenfield, & Schmidt, 2001) and one scale from the Ongoing Attachment Inventory (Hogan, Schmidt, & Coolican, 2014) in both the pre-test and post-test. Each test included additional items: demographics and the Prolonged Grief Disorder (PGD; Prigerson & Maciejewski, 2009; Prigerson, Horowitz, Jacobs, et al., 2008) at the start of the pre-test, and the PGD and items addressing clients’ subjective reactions to counselling at the end of the post-test.

Hogan Grief Reaction Checklist

The HGRC (Hogan et al., 2001) is a 61-item instrument in which respondents use a five-point Likert-type rating to indicate how well each item describes them. Hogan et al. (2001) used extensive qualitative interviews with bereaved adults and factor analysis to develop the six subscales of the HGRC, each assessing a different aspect of grief: blame and anger, despair, detachment, disorganization, panic behaviour, and personal growth. The instrument yields a score for each subtest but not a total score. No cut-off scores exist to differentiate levels of grief or to indicate caseness. Although scores do not indicate absolute standards, they can be used to measure relative changes in grief.

Scores derived from the HGRC have demonstrated evidence of acceptable to good internal consistency and test–retest reliability ranging from .77 to .90 and .56 to .85, respectively, and evidence of validity from moderate correlations with scores derived from the Grief Experiences Inventory and the Texas Revised Inventory of Grief (Gamino, Sewell, & Easterling, 2000; Hogan et al., 2001). In this study, internal consistency for pre-test and post-test scores, respectively, demonstrated good Cronbach’s alphas: blame and anger (.70, .71), despair (.86, .93), detachment (.90, .91), disorganization (.84, .84), panic behaviour (.91, .92), and personal growth (.90, .90).

Ongoing Attachment Inventory

The Ongoing Attachment Inventory (OAI; Hogan et al., 2014) is a 15-item instrument in which respondents use a five-point Likert-type rating to indicate how well each item describes them during the 2 weeks prior to inventory completion. The inventory consists of two subscales based on factor analysis: the 10-item continuing presence subscale—assessing the extent to which the respondent

feels an ongoing sense of connection to the deceased loved one—and the five-item missing and loving subscale—the extent to which the respondent continues to miss and love the deceased loved one.

For our purpose—involving the currently prevailing theory that adaptive grieving involves an ongoing, albeit changed, relationship with the deceased (Klass & Steffen, 2018)—we used the continuing presence subscale. In this study, internal consistency for pre-test and post-test scores were good, with Cronbach’s alphas of .91 and .92, respectively.

Procedures

Recruitment and Screening

After receiving Institutional Review Board approval, we recruited participants through advertisements and email announcements inviting adults grieving the loss of a loved one who died at least 1 year prior to participate in two free grief counselling sessions. We recruited through newspaper advertisements, social media websites, local grief support groups, places of worship, public announcement boards, and convenience sampling that included word of mouth and public speaking engagements, as well as from the current client population at the university-based community counselling centre where the study was conducted.

Individuals interested in learning more followed a hyperlink embedded in the advertisement or email, which took them to an informed consent form mounted on the Qualtrics online platform, as were all assessments for the study. Although the advertisements and emails referred only to a study comparing two approaches to grief counselling, the informed consent form explicitly referenced TGC and IADC. In addition, participants were notified that if they completed the study as a member of one of the groups to which they would be randomly assigned, they could then receive two additional free counselling sessions in the treatment modality they had not experienced during the study. Participants who indicated agreement to participate in the study were then directed to the qualifying questions.

Upon providing informed consent, participants responded to seven researcher-created qualifying questions and then completed the 28-item Dissociative Experiences Scale Taxon (Chu, 2011) for screening of pathological dissociation and the 22-item Modified Mini-Screen (New York State Office of Alcoholism and Substance Abuse Services, 2005) for screening of psychotic disorder and suicidality. In the few cases in which participants’ scores indicated possible disqualification, a Licensed Professional Counselor (LPC) from the research team interviewed the participant by phone to confirm or disconfirm the validity of the scores. Participants who did not qualify were provided with counselling referral options; those who qualified were contacted for scheduling.

Counsellors

The seven counsellors who provided TGC were doctoral students under clinical supervision in a CACREP-

Table 1. Descriptive statistics and adjusted means for dependent variables between grief counselling treatments.

