

EFFECTS OF A NEAR-DEATH EXPERIENCE LEARNING MODULE ON GRIEF

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The effectiveness of a near-death experience (NDE) learning module on reducing distressing aspects and enhancing a growth aspect of grief among bereaved adults was examined. In this experimental design, I randomly assigned 12 participants to the experimental group and 12 participants to the waitlist no treatment control group. Six research questions were explored.

A two-factor repeated measures analysis of variance was performed on five dependent variables to determine if the two groups performed differently across time according to the pretest and posttest results of subscales of the Hogan Grief Reaction Checklist (HGRC). A one-way analysis of covariance was performed on one dependent variable to determine if the groups were statistically different according to the posttest results of a sixth subscale of the HGRC. Univariate eta squared was hand calculated to determine practical significance.

Findings indicated that participants in the experimental group showed small effect size for interaction on Panic Behavior ($\eta^2 = .05$) and Personal Growth ($\eta^2 = .05$), large effect size for interaction on Detachment ($\eta^2 = .15$), large effect size for treatment type on Blame and Anger ($\eta^2 = .15$), and negligible effect size for interaction on Despair ($\eta^2 < .01$) and Disorganization ($\eta^2 < .01$). Effect size findings indicated modest to substantial benefits of the NDE learning module intervention for bereaved adults in the form of decreased panic behavior, blame and anger, and detachment, and increased personal growth. I discuss implications for further research beyond this initial investigation.

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CHAPTER 1

INTRODUCTION

During the course of a lifetime, virtually every person experiences the death of a loved one. Whereas the extent to which a death of a loved one affects individuals can vary, most people experience a range of changes in emotions, physical sensations, cognitions, and/or behaviors as a reaction to grief (Worden, 2009). Typical reactions include feelings of sadness, anxiety, anger, and relief; thoughts of disbelief and confusion; physical sensations of tension and depersonalization; and behaviors such as crying, sleep disturbances, and social withdrawal. In its most severe state, normal grief can matriculate into complicated grief, causing clinical manifestations such as symptomatology indicative of depression or other mood disorders (Worden, 2009).

Freud (1917/1957) was first in the psychotherapy literature to discuss grief in his influential paper, "Mourning and Melancholia." Freud distinguished normal grief—mourning—from pathological grief—melancholia—and theorized that melancholia led to a severe reduction in self-esteem. Freud's description of a reduction in self-esteem is tantamount to the modern understanding of depression. Additionally, Freud posited that mourning resolved over time. The amount of time for that resolution to occur, according to Freud, was unique to each individual.

Nearly 30 years later, Lindemann (1944) and Anderson (1949) published the first studies of grief. In qualitative interviews with 101 bereaved individuals, Lindemann (1944) noted five distinct themes of acute grief: (1) physical distress, (2) obsession with deceased loved ones, (3) feelings of guilt, (4) feelings of aggression, and (5) complications with normal daily functioning.

Moreover, Anderson (1949) found that normal grief could manifest into “morbid grief” (p. 48). He found several common themes throughout 100 case studies: pathological anxiety, hysteria, manic depression, and obsessive thoughts about the deceased person.

Historically, theorists have conceptualized grief as a reaction to the need to reestablish an attachment with the deceased person (Bowlby, 1965, 1980; Parkes, 1972). The intensity of grief depended largely upon the degree of attachment to the deceased individual. Parkes (1972) additionally noted that grief was a reaction not only to physical separation from a loved one but also to a separation from the positive feelings that the deceased loved one provided.

As important as historical models of grief (Anderson, 1949; Bowlby, 1965, 1980; Freud, 1917/1957; Lindemann, 1944; Parkes, 1972) were to understanding individuals’ reactions to loss, they were based on a medical model. Theorists aligning with the medical model view grief as a state rather than a process. Engel (1961) argued that the medical model conceptualized recovery from grief as a state in which the bereaved person returned to functioning just as that person was before their loved one died. However, contemporary theorists have noted that people are different in many ways after experiencing grief (Worden, 2009) and view grief as a process rather than a state (Stroebe & Schut, 1999). Therefore, they consider the medical model of grief to be incomplete and inaccurate.

Contemporary bereavement theorists Stroebe and Schut (1999) sought to refocus conceptualizations of grief from a state-oriented medical model to a process-oriented model. In their dual process model of coping with bereavement (DPM), they conceptualized grief as a process of oscillating between loss-orientation and restoration-orientation. Bereaved individuals experience loss-orientation as they focus primarily on processing the loss of the

deceased loved one. Bereaved individuals experience restoration-orientation as they cope with secondary stressors, such as forming a new identity—for example, identifying as a “widow” instead of a “wife.” In the DPM, as individuals oscillate between loss-orientation and restoration-orientation, they fluctuate between coping with and avoiding different stressors associated directly and indirectly with the deaths of their loved ones. Coping and avoidance mechanisms take place within and between loss-orientation and restoration-orientation. The process of oscillation is central to a reduction of distress and an increase of personal growth related to grief (Stroebe & Schut, 1999). Results of recent studies have supported central tenets of the DPM (Hogan, Greenfield, & Schmidt, 2001; Hogan & Schmidt, 2002; Richardson, 2007; Richardson & Balaswamy, 2001).

Drawing implications of the DPM for counseling bereaved individuals, mental health professionals have focused primarily on two issues: (1) the effectiveness of bereavement counseling interventions and (2) the design of bereavement counseling interventions. To address the effectiveness of bereavement counseling, researchers recently conducted several meta-analytic studies on bereavement intervention outcome (Allumbaugh & Hoyt, 1999; Currier, Holland, & Neimeyer, 2007; Currier, Neimeyer, & Berman, 2008; Fortner, 1999). These meta-analyses yielded conflicting results. Some researchers found small mean effect sizes ranging from 0.13 (Fortner, 1999) to 0.14 (Currier et al., 2007). Others found a medium mean effect size of 0.41 (Allumbaugh & Hoyt, 1999). Yet others reported a small mean effect size of 0.16 in randomized studies and a medium mean effect size of 0.51 in nonrandomized studies (Currier et al., 2008). From these data, a striking contradiction exists in the current bereavement research environment, in that the data support no firm conclusion: some results

have been too weak to affirm the overall value of bereavement interventions, yet other results have been too strong to dismiss bereavement interventions as ineffective. Therefore, more research is needed in this area.

Parkes (1980) placed bereavement intervention designs into three broad categories: professional services, voluntary services, and self-help groups. Professional services are facilitated by licensed professionals, such as mental health counselors. Voluntary services are facilitated by trained non-professionals, often supervised by licensed professionals. Self-help interventions are peer-facilitated. All three intervention designs can take place individually or in groups. Because the DPM is both an intrapersonal and interpersonal process, the DPM is suited for any of the bereavement intervention designs and formats.

In the past 15 years, near-death experience (NDE) authors and researchers (Horacek, 1997; McDonagh, 2004; Ring & Valarino, 2000) have suggested an especially innovative bereavement counseling intervention. They posited that providing information about NDEs in a psychoeducational format would decrease distressing effects of grief and increase personal growth in bereaved individuals. Psychotherapists Horacek (1997) and McDonagh (2004) provided case studies in which they assigned bereaved clients to read books and watch videos on NDEs. Both therapists reported substantial reductions in clients' grief. In addition to case studies, anecdotal evidence supports the notion that learning about NDEs can lead to reductions in distressing aspects of grief (Drumm, 1992; Sutherland, 1996).

Furthermore, Ring and Valarino (2000) discussed their experiences with their psychoeducational program about NDEs designed for bereaved individuals. They presented their program to "preexisting bereavement support groups" (p. 266) after which participants

reported decreases in grief. Unfortunately, the authors did not publish their psychoeducational program design. In a recent e-mail exchange with Ring (personal communication, February 12, 2009), he confirmed that neither the details of the program design nor the data were available in published form.

NDE researchers and theorists have asserted that learning about NDEs can therapeutically facilitate bereaved individuals' grief by instilling them with a lasting connection to the deceased and with increased confidence that the bereaved individual and the deceased loved one would once again be reunited in some form (Horacek, 1997; Ring & Valarino, 2000). These effects of learning about NDEs on grief correspond to both loss-orientation and restoration-orientation within the DPM. However, the effects of learning about NDEs on grief have yet to be empirically investigated.

Statement of the Problem

NDE researchers and authors have long theorized that increased knowledge about NDEs leads to a reduction in grief. Despite the significance of these two interconnected issues, researchers have not yet empirically investigated this connection. Although anecdotal and case study reports provide qualitative evidence to support the notion that learning about NDEs has a therapeutic effect on grief of bereaved individuals (Drumm, 1992; Horacek, 1997; International Association for Near-Death Studies, 2007; McDonagh, 2004; Ring & Valarino, 2000; Sutherland, 1996), this concept would benefit from further exploration in order to add empirical support. Therefore, studying the effectiveness of an NDE learning module as an intervention to reduce grief of bereaved adults is needed.

Purpose of the Study

The purpose of this study was to examine the effectiveness of an NDE learning module on the grief of participants in a bereavement workshop. Specifically, I examined the effects that participating in a psychoeducationally-oriented NDE learning module had on reducing distressing aspects of and increasing personal growth aspects of grief of bereaved adults as measured by a self-report instrument.

CHAPTER 2

REVIEW OF LITERATURE

The following chapter is a review of the professional literature relevant to grief and near-death experiences. I also refer to applicable literature from the fields of thanatology, medicine, nursing, psychology, and counseling. Specifically, I explore historical and contemporary theories of grief, common effects of normal grief, bereavement counseling modalities, empirical evidence regarding bereavement counseling, and the role of psychoeducation about near-death experiences in bereavement counseling.

Historical Theories of Grief

Since Sigmund Freud's (1917/1957) seminal paper, "Mourning and Melancholia," theorists in the fields of psychology and counseling have addressed the topic of grief. Freud separated grief into two categories: mourning, or normal grief, and melancholia, a pathological form of grief. He posited that mourning was a non-pathological reaction to loss of a loved one. According to Freud, melancholia mirrored many of the same processes as mourning, except that people suffering from melancholia experienced severe decreases in self-esteem. Freud (1917/1957) theorized that the mourning process resolved over an unspecified course of time.

In another influential paper, Lindemann (1944) extended Freud's thoughts on grief. He described acute grief as an explicit condition with identifiable psychological symptoms. In the first published systematic study on acute grief, Lindemann interviewed 101 bereaved participants who presented at a medical clinic about their experiences of grief. As a result of his interviews, Lindemann concluded that acute grief consisted of five characteristics: (1) physical or somatic distress manifesting in a variety of forms, (2) fixation with images of deceased loved

ones, (3) feelings of guilt and remorse regarding the deceased, (4) aggressive behavior, and (5) inability to return daily functioning to that which was previous to the death. Lindemann also detailed a sixth characteristic that some, but not all, participants displayed: development of behaviors or qualities of the deceased. Lindemann concluded that acute grief can be mitigated through grief work facilitated by religious leaders, psychiatrists, or social workers.

Whereas Lindemann (1944) only briefly noted deleterious effects of repressed grief, Anderson (1949) placed a much greater emphasis on psychological disorders that unresolved grief could produce. He used the term “morbid grief” (p. 48) to describe repressed grief that manifested in a particular set of pathological symptomatology. As a result of 100 case studies, Anderson concluded that, as a reaction to bereavement, 59% of his patients developed pathological anxiety, 19% displayed hysteria, 15% developed manic depression, and 7% developed obsessions about the bereaved person.

Bowlby (1965, 1980) characterized grief as a reaction to the need to reestablish a relationship with an object to which the person experiencing grief had an attachment. An individual would not experience grief without an attachment to a particular object. He posited that the greater the attachment to the object, the more intense the reaction to the loss (Bowlby, 1965, 1980).

Parkes (1972) expanded upon Bowlby’s conceptualization of grief. As a result of a systematic review of the literature, Parkes argued that grief had been largely ignored in academic psychiatry. Parkes added that, in addition to Bowlby’s ideas about loss, grief carried a social stigma. This social stigma complicated the process of coping with grief. Because of the stigma of grief, the individual’s social support system was likely to weaken in the midst of

discomfort and anxiety. Additionally, Parkes posited that the bereaved individual not only suffered from the physical loss of the loved one but also endured the loss of positive psychological effects the deceased loved one had provided (Parkes, 1972).

Of any theorist in the field of grief studies, Kübler-Ross (1969) likely has had the broadest impact on understanding grief, especially in popular culture (Friedman & James, 2008; Maciejewski, Zhang, Block, & Prigerson, 2007). Kübler-Ross (1969) described a model of dying in which she argued that people who were diagnosed with terminal illnesses appeared to encounter five domains of experience, famously called the five stages: denial, anger, bargaining, depression, and acceptance. According to Kübler-Ross, these stages were common domains of experience among individuals faced with their own deaths. Throughout the 1970s, her stages of dying transformed in popular culture to stages of grief (Friedman & James, 2008). Eventually, a vast majority of clinicians accepted these stages of grief as inevitable outcomes of coping with experiencing a death of a loved one. However, only one published study, titled the Yale Bereavement Study (YBS; Maciejewski et al., 2007), included empirical evaluation of the five stages of grief since the model was published in 1969. The YBS researchers did not find sufficient evidence to support consistent existence of all five stages in people grieving deaths of loved ones. Additionally, several major authors in the field of grief studies have argued that the stages of grief theory is scientifically unsupported, inaccurate, and an insufficient model to describe grief processes (Bonnano, 2009; Friedman & James, 2008; Neimeyer, 2001).

Although theorists and researchers have largely acknowledged the contributions of Freud (1917/1957), Lindemann (1944), Anderson (1949), Bowlby (1965, 1980), Parkes (1972), and even Kübler-Ross (1969) as classic works in the field of grief (Parkes, 2001), these theories

are based on a medical conceptualization of grief. In these theories, grief is characterized as a set of symptoms that are inflicted upon an individual, similar to an illness – an essentially foreign condition indicating that one’s optimal wellness has been at least temporarily compromised and from which one hopefully recovers, preferably sooner than later. In the medical model, grief is conceptualized as a psychobehavioral event or pattern of events from which an individual can either psychologically and/or somatically recover or decline. Recovery is seen through the medical model to be a process in which one returns to a condition identical to premorbid functioning (Engel, 1961). However, contemporary authors have indicated that the medical model of grief is incomplete (Stroebe & Schut, 1999; Worden, 2009) and have called for a more process-oriented model (Neimeyer, 2001). The question of the importance of relinquishing bonds versus continuing bonds partially represents these two conflicting views of bereavement.

Continuing Bonds

For a majority of the 20th century, grief theorists argued that in order to resolve grief, bereaved people must let go of their continued psychological connection with the deceased (Abraham, 1927; Clayton, Desmarais, & Winokur, 1968; Edelstein, 1984; Furman, 1984; Hofer, 1984; Peppers & Knapp, 1980; Pollock, 1975; Rando, 1986; Raphael, 1983; Sanders, 1989; Volkan, 1981; Weizman & Kamm, 1985). This continued psychological connection is known in thanatology literature as continuing bonds (Stroebe & Schut, 2005). Moreover, fostering a sense of continuing bonds with the deceased was likened to unresolved grief and psychopathology (Dietrich & Shabad, 1989; Horowitz, Wilner, Marmor, & Krupnick, 1980; Jackson, 1957; Miller, 1971). From this theoretical perspective, “the bond with the deceased is

not a part of the resolution of grief, but is an attempt to preserve the relationship by fighting against the reality that the person is dead” (Silverman & Klass, 1996, p. 4). In order to relieve distress associated with grief and move toward healing, one must surrender one’s bond to the deceased.

Conversely, in a landmark thanatology text, Klass, Silverman, and Nickman (1996) argued that the bereaved’s continuing bonds with the deceased was an essential and inherent part of the normal process of grief. According to the authors, mourners experience a variety of changes as a result of the grief process, “and part of the change is a transformed but continuing relationship with the deceased” (Silverman & Klass, 1996, p. 19). Furthermore, they argued that continuing bonds facilitated healthy emotional and cognitive processes associated with grief.

However, after reviews of research on continuing bonds, several authors recently concluded that researchers have not provided conclusive evidence to support either the continuing bonds perspective or the relinquishing bonds perspective (Field, Gao, & Paderna, 2005; Stroebe & Schut, 2005). Field et al. (2005) contended that continuing bonds is a “multidimensional construct” (p. 295), and to conclude that continuing bonds should necessarily be part of the normal trajectory of grief would be erroneous. Similarly, Stroebe and Schut (2005) argued that the only reliable conclusion one can draw from the current research evidence on continuing bonds is that “certain types of continuing bonds may be sometimes helpful/harmful, whereas certain types of relinquishing bonds may sometimes be helpful/harmful” (p. 489). They argued that individual and cultural differences must be accounted for in the process of examining the helpfulness or harmfulness of continuing or relinquishing bonds. As a result of the lack of extensive clarity regarding continuing bonds, it

seems reasonable to conclude that no general assumptions or conclusions are either theoretically or empirically justified regarding the role of continuing or relinquishing bonds as universal healing factors in grief.

One contemporary model of bereavement is the dual process model of coping with bereavement (Stroebe & Schut, 1999). This model is process-oriented and might be conceptualized as including aspects of both continuing bonds and relinquishing bonds. I review this model in the next section.

Dual Process Model of Coping with Bereavement

Rather than being a stage or phase model, the dual process model of coping with bereavement (DPM; Stroebe & Schut, 1999) is a “waxing and waning” (p. 213) process that involves three phenomena: loss-orientation, restoration-orientation, and oscillation. During loss-orientation, the bereaved person focuses primarily on processing the loss of the deceased person or a direct aspect thereof. Loss-orientation includes features such as continually thinking about the deceased, ruminating about experiences leading up to and surrounding the loss, and a sense of longing for the deceased. Loss-orientation also manifests in behaviors such as reviewing photographs of the deceased and crying about the loss. The process of continuing bonds can also occur within loss-orientation. Whereas loss-orientation typically is dominated by painful emotions, it can include a range of emotions even as positive as relief.

The restoration-orientation component of the DPM (Stroebe & Schut, 1999) involves what an individual copes with after a loss (e.g., isolation) and how that individual copes with it (e.g., by utilizing social support systems). What an individual copes with is called a secondary stressor. Secondary stressors include becoming proficient in household or related tasks that the

deceased had previously carried out; changing one's self-identity, such as from "spouse" to "widow"; and conducting tasks to deal with readjusting to life without the deceased, such as discarding the deceased loved one's old clothes. The process of coping with secondary stressors enables the bereaved individual to "accept the reality of the changed world" (p. 215) through redefining the individual's subjective internal view of oneself, others, and the external environment. Additionally, the concept of relinquishing bonds can be part of restoration-oriented processes. As in loss-orientation, restoration-orientation often includes a range of pleasurable and painful emotions.

Oscillation is the third component in the DPM (Stroebe & Schut, 1999). Oscillation is a dynamic process in which the individual fluctuates within and between loss-oriented and restoration-oriented coping processes. In this alternation between different but related processes, the individual both confronts and avoids stressors related to the loss directly. Stroebe and Schut argued that to maintain functional physical and mental health, bereaved people need to oscillate between confrontation with and avoidance of stressors related to grief. They conceptualized this confrontation-avoidance oscillation as the central healing process in the DPM.

Both confrontation and avoidance dynamically oscillate within and between the processes of loss-orientation and restoration-orientation. Coping and avoidance are not states, argued Stroebe and Schut (1999), but "back-and-forth" (p. 216) processes. To illustrate this process, I present the example of a widowed adult male whose wife recently died. The widower responds by crying about his wife's death, ruminating about circumstances surrounding her death, and repeatedly viewing old photographs of her. By directly experiencing the loss, his

responses represent coping with stressors associated with loss-orientation. After a week off of work, the widower must return to his job. In order to optimally perform his duties at work, the widower suppresses painful emotions associated with his grief. By suppressing these emotions, his response indicates avoidance of stressors associated with loss-orientation. His avoidance is not necessarily detrimental or negative but is a beneficial response in the context of his situation. These responses demonstrate the roles of coping and avoidance mechanisms within loss-orientation.

To continue this example, the widower can no longer afford the two-bedroom apartment he shared with his wife and decides to move to a smaller apartment. Because of space limitations, he must now discard his deceased wife's old clothes. As he is packing up her clothes, he begins to cry; soon, he once again suppresses his emotions and continues packing, representing oscillation between restoration-orientation, loss-orientation, and back to restoration-orientation. After packing three boxes, the widower begins to feel distressed with the process of discarding his wife's clothes and leaves his apartment. This response indicates avoidance of stressors within restoration-orientation. This example demonstrates the oscillation of coping and avoidance mechanisms within and between loss-orientation and restoration-orientation processes.