Variable	M_{co}	SD_{co}	M_{post}	SD_{post}	adj M	n
IADC						
Despair	28.08	8.38	24.42	10.58	23.47	26
Panic Behavior	28.00	11.12	26.84	11.09	26.70	26
Personal Growth	34.38	9.33	31.00	9.55	30.36	26
Blame & Anger	11.27	3.44	10.11	3.43	9.56	26
Detachment	16.73	4.10	16.00	8.30	14.68	26
Disorganization	14.69	5.21	14.08	4.69	13.59	26
Continuing Bond	36.04	9.68	40.54	9.73	41.27	26
TGC						
Despair	26.60	9.80	27.33	11.51	28.99	15
Panic Behavior	28.47	11.12	29.60	12.32	29.85	15
Personal Growth	35.73	9.86	33.60	8.34	34.70	15
Blame & Anger	10.27	3.15	10.27	2.40	11.23	15
Detachment	12.53	4.10	13.07	3.37	15.36	15
Disorganization	14.13	5.21	14.20	4.36	15.04	15
Continuing Bond	38.47	10.91	39.60	9.32	38.32	15

Note. IADC = induced after-death communication; TGC = traditional talk therapy; M_{co} = mean of covariate; SD_{co} = standard deviation of covariate; M_{post} = mean of post-test score; SD_{post} = standard deviation of post-test score; adj M = adjusted mean score

accredited Counselor Education and Supervision program: one LPC, five LPC Interns, and one unlicensed internationally-trained clinician. TGC clinicians' post-master's counselling experience ranged from 2–8 years, with an average of 4.14 years. Although some counsellors providing TGC were aware of the purpose of the study, none had sought training in IADC. Rather, they received 3 hours of online training in grief counselling from an LPC with extensive experience in grief counselling; this training was based primarily on Worden's (2009) seminal text in the treatment of grief, loss, and bereavement.

The five counsellors who provided IADC included one LPC-Supervisor (LPC-S), one LPC unaffiliated with the above-referenced doctoral program, and three doctoral students—one LPC-S and two LPC Interns—under clinical supervision in the program. IADC clinicians' post-master's experience ranged from 2–22 years, with an average of 9.2 years. Prior to the start of the study, counsellors providing IADC were trained in the IADC procedure through a 2-day in-person intensive workshop by an LPC who was an IADC clinician/trainer.

Interventions

Each participant completed two 90-minute TGC or IADC sessions held 1 week apart with the same counsellor. Each participant also completed the pre-test prior to the first session and the post-test immediately following the second session.

We used two forms of fidelity checks to ensure that counsellors were adhering to their assigned counselling approach. First, the lead investigator, who did not provide counselling in the study but had been trained in IADC and was knowledgeable about counselling based on Worden's (2009, 2018) tasks of grief, conferred with each counsellor immediately after each session to review the general content of the session and ensure counsellor adherence to the relevant approach—as well as participant welfare. Second, the IADC counsellors

met twice for group consultation to ensure treatment consistency. All sessions were video-recorded to refer to if questions arose regarding fidelity to the treatment protocol, but none did.

Data Analysis

To address our research question, we originally planned to perform a MANCOVA on all seven grief-related variables to determine if a statistically significant difference on the linear combination of grief existed between IADC and TGC, while controlling for the influence of pre-test scores. Utilization of a MANCOVA seemed prudent, despite random assignment, given the brevity of time between test administrations, the significant correlations between respective pre- and post-test administrations (average $r = .81$), and the relatively small study sample size, as a mechanism to maximize statistical power and minimize individual differences (Tabachnick & Fidell, 2013).

In planning the MANCOVA, we assumed a relationship between the six HGRC subscale scores and the Continuing Bonds (CB) continuing presence scores. However, in checking for MANCOVA assumptions, we discovered that although a bivariate correlation between each of the HGRC subscale scores was significant ($p < .05$), bivariate correlation between the continuing presence scores and each of the six HGRC subscale scores was not significant ($p > .05$). Therefore, we proceeded with MANCOVA of the six HGRC subscale scores (research question 1a) and with a separate analysis of covariance (ANCOVA) to determine if a statistically significant difference on continuing presence existed between IADC and TGC, while controlling for the influence of pre-test scores (research question 1b).

To assess statistical significance for the omnibus tests, we used an alpha level of $p < .05$. Post hoc analysis for MANCOVA consisted of six ANCOVAs to differentiate the linear combination of grief to determine where

Table 2. ANCOVA post hoc nonsignificant results.

Dependent Variable	<i>F</i>	df	df error	<i>p</i>	η^2	1- β
Despair	7.72	1	33	.009	.19	.77
Panic Behavior	2.27	1	33	.14	.06	.31
Personal Growth	3.74	1	33	.06	.10	.47
Detachment	0.34	1	33	.56	.01	.08
Disorganization	2.81	1	33	.10	.08	.37

F = Fisher's *F* value; df = degrees of freedom between; df error = degrees of freedom within; *p* = *p*-value; η^2 = partial eta squared effect size; 1- β = observed power

statistical significance existed. To account for the accumulation of Type 1 error in our post hoc procedure, a Bonferroni correction (.05/6) was performed that resulted in an adjusted alpha level of .008 from which to evaluate statistical significance. To assess practical significance, in the absence of norms for effect size in grief intervention research, we used Jacob Cohen's (1988) cautious specifications: $\eta^2 \geq .02$ to indicate a small effect, $\eta^2 \geq .13$ to indicate a medium effect, and $\eta^2 \geq .26$ to indicate a large effect.