The literature on the DPM includes empirical support. In a study of 200 widowed men, Richardson and Balaswamy (2001) investigated factors that most contributed to coping among participants, who were in their second year after their losses. The researchers divided participants into two groups: an early bereaved group, or participants who were widowers for less than 500 days; and a later bereaved group, or participants who were widowers for more

than 500 days. They interviewed participants about circumstances surrounding the deceased spouse, social relationships, and psychological health. The interviews included both open-ended and closed-ended questions. The researchers designed the closed-ended questions to measure a number of loss- and restoration-oriented variables. Additionally, participants completed Bradburn's (1969) Affect Balance Scale (ABS), a measure of psychological well-being. The ABS is composed of two subscales: Positive Affect and Negative Affect.

Results of the study indicated support for the DPM, in that the presence of both loss and restoration-oriented variables correlated with the ability of participants in the early bereaved group to cope with negative affect associated with grief (Richardson & Balaswamy, 2001). Although members of the later bereaved group who scored high on loss- and restoration-oriented variables did not show reduced negative affect, they nevertheless showed overall greater psychological well-being.

Richardson and Balaswamy's (2001) investigation was not without limitations. The generalizability of the study to a larger population, even to that of widowers, is questionable because of the small sample size. The sample also lacked diversity in that participants were grouped according to time since the loss. Additionally, the researchers may not have identified all specific variables related to loss- and restoration-orientation. However, overall, the results from this study provided some preliminary empirical support for the DPM (Richardson & Balaswamy, 2001).

In a similar study designed to test the constructs of the DPM among elderly widows and widowers, Richardson (2007) conducted interviews with 319 participants using a protocol from a previous study (Richardson & Balaswamy, 2001) designed to measure a number of loss- and

restoration-oriented variables. Participants also completed Bradbury's (1969) Affect Balance Scale (ABS) in an effort to measure psychological well-being. The researchers both conducted the interview and administered the ABS at six months (Wave 1), 18 months (Wave 2), and four years (Wave 3) after the death of the spouse.

Participants reported that they engaged in loss- and restoration-oriented activities at all three Waves (Richardson, 2007). Results also indicated that both loss- and restoration-oriented variables were related to psychological well-being at all three Waves. For example, taking part in hobbies, a restoration-oriented activity, was associated with well-being at Waves 1 and 3. Social engagement with friends, a restoration-oriented activity, was also related to psychological well-being at all three waves. Additionally, rumination about deceased loved ones, a loss-oriented activity, had an inverse relationship with psychological well-being at Waves 1 and 2. These results, along with those of a previous study (Richardson & Balaswamy, 2001), indicated support for the constructs of loss-orientation and restoration-orientation in the DPM.

However, Richardson's (2007) study also contained limitations. Widows outnumbered widowers in the study, making it difficult to generalize this study to a larger population. Additionally, the average age of participants was 69 for women and 73 for men, again making it difficult to generalize to an older or younger population of widows and widowers. Despite these limitations, the results of the study contributed further evidence for the applicability of the DPM.

Other researchers have also provided partial support for the basic constructs of loss-orientation and restoration-orientation within the DPM (Hogan et al., 2001; Hogan & Schmidt,

2002). During the development of the Hogan Grief Reaction Checklist (HGRC; Hogan et al., 2001), authors of the instrument determined convergent and divergent validity by correlating it with a number of instruments, including the Impact of Event Scale (IES; Horowitz, Wilner, & Alvarez, 1979). Results indicated that the Intrusion subscale of the IES showed moderate correlations with all subscales of the HGRC. The Intrusion subscale measures “an individual’s preoccupation with a traumatic event” (Hogan & Schmidt, 2002, p. 622). Thus, respondents who reported less intense grief on the HGRC also tended to report reduced preoccupation with the loss. As reduced preoccupation with a loss corresponds theoretically to facets of loss-orientation in the DPM, these results added support for the loss-orientation construct of the DPM.

Using structural equation modeling (SEM), Hogan and Schmidt (2002) tested the DPM as a theory of grief and its relationship to intrusivity, avoidance, and personal growth. The model that provided the best fit statistically displayed a strong relationship between intrusion, avoidance, grief, and personal growth. The model appeared to demonstrate that grief lead to personal growth through the pathway of intrusion and avoidance. This pathway indicated that grievers initially cope with factors related to loss-orientation and then eventually avoid stressors directly associated with loss-orientation. These results provide partial support for both loss-orientation as a construct in coping with grief and the process of oscillation in the DPM.

An extensive review of the literature revealed no research results that disconfirmed the DPM. Therefore, based on the review of the contemporary literature on grief theory and increasing empirical support for the dual process model of coping with bereavement, the DPM

appears to have potential as a consistent and useful framework for understanding the grief process.

Common Effects of Normal Grief

Individuals can experience a multitude of effects from normal grief (Worden, 2009). Worden classified these effects into four broad categories: feelings, physical sensations, cognitions, and behaviors. Feelings can include emotions such as sadness, anger, guilt, anxiety, loneliness, and fatigue. Feelings can also include a sense of helplessness, numbness, shock, and yearning. However, bereaved individuals can also feel positive emotions such as emancipation or relief (Worden, 2009).

Bereaved individuals also experience a number of physical sensations (Worden, 2009). These physical sensations can include “hollowness in the stomach; tightness in the chest; tightness in the throat; oversensitivity to noise; a sense of depersonalization: ‘I walk down the street and nothing seems real, including me’; breathlessness, feeling short of breath; weakness in the muscles; lack of energy; and dry mouth” (pp. 23-24).

The third category of effects from grief is cognitions (Worden, 2009). Cognitions can include a sense of disbelief, confusion, and preoccupation or “obsessive thoughts about the deceased” (p. 25). Bereaved individuals may also experience a sense of presence, or a sense that the deceased is physically in the room with them at a particular time. Additionally, the bereaved can experience auditory and visual hallucinations that often disappear within a short period of time (Worden, 2009).

Finally, a variety of particular behaviors are commonly related to bereaved individuals (Worden, 2009). These behaviors can include sleep disturbances, whereby a person has trouble

falling asleep or wakes up often in the middle of the night. The bereaved also often experience appetite disturbances, whereby a person either overeats or undereats. According to Worden, undereating is far more common than overeating as a reaction to grief. Bereaved individuals also commonly experience absentminded behavior or social withdrawal. Other behaviors associated with grief include dreaming about the deceased, avoiding reminders of the deceased, searching and calling out for the deceased, sighing, restless hyperactivity, crying, visiting places or carrying objects that remind the survivor of the deceased, and treasuring objects that belonged to the deceased (Worden, 2009).

Bereavement Counseling Modalities

In this section, I discuss three different modes of bereavement counseling (Parkes, 1980): professional services, voluntary services, and self-help groups. For each modality, I outline specific descriptions. I also describe typical features of each category of bereavement counseling.

Professional services include bereavement counseling facilitated by licensed and trained mental health professionals such as counselors, clinical social workers, or psychologists (Parkes, 1980). Often, these professionals have additional training in thanatology. Professional services can be rendered individually or in a group setting. Depending on the needs of the bereaved individual, this form of bereavement counseling can range from basic support counseling to goal-oriented psychotherapy.

Voluntary services include bereavement counseling facilitated by trained volunteers who are directly supervised by licensed professionals (Parkes, 1980). An example of voluntary

services are widow-to-widow programs, in which widows volunteer and enroll in training programs designed to support and counsel other widows (Worden, 2009).

Self-help groups include bereavement support groups in which bereaved laypersons offer support and assistance to other bereaved individuals (Parkes, 1980). Sometimes these groups are supported or supervised by licensed professionals, but often they are not (Worden, 2009). An example of self-help groups is Compassionate Friends, an international network of peer bereavement support groups.

Empirical Evidence Regarding Bereavement Counseling

In this section, I review the empirical evidence concerning bereavement counseling efficacy, including several recent meta-analytic studies and controversies in bereavement research literature. I also address methodological issues of bereavement counseling research.

Meta-Analyses of Bereavement Counseling Efficacy

Neimeyer (2000) published controversial data regarding efficacy of bereavement counseling based on findings in an unpublished doctoral dissertation (Fortner, 1999). For his dissertation research, Fortner (1999) performed a meta-analysis on all bereavement counseling outcome studies published between 1975 and 1998 that met the following qualifications: (1) studies focused on bereaved individuals grieving death of a significant other; (2) participants in the studies received psychotherapy, counseling, or a support group intervention; and (3) studies used random assignment to experimental and control groups. Fortner analyzed a total of 23 outcome studies that met the above criteria involving approximately 1,600 participants. Using a new statistical analysis called treatment-induced deterioration effect (TIDE), Fortner reached a “sobering” (Neimeyer, 2000, p. 545) conclusion: 38% of the 1,600 study participants

“would have fared better if assigned to the no-treatment condition” (p. 545). Additionally, Fortner (1999) found an overall small effect size of 0.13 regarding bereavement counseling outcome. Neimeyer (2000) concluded from Fortner’s (1999) data that “grief therapy for normal bereavement is difficult to justify” (Neimeyer, 2000, p. 546).

A meta-analytic study of bereavement interventions with children resulted in similar conclusions (Currier, Holland, & Neimeyer, 2007). The meta-analysis reviewed 13 published and unpublished (dissertation) studies. The primary bereavement intervention for twelve of the 13 outcome studies included in the meta-analysis was group counseling with “a strong psychoeducational component” (p. 255). After a systematic review of 13 treatment to no-treatment comparison outcome studies, the authors found no overall statistical significance ($p = .08$). Their analyses also resulted in an overall meta-analytic small effect size of 0.14, indicating that the children who participated in bereavement counseling interventions were not significantly less distressed than the children in the no-treatment group. Although this result added further evidence to support Neimeyer’s (2000) claim that bereavement counseling is generally ineffective for individuals undergoing normal grief, several of the studies had less than ideal methodological rigor. Only 7 of the studies evaluated by Currier et al. (2007) used random assignment and 9 of the studies did not specifically assess for grief as part of their original analyses.

However, after a systematic evaluation of the statistical analysis in Fortner’s (1999) study that Neimeyer (2000) used to support his conclusions, Larson and Hoyt (2007) argued that little empirical evidence existed to support Neimeyer’s (2000) notion that bereavement interventions “are typically ineffective, and perhaps even deleterious, at least for persons

experiencing a normal bereavement” (p. 541). Larson and Hoyt (2007) submitted TIDE, the statistical analysis that Fortner (1999) used in his dissertation, to a blind peer-review. The expert reviewers concluded that TIDE was “seriously flawed” (Larson & Hoyt, 2007, p. 349) and was an inadequate statistical method to account for deterioration in bereavement counseling study participants. Based on statistical flaws in prior studies, Larson and Hoyt strongly debunked three prior claims relative to bereavement interventions: (1) a significant number of clients deteriorate; (2) bereavement counseling outcome studies produce “trivial” (p. 352) effect sizes; and (3) bereavement counseling is often unjustified and can be harmful for individuals experiencing normal grief. According to Larson and Hoyt, none of these claims could be substantiated.

Furthermore, evidence exists to support the argument that bereavement counseling is at least moderately effective. In the first published meta-analysis of bereavement counseling outcome studies (Allumbaugh & Hoyt, 1999), researchers analyzed 35 published and unpublished bereavement intervention studies. Researchers only included studies in their meta-analysis that met the following criteria: (1) studies investigated “effectiveness of any type of grief therapy” (p. 371); (2) measured outcome through quantitative means; and (3) reported effect size data. The types of grief therapy included in studies in their meta-analysis consisted of group interventions and individual interventions with both professional and nonprofessional facilitators. Additionally, studies in their meta-analysis used both random and non-random assignment. Their meta-analysis revealed an overall medium weighted aggregate effect size of 0.41 (Cohen, 1988). This result indicated that bereavement counseling was moderately effective for participants in those studies (Allumbaugh & Hoyt, 1999). The authors noted that a

significant moderator to intervention efficacy was the amount of time that had passed since individuals' losses. Individuals who sought bereavement counseling within 3 to 6 months of their losses were more likely to experience greater benefit from intervention than those who waited longer than 6 months to seek help.

Additionally, the most recent meta-analysis of bereavement counseling outcome studies resulted in similar findings (Currier, Neimeyer, & Berman, 2008). The authors reviewed 61 published and unpublished (dissertation) bereavement intervention outcome studies. Bereavement intervention modalities used included group (63%), individual (25%), and family (12%). Professionally facilitated support groups accounted for 17% of the studies and professional counseling approaches accounted for 63% of the studies. Currier et al. (2008) analyzed effect sizes according to immediate posttreatment results and follow-up results in both randomized studies and nonrandomized studies. For randomized studies, the authors reported small mean effect sizes of 0.16 for posttreatment outcome and 0.05 for follow-up outcome. For nonrandomized studies, the authors reported a medium mean effect size of 0.51 for posttreatment outcome and small mean effect size of 0.04 for follow-up outcome. Consequently, the authors concluded that grief interventions included in their meta-analysis showed statistical significance overall and a small effect size but did not show a statistically significant effect at follow-up measurements. Although these results do not further clarify inconsistencies found in meta-analytic studies of bereavement interventions in a dramatic fashion, they also directly conflict with earlier notions (Fortner, 1999; Neimeyer, 2000) about deterioration effects.

One major reason controversy and conflicting evidence exist regarding outcome studies on bereavement interventions is that many of these studies are fraught with methodological problems (Forte, Hill, Pazder, & Feudtner, 2004; Jordan & Neimeyer, 2003; Stroebe, Stroebe, & Schut, 2003). In the following section, I discuss these methodological issues relative to research on bereavement intervention outcome studies.

Methodological Issues in Bereavement Counseling Research

Several authors (Forte et al., 2004; Jordan & Neimeyer, 2003; Stroebe et al., 2003) have published reviews of methodological issues relative to bereavement counseling outcome research. These experts in bereavement research agreed that matching methodology to desired outcome is central to quality investigations. Forte et al. (2004) were more specific on this topic, arguing that “a number of recurring methodological flaws ... greatly limit inferences regarding treatment effects” (p. 11) of bereavement counseling interventions, including lack of control groups, non-random assignment, and use of ad hoc and untested assessment instruments. These methodological mistakes could be major contributors to inconsistent results found in meta-analytic studies from the last 10 years (e.g., Allumbaugh & Hoyt, 2007; Currier et al., 2008; Forte et al., 2004; Jordan & Neimeyer, 2003; Stroebe et al., 2003).

Notwithstanding methodological flaws in bereavement counseling research, interventions designed to assist bereaved individuals resulted in small to medium effects in a number of meta-analytic studies (Allumbaugh & Hoyt, 1999; Currier et al., 2007; Currier et al., 2008; Fortner, 1999). Because results from these studies conflict, more research is needed to clarify effectiveness of bereavement counseling. Therefore, further investigation into bereavement counseling intervention outcome is strongly warranted.

Psychoeducation about Near-Death Experiences in Bereavement Counseling

Overview of Research on Near-Death Experiences

Moody (1976) first formally described phenomena he identified as near-death experiences (NDEs) as a result of his interviews with more than 150 people who reported having come close to death. Moody argued that NDEs could be generally defined by 15 characteristics, though he acknowledged that no two NDEs were exactly alike—and none of his participants reported experiences that contained all 15 elements. These 15 elements included:

1. Ineffability, or NDEs having an indescribable quality
2. The ability to hear people talk while near-death experiencers (NDErs) were unconscious
3. Intense feelings of peace
4. Unusual auditory sensations or noises, such as buzzing
5. Passage through a dark tunnel
6. Out of body experiences
7. Meeting spiritual beings
8. An encounter with a bright light
9. A life review, or the sensation of viewing one's own life from birth until the present moment
10. A border experience or point of no return
11. A return to the physical body
12. Complete certainty of the reality of the experience
13. Subsequent to an NDE, a variety of effects on lives of NDErs

14. Change in the view of death

15. Corroborating evidence by doctors or nurses to support some of the events during NDEs, such as something that was viewed during an out of body experience

Although no one NDE is exactly alike, several common phases can be attributed to a majority of NDEs (Moody, 1976; Ring & Valarino, 2000; Zingrone & Alvarado, 2009). Phase 1 includes a feeling of separation from the physical body. In this phase, NDErs sense a shift from being outside of their bodies. In some cases, NDErs report an ability to see or hear things they should not be able to see or hear due to their medical conditions. Often, NDErs float outside of their bodies and view themselves, similar to an out of body experience. Phase 2 includes movement toward a light or through a dark tunnel. It is during this phase that NDErs often report developing a deep and profound sense of peace, calm, and love. In addition, although movement through a tunnel or toward a light seems to happen at extremely high rates of speed, NDErs often report feeling no fear.

Phase 3 often involves entering an all-encompassing, bright light (Moody, 1976; Ring & Valarino, 2000; Zingrone & Alvarado, 2009). In this phase, NDErs encounter a supreme being, often perceived as God or other spiritual or religious figures. This supreme being is experienced as all-knowing and absolutely, unconditionally loving. NDErs also often report an ability to telepathically communicate with the supreme being. In Phase 4, NDErs typically experience life reviews in which they see and hear every scene from their lives and re-experience the thoughts and emotions attached to those scenes. This life review often occurs as a whole and, at the same time, is experienced with every single detail of their lives. NDErs experience time and space in a different way during NDEs, allowing life reviews to happen in as little as seconds

according to “Earth time.” During this phase, NDErs also report encountering other spiritual beings as well as deceased loved ones, including friends, relatives, and pets.

The final phase of a typical NDE is a return to the physical body (Moody, 1976; Ring & Valarino, 2000; Zingrone & Alvarado, 2009). Sometimes this return to the physical body is sudden, unexpected, and painful. Other times, NDErs are given a choice whether or not to return by one or more spiritual entities during their NDEs. In yet other NDEs, experiencers are told to return to complete a specified or unspecified meaning or purpose. It is at this point that NDErs complete their returns to their physical bodies.

After Moody’s (1976) initial description of NDEs, researchers (Cressy, 1994; Pennachio, 1986) compared and contrasted NDEs with mystical experiences as described by James (1902). James identified four features typical of mystical experiences: ineffability, noetic quality, transiency, and passivity. Ineffability reflected the indescribable nature of mystical experiences. Noetic quality referred to a transcendence of space and time in which insight and knowledge that defied intellect came to the mystical experiencer. Transiency referred to a dichotomy of a sense of time in which mystical experiences happened instantaneously according to linear time, but seemed to last *ad infinitum* during those experiences. Passivity reflected a sense of being lifted and supported by a force outside of oneself.

Using typology outlined by Pahnke and Richards (1966) based on James’ (1902) description of mystical experiences, Pennachio (1986) theorized that NDEs essentially approximated mystical experiences. Pennachio contended that although not every NDE featured all nine categories of Pahnke and Richards’s (1966) typology, at the very least, NDEs were intimately related to mystical experiences.

Although NDEs often contain similar elements as mystical experiences, Greyson (1994, 1999, 2000) identified NDEs as particularly distinct from purely mystical experiences. Noting that NDE researchers continued to struggle with arriving at a single consensus definition of the NDE phenomenon, Greyson (2000) defined NDEs as

profound psychological events with transcendental and mystical elements, typically occurring to individuals close to death or in situations of intense physical or emotional danger. These elements include ineffability, a sense that the experience transcends personal ego, and an experience of union with a divine or higher principle. (p. 316)

Thus, he defined NDEs as containing mystical, but also other, elements. He elaborated that NDEs include the elements of

(a) cognitive features of time distortion, thought acceleration, a life review and revelation; (b) affective features of peace, joy, cosmic unity and an encounter with light; (c) paranormal features of vivid senses, apparent extrasensory perception and precognitive visions, and an out-of-body experience; and (d) transcendental features of otherworldly encounters with mystical beings, visible spirits, and an uncrossable border. (Greyson, 1999, pp. 11-12)

In addition, not every NDE contains all of the characteristics listed above, and rarely if ever are any two NDEs exactly alike. Furthermore, some people report a type of NDE characterized by different features than even Greyson (1999, 2000) defined, known as distressing NDEs (Bush, 2009).

Distressing NDEs. Whereas a majority of reported NDEs are dominated by reassuring experiences, a minority of individuals report distressing NDEs (Greyson & Bush, 1992) that Bush (2009) defined as “a category of experiences dominated by disturbing emotions” (p. 65).

Greyson and Bush (1992) identified three distinct categories of distressing NDEs. They described the most frequently reported kind of distressing NDE, Type I, as an inverted experience in which NDErs experienced features of a pleasurable NDE but interpreted their

experiences as terrifying. Type II, the void experience, involved an overwhelming “sense of despair” (p. 101) in which NDErs experienced a sense of “being condemned to a featureless void for eternity” (p. 101). The least frequently reported kind of distressing NDE is Type III. Type III, the hellish experience, was typified by horrifying experiences involving frightening demons or “falling into a dark pit” (Bush, 2009).