Results

A preliminary MANOVA comparison of IADC and TGC groups' pre-test scores on all seven variables showed a nonsignificant difference, Wilks's $\lambda = .81$, $F(7, 33) = 1.10$, $p = .39$ (Table 1). However, 19% of the variance across the seven grief-related variables was explained prior to the intervention phase, further supporting our covariate approach. For research question 1a, involving the six HGRC scales, data were analyzed using a MANCOVA. The model assumptions for MANCOVA were met, particularly the homogeneity of regression slopes for the linear combination of covariates, Wilks's $\lambda = .60$, $F(12, 52) = 1.27$, $p = .27$. After controlling for pre-test scores, a statistically significant treatment effect on the linear combination of grief was apparent, Wilks's $\lambda = .61$, $F(6, 28) = 3.05$, $p = .02$, $\eta^2 = .40$. A large effect size was noted, indicating 40% of the variance observed in the linear combination of grief could be attributed directly to difference in treatment. Power of the study was sufficient for this effect, 1- $\beta = .83$.

Six Bonferroni-adjusted ANCOVAs were utilized to differentiate the linear combination of grief between treatments. For blame and anger, there was a statistically significant treatment effect, $F(1, 33) = 8.19$, $p = .007$, $\eta^2 = .20$, with a medium effect size, indicating that 20% of the variance observed in scores can be attributed directly to a difference in treatment. Power of the study was sufficient for this effect, 1- $\beta = .79$. For despair, panic behaviour, personal growth, detachment, and disorganization, a statistically nonsignificant treatment effect was evident with one case of no effect, three cases of small effect, and one case of medium effect size (Table 2).

For research question 1b, involving the one OAI scale, data were analyzed using an ANCOVA. The model assumptions for ANCOVA were met, particularly the homogeneity of regression slopes for continuing presence, $F(1, 37) = .07$, $p = .80$. After controlling for pre-test scores, a statistically nonsignificant treatment effect on continuing presence was apparent, $F(1, 38) =$

3.71, $p = .06$, $\eta^2 = .09$. A small effect size was noted, indicating that 9% of the variance observed in scores can be attributed directly to a difference in treatment. Power of the study was low for this effect, 1- $\beta = .47$. We conducted a sensitive power analysis using the G*Power 3.1 statistical power analysis program (Faul, Erdfelder, Lang, & Buchner, 2007) to determine the minimum effect size required to find statistical significance. Using our study's current sample size of 41 and chosen alpha level of .05, statistical significance would only have been detected for approaching medium to large effect sizes, $\eta^2 \geq .16$.

Discussion and Implications for Counsellor Practice

In our view, for such a brief treatment to show such differences between two modalities of grief counselling is noteworthy. A large effect overall and a medium effect for two of seven variables indicates that something is present in IADC counselling that is absent in TGC counselling for grief. We believe the effects are due to one or both of two unique features of IADC that occur with bilateral stimulation: reduction in core sadness and/or facilitation of ADC.

Results of this study lend weight to results from previous reports on the effectiveness of IADC that involved less rigorous methodology (Botkin & Hannah, 2013; Hannah et al., 2013). Regarding prolonged grief disorder, at pre-test, two TGC participants' scores (13.3%) met criteria (participants 3 and 14), with the same number at post-test (participants 6 and 14). By comparison, four IADC participants' scores at pre-test (15.4%) met criteria (participants 19, 22, 37, and 38), and only two (7.7%) at post-test (participants 19 and 37). The fact that the vast majority of our participants did not meet the criteria for PGD suggests that, contrary to Schut's (2010) and Hall's (2014) assertions that grief counselling is more effective for clients at-risk or evidencing complicated grief, IADC may be an effective intervention for the majority of bereaved clients who do not evidence prolonged grief disorder.

Counsellors providing grief counselling now have a rationale for becoming trained in and providing IADC—at least to their mentally healthy adult bereaved clients seeking such treatment. Considering the apparently unique benefits of this approach for grieving clients, the investment of a one-time fee for a one-weekend training workshop seems more than warranted (<http://www.induced-adc.com>). During that training, counsellors learn such aspects as procedural nuances and contraindications.

Limitations and Recommendations for Future Research

Our study involved several limitations, including small sample size, limited diversity of demographics among participants, differences in experience levels of counsellors from the two treatment groups, and absence of follow-up data. Future researchers could replicate our study in ways that correct for these limitations.

Another recommendation for future research is a comparison of IADC with EMDR, another grief counselling approach that involves bilateral stimulation. An internet and PsycINFO search revealed only four peer-reviewed publications addressing EMDR for grief (Shapiro, 2014; Solomon & Rando, 2007, 2012; van Denderen, de Keijser, Stewart, & Boelen, 2018), none of which involved a study comparable to ours. A key focus of an IADC–EMDR study would compare the EMDR strategy of processing the “worst memory” associated with the loss (Solomon & Rando, 2012, p. 233) with the IADC strategies of processing the core sadness—the most emotionally painful aspect of the loss—and facilitating ADC.

Conclusion

In this experimental study, mentally healthy adult bereaved clients benefited significantly more from IADC than from TGC. Evidence is mounting that IADC may represent an effective intervention for the great majority of bereaved people who do not meet criteria for prolonged grief disorder. Additional experimental studies are needed to confirm our findings.

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