Incidence data suggest that distressing NDEs account for “a percentage [of the total number of NDEs reported] possibly in the mid- to high teens” (Bush, 2009, p. 81), indicating that distressing NDEs appear to account for a relatively small yet still substantial minority of NDEs. However, one postulation is that current incidence data may be inaccurately underrepresentative because people who have experienced distressing NDEs may be reluctant to report them, especially for fear of being pathologized or demonized.

Whereas distressing NDEs are initially frightening or terrifying and tend to result in negative effects for NDErs in the short-term, NDErs who experience distressing NDEs also often report positive transformative effects in the long-term (Ellwood, 2001). Distressing NDErs often interpret them as a “wake-up call” (p. 95) to make changes in their lives. Similarly, Atwater (1994) reported that approximately 50% of distressing NDEs resulted in growth-oriented, positive changes for experiencers.

However, concluding that distressing NDEs are opposite of and in conflict with pleasurable NDEs is potentially erroneous. Instead, distressing NDEs may be incomplete NDEs (Bach, 1994, 1996)—interrupted before reassuring and pleasurable experiences become available to the NDEr. Bache conceptualized NDEs through Grof’s (1975, 1985, 1988) work with perinatal matrices, arguing that distressing NDEs are traumatic and frightening pathways that, if

experienced completely, necessarily lead to rebirth and an ultimate experience of unity with a divine or higher entity or principle. This ultimate unity is replete with peace and love, features common to pleasurable NDEs. Distressing NDEs appear to result in positive aftereffects in the long term for experiencers. Additionally, distressing NDEs appear to be incomplete NDEs, representing pathways on the way to an ultimate experience of unity.

Effects of Knowledge about NDEs on Non-NDErs

In 1995, Ring argued for increased research regarding the effects of learning about NDEs on people who have never experienced NDEs, or non-NDErs. Ring (1995) published a strong statement concerning the paucity of research in this area:

It's curious that for all the work that has so far been reported on the effects of near-death experiences on the experiencers themselves, there has been almost nothing published in the literature concerning how nonexperiencers are affected by their exposure to information about NDEs. (p. 223)

Almost 15 years later, his statement is still valid. Researchers in the field of NDEs have published few investigations regarding the role of NDEs as change agents in non-NDErs' lives (Foster, James, & Holden, 2009). Those that do exist have been exploratory in nature.

Flynn (1986) described a study performed in his undergraduate sociology classes at Miami University of Ohio. Students in Flynn's class watched videotaped interviews with NDErs, kept a journal documenting how the class assignments affected any attitude or behavior changes, and participated in small discussion groups. At the end of the course, Flynn administered a questionnaire to his students. The survey contained questions about students' changes in values and attitudes, such as concern for others, personal growth, death-related attitudes, spirituality and religion, and materialism. The results indicated that of 428 undergraduates, over 80% reported an increased sense of compassion, and 65% reported an

increased sense of self-worth. Additionally, 30% reported an increase in the belief in life after death. One year later, a follow-up assessment indicated that these effects generally tended to last—83% reported at least some continuing effects—although a minority of participants (14%) indicated a decline. These results indicated that learning about NDEs contributed to both immediate and long-term changes in students' values and beliefs.

However, Flynn's study (1986) had some limitations. Because of the nature of the study, the sample lacked diversity. Additionally, validity and reliability data were not provided for the questionnaire used in the study. Furthermore, Flynn did not indicate if his study included interviews with people who had experienced only pleasurable NDEs or if he also included those who had distressing NDEs. However, one can presume that he likely only included pleasurable NDEs, as the title of his in-class study was the "Love Project." Whereas Flynn's study contained some methodological limitations, it was the first of its kind, providing future researchers rationale for furthering investigation about the effects of learning about pleasurable NDEs on non-NDEs' values, attitudes, and behaviors.

Ring (1995) published similar evidence. Ring outlined results from three sections of two undergraduate courses expressly on the subject of NDEs: one section at Montana State University (MSU) and two sections at the University of Connecticut (UConn). During the course, students read several NDE books, watched video interviews of NDEs, were present during a panel of NDEs who spoke in class, and participated in small discussion groups. At the conclusion of the courses, a majority of the total 111 students indicated that they were more convinced of the validity of NDEs (96% at MSU, 90% and 96% at UConn); reported a reduction in their fear of death (71% at MSU, 60% and 71% at UConn); a more positive view of death (82%

at MSU, 90% and 82% at UConn); an increase in the belief in life after death (82% at MSU, 90% and 76% at UConn); increased spirituality (61% at MSU, 57% and 64% at UConn); an increase in a sense of purpose and meaning (68% at MSU, 79% and 58% at UConn); and stated that their beliefs about God had changed (72% at MSU, 87% and 65% at UConn)—some specifically affirming their conviction of God had strengthened and some indicating it had diluted. These results indicated that learning about NDEs through a variety of media influenced participants' core beliefs and value systems.

Ring's (1995) study contained some limitations. With such a small sample size, it is difficult to generalize to a larger population. Additionally, Ring worked with a convenience sample. The students who enrolled in his classes may have already had some level of interest in NDEs or a related subject area. The nature of the survey instrument was such that it is impossible to know what the students' beliefs and values were prior to taking the class compared to their values and beliefs after the class ended—it is only known that some changes took place. Furthermore, Ring only presented information regarding pleasurable NDEs to his students. However, despite methodological limitations to Ring's study, it did provide directions for future research.

In addition to evidence indicating that learning about NDEs influences changes in non-NDEs' beliefs and values (Flynn, 1986; Ring, 1995), several authors have argued through anecdotal and case study evidence that learning about NDEs has therapeutic effects on non-NDEs. Sullivan (1984) theorized that providing information about NDEs could provide "supportive preparation for those facing combat" (p. 151), such as soldiers going to war. Additionally, Vinter (1994) informally observed that the provision of knowledge about NDEs in

hospice settings assisted and comforted terminally ill patients. Neither Sullivan nor Vinter addressed the use of pleasurable or distressing NDEs.

Another such area in which authors have asserted the potential importance of learning about NDEs is the reduction of suicidal ideation (Ring & Franklin, 1981-1982). Ring and Franklin theorized that if suicidal ideators were introduced to information regarding NDEs, these individuals would experience a reduction or altogether disappearance of suicidal thoughts and urges.

Winkler (2003) reported a case study to support Ring and Franklin's (1981-1982) theory. A psychotherapist practicing in Austria, Winkler discussed a 9-year old child client named Patrick who was suicidal following the suicide of the boy's father. During Patrick's treatment, Winkler wrote a developmentally appropriate storybook depicting a pleasurable NDE. Winkler gave the book to Patrick, his mother, and his siblings; subsequently, Patrick's suicidal ideation ceased. Similarly, McDonagh (2004), also a psychotherapist, reported profound reductions in suicidal ideation after showing videotaped interviews of NDErs who discussed their pleasurable NDEs to clients who presented with such thoughts.

Despite some methodological limitations, most notably the lack of broad generalizability, results from exploratory investigations and other anecdotal evidence presented in this review indicate that the effects of learning about pleasurable NDEs on non-NDErs in settings such as educational institutions and therapeutic environments is a productive subject for continued empirical research. With this evidence in mind, in the following section I review the professional literature concerning the effects of learning about NDEs on bereaved non-NDErs.

Effects of knowledge about NDEs on the bereaved. Many authors (Horacek, 1997; International Association for Near-Death Studies, 2007; McDonagh, 2004; Ring & Valarino, 2000; Sutherland, 1996) in the field of NDE research have written about the possible implications of psychoeducation about NDEs for bereavement counseling of non-NDEs. However, after a thorough literature review, I found no published studies in which researchers empirically investigated the effect of learning about NDEs on bereaved non-NDEs. Yet anecdotal evidence exists to support further empirical exploration of the matter.

In 1992, Deborah Drumm, a nurse who had recently received a diagnosis of breast cancer, wrote a letter to the *Journal of Near-Death Studies*, the leading scientific research journal on NDEs and related phenomena. In her letter, Deborah described the therapeutic effect that reading personal accounts of NDEs had on her own process of facing death. She also illustrated the powerful effect that it had on others who were in the midst of grief:

And the hope offered by the NDE is infectious. When these stories [about NDEs] are shared with others who are afraid or grieving, it seems to provide them peace also. For instance, I recently met a woman whose 23-year-old daughter had committed suicide one month before our conversation. This woman was tormented because some persons in her church had told her that her daughter would go to hell. I showed her an article ... in which the NDEs of suicide attempts were described as being beautiful and tranquil, like any other NDE. After reading the article, she told me that she felt greatly relieved, and added, 'God bless you.'

I hope ... psychiatrists, physicians, nurses and other health-care professionals ... will seriously consider exploring the use of NDE accounts with the seriously ill and grieving, as well as, certainly, dying patients and their families. I can attest to the inspiring, invigorating power of this 'therapy.' I am stronger and more confident than I was before my illness, because I have finally dealt with my fear of death.... [NDE accounts] give peace of mind and renewed purpose, and allow life to move ahead. (p. 69)

Deborah's letter is not unlike the many letters that psychologist Kenneth Ring received in which bereaved individuals described the comforting effects of reading about NDEs on their grief

(Ring & Valarino, 2000). Presumably, the NDEs contained in these bibliographic accounts were pleasurable rather than distressing.

Similarly, Cherie Sutherland (1996) described her personal experiences of bereaved parents approaching her after attending one of Sutherland's lectures on children's NDEs. These parents often related to Sutherland how hearing about NDEs had positive effects on their processes of grief. In her book *Children of the Light*, Sutherland highlighted a letter that a woman named Maria sent her. Maria, whose young son had died in an accidental drowning, detailed the powerful effect that learning about NDEs had on her grief: "I read everything I could find about [NDEs], and with each new account, the bottomless, black despair I had felt for so long receded, and a wonderful new hope was born somewhere deep within me" (p. 6).

In addition to anecdotal reports, two psychotherapists (Horacek, 1997; McDonagh, 2004) published case studies in which they concluded that learning about NDEs assists non-NDErs in their grief. Horacek (1997) reported a case in which a 16-year-old girl read Moody's *Life after Life* (1976) shortly before being hospitalized for a terminal form of bronchial pneumonia. While in the hospital, the girl shared information about NDEs with her parents. The girl's parents reported that learning about NDEs comforted them throughout and subsequent to their daughter's process of dying. Horacek (1997) concluded that general knowledge of NDEs assisted the grief of non-NDEr loved ones. Because the NDErs featured in Moody's (1976) book described pleasurable NDEs, it cannot be known what effect descriptions of distressing NDEs might have had on Horacek's (1997) clients.

Likewise, McDonagh (2004) reported results that supported previous anecdotal evidence in a case study review of his clinical experiences utilizing NDEs in a psychoeducational

manner as a therapist. He reported several cases in which he showed videotaped interviews of NDErs who had pleasurable experiences to clients who were grieving the deaths of loved ones. He concluded that the presentation of NDEs in a psychoeducational format not only decreased his clients' grief but also "generate[d] movement on personal issues that [went] beyond the grieving process" (p. 272).

Recently, the International Association for Near-Death Studies (IANDS; 2007) made available a brochure on its website designed to comfort bereaved individuals. The brochure contained summarized information regarding common features and aftereffects of NDEs. It concluded with a statement outlining how NDEs may be able to assist bereaved non-NDErs:

From near-death and related experiences, a bereaved person can find implications that the deceased did not suffer at the time of death, that he/she may continue to exist healthfully in some other form and dimension, that contact might occur between the deceased and the bereaved person, and that a reunion might await the deceased and the bereaved. At the same time, a very strong implication is that each person's life has a purpose, and there are probably reasons beyond our understanding as to why some people die from earthly existence while others are left to continue on in that existence. As a group, NDErs would tend to say that, by learning to endure the (apparently) temporary separation from those we love who have gone ahead into death, we enable ourselves to fulfill the purpose of our own earthly existence: to continue our own process of psychospiritual development. Knowledge of near-death experiences cannot take away all the hurt and pain associated with a loved one's death, but it can provide some comfort and can help a grieving person endure the loss. (p. 5)

This statement reflects the anecdotal and case study evidence supporting the notion that learning about pleasurable NDEs reduces grief in bereaved non-NDErs.

Furthermore, Ring and Valarino (2000) suggested that it would be efficacious to design psychoeducational programs for "preexisting bereavement support groups" (p. 266). They reported that pilot testing of their own psychoeducational NDE programs resulted in decreased grief among participants in bereavement support groups. However, Ring and Valarino provided

details about neither the programs they designed nor empirical results. Recently, Ring (personal communication, February 12, 2009) indicated to me that he no longer had this information.

Strong anecdotal and case study evidence exists to support the idea that pleasurable NDEs psychoeducationally presented to bereaved individuals decreases grief (Drumm, 1992; Horacek, 1997; McDonagh, 2004; Ring & Valarino, 2000; Sutherland, 1996). Additionally, anecdotal evidence supports the therapeutic value of psychoeducational NDE programs presented to participants in bereavement support groups (Ring & Valarino, 2000). However, researchers have published no empirical studies designed to investigate this area, reflecting a heightened need for research on effects of psychoeducational NDE programs as bereavement counseling interventions on grief of bereaved individuals. Furthermore, researchers have rarely, if ever, included distressing NDEs in their psychoeducational presentations. Therefore, a need exists to at least briefly address distressing NDEs alongside pleasurable NDEs in related psychoeducational programs.

Additionally, conflicting evidence exists regarding efficacy of bereavement counseling interventions in general. Methodological issues in past bereavement intervention research is at least partially to blame. Because normal grief often has a number of distressing effects on bereaved individuals, more methodologically sound outcome research is needed to clarify effectiveness of bereavement counseling interventions. Therefore, I designed this study to address three major needs: (1) a need for investigating the effects of a psychoeducational NDE program as a bereavement counseling intervention for adults experiencing grief; (2) a need for methodologically sound bereavement intervention research; and (3) a need for exploring effectiveness of bereavement counseling interventions. Consequently, in this study, I

investigated the effects of an NDE learning module on grief of participants in bereavement support groups.

CHAPTER 3

METHODS AND PROCEDURES

In this chapter, I focus on the methods and procedures I used to measure the effects of an NDE learning module on grief of participants in bereavement support groups. Included in this chapter are the research questions as well as experimental research design, operational definitions, instrumentation, subject selection and recruitment, and specific procedures used to collect and statistically analyze pertinent data.

Research Questions

The purpose of this study was to investigate the effects of an NDE learning module on reducing distressing symptoms of grief. The current study was based on the following research questions. Among bereaved individuals:

1. Do participants in a near-death experience learning module report reduced despair compared to reports of waitlist control group participants?
2. Do participants in a near-death experience learning module report reduced panic behavior compared to reports of waitlist control group participants?
3. Do participants in a near-death experience learning module report increased personal growth compared to reports of waitlist control group participants?
4. Do participants in a near-death experience learning module report reduced blame and anger compared to reports of waitlist control group participants?
5. Do participants in a near-death experience learning module report reduced detachment compared to reports of waitlist control group participants?

6. Do participants in a near-death experience learning module report reduced disorganization compared to reports of waitlist control group participants?

Definition of Terms

Bereavement support group is defined for the purpose of this study as a nonprofessional peer-facilitated group designed to provide emotional and social support for adults experiencing grief.

Blame and anger is defined as feelings of hostility and bitterness resulting from grief. For the purpose of this study, blame and anger was operationally defined as the Blame and Anger subscale score on the Hogan Grief Reaction Checklist (Hogan et al., 2001).

Despair is defined as feelings of sadness, loneliness, missing the deceased loved one, and hopelessness resulting from grief. For the purpose of this study, despair was operationally defined as the Despair subscale score on the Hogan Grief Reaction Checklist (Hogan et al., 2001).

Detachment is defined as behaviors including avoidance of inter- and intrapersonal intimacy, withdrawal from interpersonal relationships, and identity changes resulting from grief. For the purpose of this study, detachment was operationally defined as the Detachment subscale score on the Hogan Grief Reaction Checklist (Hogan et al., 2001).

Disorganization is defined as “difficulty with concentration and problems learning new information and recalling familiar previously remembered information” (Hogan et al., 2001, p. 17) resulting from grief. For the purpose of this study, disorganization was operationally defined as the Disorganization subscale score on the Hogan Grief Reaction Checklist.

Grief is defined conceptually as a normal “emotional (affective) reaction to the loss of a loved one through death” (Stroebe, Hansson, Schut, & Stroebe, 2008, p. 5) and incorporates psychological, interpersonal, behavioral, and somatic reactions. For the purpose of this study, grief was operationally defined by scores on the subscales of Despair, Panic Behavior, Personal Growth, Blame and Anger, Detachment, and Disorganization on the Hogan Grief Reaction Checklist (Hogan et al., 2001).

Near-Death Experiences (NDEs) is defined for the purpose of this study as

profound psychological events with transcendental and mystical elements, typically occurring to individuals close to death or in situations of intense physical or emotional danger. These elements include ineffability, a sense that the experience transcends personal ego, and an experience of union with a divine or higher principle. (Greyson, 2000, p. 316)

NDEs include

(a) cognitive features of time distortion, thought acceleration, a life review and revelation; (b) affective features of peace, joy, cosmic unity and an encounter with light; (c) paranormal features of vivid senses, apparent extrasensory perception and precognitive visions, and an out-of-body experience; and (d) transcendental features of otherworldly encounters with mystical beings, visible spirits, and an uncrossable border. (Greyson, 1999, pp. 11-12)

Near-Death Experience (NDE) learning module is defined for the purpose of this study as a psychoeducational treatment method that includes a self-authored educational digital video disc (DVD), excerpts from an NDE documentary titled *Round Trip* (O’Reilly, 1996), and a semi-structured group discussion that I facilitated.

Panic behavior is defined as feelings of fear, panic, and associated physiological reactions including headaches, fatigue, and stomachaches resulting from grief. For the purpose of this study, panic behavior was operationally defined as the Panic Behavior subscale score on the Hogan Grief Reaction Checklist (Hogan et al., 2001).

Personal growth is defined as “a sense of having become more compassionate, tolerant, forgiving, and hopeful” (Hogan et al., 2001, p. 14) resulting from grief. For the purpose of this study, personal growth was operationally defined as the Personal Growth subscale score on the Hogan Grief Reaction Checklist.

Instruments

I utilized a bereavement history form and the Hogan Grief Reaction Checklist (HGRC; Hogan et al., 2001) in this study. In this section, I describe both of these instruments in detail.

Bereavement History Form

Each participant in this study provided demographic information by completing a bereavement history form (Appendix B). The form required the participant to report one’s age, sex, primary relationship status, religious or spiritual affiliation, ethnicity, occupation, education level, relationship to the deceased, and the amount of time that had passed since the deceased’s death. This instrument typically takes approximately 5 minutes to complete.

Hogan Grief Reaction Checklist

The HGRC (Hogan et al., 2001) is a 61-item instrument (Appendix C) on which individuals are asked to rate each item according to how well the item describes oneself. The HGRC utilizes a five-point Likert-type scale. Authors of the HGRC and others (Gamino, Sewell, & Easterling, 2000) concluded that the instrument supported Stroebe and Schut’s (1999) dual process model of coping with bereavement. The instrument typically takes approximately 20 minutes to complete.

Hogan et al. (2001) empirically developed the items based on extensive qualitative interviews with bereaved adults. As a result of their analyses, they identified six categories.

These categories contributed to the six subscales on the HGRC that measure different aspects of grief reactions. These subscales are Despair, Panic Behavior, Personal Growth, Blame and Anger, Detachment, and Disorganization. Each item on the HGRC contributes to only one subscale. The HGRC yields six subtest scores but does not yield a total score. Hogan et al. have not published cutoff scores to differentiate levels of grief or to indicate caseness. Thus, the instrument is useful in measuring relative changes in grief but not level of grief with reference to an absolute standard.

The Despair subscale is composed of items that measure sadness, loneliness, missing the deceased loved one, and hopelessness. The Panic Behavior subscale measures fear, panic, and associated physiological reactions including headaches, fatigue, and stomachaches. The Personal Growth subscale consists of items that measure “a sense of having become more compassionate, tolerant, forgiving, and hopeful” (Hogan et al., 2001, p. 14). The Blame and Anger subscale measures emotions such as hostility and bitterness. The Detachment subscale measures avoidance of intimacy, withdrawal from interpersonal relationships, and identity changes. The Disorganization subscale consists of items that measure “difficulty with concentration and problems learning new information and recalling familiar previously remembered information” (p. 17).

Researchers have found the HGRC to be a psychometrically reliable and valid instrument (Gamino et al., 2000; Hogan et al., 2001). All six subscales were shown to have good internal consistency (Hogan et al., 2001). Exploratory factor analysis using principal axis factoring and a varimax rotation resulted in 61 items factored into six categories. Cronbach’s alpha coefficients for internal consistency of each subscale were Despair, .89; Panic Behavior, .90; Personal

Growth, .82; Blame and Anger, .79; Detachment, .87; and Disorganization, .84. The HGRC also displayed a total internal consistency of .90. Test-retest reliability also resulted in acceptable stability for the subscales: Cronbach's alpha coefficients were Despair, .84; Panic Behavior, .79; Personal Growth, .81; Blame and Anger, .56; Detachment, .77; and Disorganization, .85 (Hogan et al., 2001).

To establish construct validity, instrument developers compared the HGRC to widely used measures of grief including the Grief Experiences Inventory (GEI) and the Texas Revised Inventory of Grief (TRIG). They found the HGRC correlated moderately with these measures, leading both them and other researchers to conclude that the HGRC has good construct validity with the GEI (Gamino, et al., 2000; Hogan et al., 2001) and the TRIG (Hogan et al., 2001). The authors of the instrument also determined that the HGRC has acceptable divergent validity (Hogan et al., 2001).

Participant Selection and Recruitment

Before recruitment of participants for this study, I first gained approval from the University of North Texas Institutional Review Board. The population consisted of bereaved adults in the Dallas-Fort Worth region of Texas.

For inclusion in this study, participants met the following criteria: a) the participant was aged 18 or older; b) the participant had the ability to speak and understand English; c) the participant agreed to and signed the informed consent document; d) the participant experienced the death of a significant other; and e) the participant did not participate in any other form of counseling or intervention during the treatment phase of this study.

To recruit participants, I promoted this study in a variety of ways. I attended undergraduate and graduate level counseling classes at the University of North Texas and introduced this study to students in these classes. I invited participation from students and anyone they knew who might be interested in participating in this study. I handed out flyers with a brief description of the study along with my e-mail address and mobile telephone number. Additionally, I attended a bereavement luncheon sponsored by a local hospice in Denton, Texas. At the luncheon, I introduced my study and handed out flyers with my contact information. Also, I contacted the editor of a local newspaper in Denton who printed an article about my study along with my office telephone number. Finally, I posted the flyer describing my study and contact information on Meetup.com, a Web site designed to recruit participants for local groups.

When potential participants contacted me, I described the study in more detail, answered any questions they had, and used a random permutation table (Pocock, 1983) to assign each participant to the experimental group or the waitlist control group. I then told potential participants in both groups the dates on which they could attend their respective intervention sessions.

I then scheduled an intake appointment with each participant within 5 days prior to the first bereavement support group meeting for which the participant was scheduled. At the intake appointment, I included a screening to ensure that each participant met all participant qualifications as outlined above. I then presented, explained, and ultimately attained informed consent from each participant.

A total of 29 participants qualified for the study and signed informed consent forms. Using a random permutation table (Pocock, 1983) for random assignment, 15 of these participants were assigned to the experimental group, and 14 were assigned to the control group. Two of the participants in the experimental group dropped out of the study due to unforeseen scheduling conflicts. Two of the participants – one in the experimental group and one in the control group – did not attend any of the sessions and did not complete the posttest. One of the participants in the experimental group attended all bereavement support group meetings but began attending individual counseling during the treatment phase of this study. Therefore, data for five of the original qualified participants were not included in the results or demographics of this study.

As a result of attrition, the final total number of participants was 24. The experimental group included 12 participants and the waitlist control group included 12 participants. Table 1 presents demographic information for participants in the experimental and control groups.

Table 1

Demographic Information for Participants in the Experimental (n = 12) and Control (n = 12) Groups

	Experimental	Control
Sex		
Male	2	0
Female	10	12
Ethnicity		
African American	1	1
Asian	2	1
Latina/o	1	1
White, non-Latina/o	8	9
Mean Age	35.5	35.2
Relationship Status		
Single	5	7
Partnered	1	1
Married	4	1
Widowed	2	1
Other	0	2
Religious/Spiritual Affiliation		
Christian	8	7
Hindu	1	0
Muslim	0	1
Spiritual, not religious	2	2
Neither religious nor spiritual	1	2
Deceased's Relationship to Participant		
Child	1	0
Grandparent	5	5
Parent	1	2
Sibling	2	0
Spouse/Partner	2	2
Other	0	3
Amount of Time Since Deceased's Death		
< 3 months	1	2
3 to < 6 months	1	1
6 to < 12 months	3	5
1 to < 2 years	1	2
≥ 2 years	6	2

Data Collection Procedures

Upon receiving a completed informed consent form from a participant during the intake appointment, I provided the participant with a bereavement history form and an HGRC (pretest) and asked the participant to complete them and return the completed forms to me. A research assistant assigned a code number to each participant and separated identifying information from the bereavement history form. The research assistant created a database indicating code numbers for each participant. I did not have access to this database until the conclusion of this study.

The day before each session of a learning module, I telephoned participants to remind them of their participation in the module using the following telephone script:

Hi, [name of participant]. This is Ryan Foster. I just wanted to briefly touch base with you to say I look forward to seeing you at your [1st, 2nd, 3rd] meeting tomorrow at [time of session]. See you then.

The experimental group ($n = 12$) consisted of adults who received 3 bereavement support group sessions over 3 consecutive weeks. The waitlist control group ($n = 12$) consisted of adults who were placed on a waiting list and received no treatment intervention during the treatment phase. At the end of the 3-week treatment phase, I administered the HGRC to all participants as a posttest measure. Upon completion of posttesting, adults in the waitlist control group also received the bereavement support group intervention.

I kept all information collected confidential. Names of participants were excluded from any documentation and reports of the study. A research assistant used the code number database he created to code the pretests and posttests. The research assistant made these code numbers available to me only at the end of this study. I recorded the pretest and posttest

information by the use of a code number for each participant. Upon conclusion of the study, I destroyed names of all participants.

Experimental Group Procedures

Participants randomly assigned to the experimental group ($n = 12$) were split into two bereavement support groups. Group 1 had seven participants, and Group 2 had five participants. In Session 1 of the experimental group modules, I began with introductions and then facilitated open discussion of participants' bereavement history. After this discussion, participants viewed a 7-minute educational video on NDEs and a 40-minute video excerpt from *Round Trip* (O'Reilly, 1996). Following the videos, I facilitated participants' interaction using a semi-structured discussion (Appendix D). In Session 2, I facilitated another group discussion for participants using another semi-structured discussion (Appendix D). In Session 3, I facilitated a final group discussion for participants using a third semi-structured discussion (Appendix D). This discussion included any final thoughts or follow-up topics; I also facilitated termination of the group. At the end of Session 3, I administered the HGRC as a posttest to the participants. Session 1 lasted approximately three hours and Sessions 2 and 3 approximately two hours.

The materials I used in this study included an educational digital video disc (DVD) and excerpts from a DVD documentary titled *Round Trip* (O'Reilly, 1996). Prior to beginning this study, a graduate course instructor invited me to present my proposed research to her class, for which the topic of this study had relevance. In doing so, I showed a draft version of the educational DVD, showed *Round Trip* in its entirety, and invited students to critique the educational component of my research design. The students' and instructor's feedback

provided me with valuable information with which to refine both materials. The following section includes a detailed outline of these materials.

Educational DVD. The educational DVD was a 7-minute video consisting of general introductory information about NDEs that I produced. The information provided on the educational DVD included a definition (Greyson, 1999, 2000) and description of NDEs. The educational DVD described common features of NDEs, including the five common phases of NDEs. Because the topic of distressing NDEs has been widely publicized in popular media, and because the topic is relevant to the proposed research, I included a brief reference to it.

Round Trip DVD. *Round Trip* (O'Reilly, 1996) is a 43-minute documentary composed of interviews with five near-death experiencers (NDErs), or people who experienced pleasurable NDEs. The interviewees described features of their NDEs and how they perceived themselves and their lives to have been changed subsequent to and resulting from their NDEs.

A couple of brief segments from the video did not pertain to NDEs and their aftereffects, such as NDErs speculating about the relationship of NDEs to religion. Therefore, I excerpted the majority of the DVD that pertained, resulting in a 40-minute presentation. I procured Tim O'Reilly's permission to use the excerpted version of his DVD for this study.

Statistical Analysis

Following the completion of this study, I hand scored the pretest and posttest Hogan Grief Reaction Checklist data according to the manual. To determine if the NDE learning module treatment and the control group were statistically equal over time, I performed a two factor repeated measures analysis of variance (RM-ANOVA) (Time X Treatment Group) on five dependent variables (Despair, Panic Behavior, Personal Growth, Detachment, and

Disorganization) to determine if the experimental group who received the 3-session NDE learning module performed differently from the control group across time. The two levels of group were defined as the treatment group (NDE learning module group) and the waitlist control group. The two levels of time were pretest and posttest for each dependent variable. Significant differences between the means across time were tested at the .05 alpha level.

To determine if the NDE learning module treatment and the control group were statistically different at posttest, I performed a one-way analysis of covariance (ANCOVA) on the Blame and Anger dependent variable. The two levels of group were defined as the treatment group (NDE learning module group) and the waitlist control group.

For each analysis, I hand calculated an effect size using univariate eta squared to assess the practical significance of findings.

CHAPTER 4

RESULTS

In this chapter, I discuss the results of this study. I present results of data analyses in the order in which the research questions were examined.

Results of Data Analyses

Preliminary Analyses

Table 2 presents the pretest and posttest means for each subscale of the HGRC for both groups. Although random assignment was employed, pretest means appeared to show possible differences between the experimental and waitlist control groups. Therefore, an independent-samples *t*-test was conducted comparing each pretest subscale score of the HGRC for the experimental and waitlist control groups to ensure the groups were statistically equal at pretest. Table 3 presents the results of *t*-tests for all subscales. Results indicated that at pretest both groups reported statistically equivalent despair, panic behavior, personal growth, detachment, and disorganization, whereas the experimental group reported significantly more blame and anger than the control group.

Table 2

Mean Scores on the Despair, Panic Behavior, Personal Growth, Blame and Anger, Detachment, and Disorganization Subscales on the Hogan Grief Reaction Checklist (HGRC)

	<i>Experimental Group (n = 12)</i>		<i>Control Group (n = 12)</i>	
	Pretest	Posttest	Pretest	Posttest
Despair				
Mean	30.00	28.25	30.08	28.58
SD	12.80	9.88	10.82	13.27
Panic Behavior				
Mean	36.58	32.50	33.00	32.50
SD	14.30	8.96	15.14	15.62
Personal Growth				
Mean	35.67	47.75	44.00	46.50
SD	12.03	7.99	8.38	8.91
Blame and Anger				
Mean	15.50	12.33	11.00	12.33
SD	5.40	5.12	2.76	4.48
Detachment				
Mean	18.67	16.58	15.92	17.50
SD	6.08	5.18	7.42	7.93
Disorganization				
Mean	16.83	16.67	17.50	17.75
SD	5.06	3.50	7.48	8.06

Note: A decrease in mean scores on the Despair, Panic Behavior, Blame and Anger, Detachment, and Disorganization subscales, and an increase on the Personal Growth subscale, indicate improvement.

Table 3

Summary of Independent Samples t-test for Pretest Scores on the Despair, Panic Behavior, Personal Growth, Blame and Anger, Detachment, and Disorganization Subscales on the Hogan Grief Reaction Checklist (HGRC)

	<i>p</i>	<i>t</i>	<i>df</i>
Despair	.99	-0.02	22
Panic Behavior	.56	0.60	22
Personal Growth	.06	-1.97	22
Blame and Anger	.02*	2.57	22
Detachment	.33	0.99	22
Disorganization	.80	-0.26	22

Note: * indicates significance at $p < .05$.

Research Questions Analyses

Because the independent samples *t*-test performed on the pretest blame and anger scores indicated a significant difference between the experimental group and control group, a one-way analysis of covariance (ANCOVA) was conducted to examine the effect of treatment type (experimental, control) on the dependent variable of blame and anger. After determining that the data met all requisite assumptions including normality of distribution and homogeneity of variance, a two factor (Time x Treatment Group) repeated measures analysis of variance (RM-ANOVA) was conducted to examine the interaction effects of treatment type (experimental, control) and time (pretest, posttest) on five of the dependent variables: despair, panic behavior, personal growth, detachment, and disorganization. Because RM-ANOVA analysis accounts for change in dependent variable measures over time and ANCOVA analysis

only controls for pretest differences but not time, I performed an RM-ANOVA on five of the dependent variables instead of ANCOVA. Regarding differences in pretest versus posttest scores, a decrease on the Despair, Panic Behavior, Blame and Anger, Detachment, and Disorganization subscales, and an increase on the Personal Growth subscale, indicated improvement in the targeted measure.

For the dependent variables of despair, panic behavior, personal growth, detachment, and disorganization, Wilks's Lambda was used to interpret results. For the dependent variable of blame and anger, *F* was used to interpret results. Univariate eta squared (η^2) effect sizes were hand calculated to assess treatment effect and practical significance and to establish the magnitude of difference attributed to treatment between the two groups (Kazdin, 1999). In the absence of previous research or other guidelines to indicate the contrary, Cohen's (1988) guidelines were used to interpret η^2 : 0.01 = small, 0.06 = medium, and 0.14 = large.

Research Question 1: Despair. Do participants in a near-death experience learning module report reduced despair compared to reports of waitlist control group participants?

Table 4 presents the results of the repeated measures ANOVA for the Despair subscale. Results indicate that the reduction in despair reported from pretest to posttest by adults who attended the NDE learning module was not significantly different from the reduction in despair the control group reported from pretest to posttest. These results also indicate that when grouped together, adults who attended the NDE learning module and the control group did not improve significantly in their grief-related despair from pretest to posttest. However, according to Cohen's (1988) guidelines, the effect size of 0.03 for change over time yielded a small effect

size, indicating that participants in both the NDE learning module and the control group did benefit modestly in the form of reduced despair.

Table 4
Summary of Repeated Measures Analysis of Variance for the Despair Subscale of the HGRC According to Group Assignment

Source	λ	<i>df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>p</i>	η^2
Between subjects							
Intercept		1	41008.52	41008.52	181.51	< .01	.89
Group		1	0.52	0.52	< 0.01	.96	< 0.01
Error		22	4970.46	225.93			
Within subjects							
Time	0.97	1	31.69	31.69	.62	.44	.03
Time x Group	1.00	1	0.19	0.19	< 0.01	.95	< 0.01
Error		2	1129.63	51.35			

Research Question 2: Panic behavior. Do participants in a near-death experience learning module report reduced panic behavior compared to reports of waitlist control group participants?

Table 5 presents the results of the repeated measures ANOVA for the Panic Behavior subscale. Results indicate that the reduction in panic behavior from pretest to posttest by adults who attended the NDE learning module was not significantly different from the reduction in panic behavior the control group reported from pretest to posttest. These results also indicate that when grouped together, adults who attended the NDE learning module and the control group did not improve in their grief-related panic behavior from pretest to posttest. However, according to Cohen’s (1988) guidelines, the effect size of 0.05 for interaction yielded a small effect size, indicating that participants in the NDE learning module did benefit modestly in the form of reduced panic behavior by comparison with the control group. Additionally, the

effect size of 0.07 for change over time yielded a medium effect size, indicating that participants in both the NDE learning module and the control group did benefit moderately in the form of reduced panic behavior.

Table 5
Summary of Repeated Measures Analysis of Variance for the Panic Behavior Subscale of the HGRC According to Group Assignment

Source	λ	<i>df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>p</i>	η^2
Between subjects							
Intercept		1	54338.02	54338.02	158.80	< .01	.88
Group		1	38.52	38.52	0.11	.74	< 0.01
Error		22	7527.96	342.18			
Within subjects							
Time	0.93	1	63.02	63.02	1.71	.20	0.07
Time x Group	0.96	1	38.52	38.52	1.05	.32	0.05
Error		22	808.96	36.77			

Research Question 3: Personal growth. Do participants in a near-death experience learning module report increased personal growth compared to reports of waitlist control group participants?

Table 6 presents the results of the repeated measures ANOVA for the Personal Growth subscale. Results indicate that the increase in personal growth reported from pretest to posttest by adults who attended the NDE learning module was not significantly different from the increase in personal growth the control group reported from pretest to posttest. These results also indicate that when grouped together, adults who attended the NDE learning module and the control group did improve significantly in their grief-related personal growth from pretest to posttest. However, the effect size of 0.05 for interaction yielded a small effect size, indicating that participants in the NDE learning module did benefit modestly in the form of

increased personal growth by comparison with the control group. Additionally, the effect size of 0.23 for change over time yielded a large effect size, indicating that participants in both the NDE learning module and the control group did benefit substantially in the form of increased personal growth.

Table 6
Summary of Repeated Measures Analysis of Variance for the Personal Growth Subscale of the HGRC According to Group Assignment

Source	λ	<i>df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>p</i>	η^2
Between subjects							
Intercept		1	84588.02	84588.02	581.55	< .01	0.96
Group		1	513.52	513.52	3.53	.07	0.14
Error		22	3199.96	145.45			
Within subjects							
Time	0.77	1	221.02	221.02	6.59	.02*	0.23
Time x Group	0.95	1	38.52	38.52	1.15	.30	0.05
Error		22	737.96	33.54			

Note: * indicates significance at $p < .05$.

Research Question 4: Blame and anger. Do participants in a near-death experience learning module report reduced blame and anger compared to reports of waitlist control group participants?

Table 7 presents the results of the ANCOVA for the Blame and Anger subscale. Results indicated that after adjusting for pretest scores, there was no significant difference between the two treatment groups (experimental, control) on posttest Blame and Anger scores on the HGRC. The effect size of 0.15 for treatment type indicates a large effect size according to Cohen's (1988) guidelines, indicating that participants in the NDE learning module did benefit substantially in the form of reduced blame and anger by comparison with the control group.

Table 7

Summary of Analysis of Covariance for the Blame and Anger Subscale on the HGRC According to Group Assignment

Source	<i>df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>p</i>	η^2
Intercept	1	14.41	14.41	1.04	.320	0.05
Group	1	50.26	50.26	3.62	.07	0.15
Error	21	291.53	13.88			
Total	24	4160.00				

Research Question 5: Detachment. Do participants in a near-death experience learning module report reduced detachment compared to reports of waitlist control group participants?

Table 8 presents the results of the repeated measures ANOVA for the Detachment subscale. Results indicate that the reduction in detachment reported from pretest to posttest by adults who attended the NDE learning module was not significantly different from the reduction in detachment the control group reported from pretest to posttest. These results also indicate that when grouped together, adults who attended the NDE learning module and the control group did not improve significantly in their grief-related detachment from pretest to posttest. However, according to Cohen’s (1988) guidelines, the effect size of 0.15 for interaction yielded a large effect size, indicating that participants in the NDE learning module did benefit substantially in the form of reduced detachment by comparison with the control group.

Table 8

Summary of Repeated Measures Analysis of Variance for the Detachment Subscale of the HGRC According to Group Assignment

Source	λ	<i>df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>p</i>	η^2
Between subjects							
Intercept		1	14145.33	14145.33	175.27	< .01	0.89
Group		1	10.08	10.08	0.13	.73	< 0.01
Error		22	1775.58	80.71			
Within subjects							
Time	1.00	1	0.75	.75	0.07	.79	< 0.01
Time x Group	0.85	1	40.33	40.33	4.00	.06	0.15
Error		22	221.91	10.09			

Research Question 6: Disorganization. Do participants in a near-death experience learning module report reduced disorganization compared to reports of waitlist control group participants?

Table 9 presents the results of the repeated measures ANOVA for the Disorganization subscale. Results indicate the reduction in disorganization reported from pretest to posttest by adults who attended the NDE learning module was not significantly different from the reduction of disorganization the control group reported from pretest to posttest. These results also indicate that when grouped together, adults who attended the NDE learning module and the control group did not improve significantly in their grief-related disorganization from pretest to posttest. Additionally, according to Cohen's (1988) guidelines, the effect size of less than 0.01 for interaction yielded a negligible effect size, indicating that participants in both the NDE learning module and the control group benefited to a negligible degree in the form of reduced disorganization.

Table 9

Summary of Repeated Measures Analysis of Variance for the Disorganization Subscale of the HGRC According to Group Assignment

Source	λ	<i>df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>p</i>	η^2
Between subjects							
Intercept		1	14179.69	14179.69	214.90	< .01	0.91
Group		1	9.19	9.19	0.139	.71	< 0.01
Error		22	1451.63	65.98			
Within subjects							
Time	1.00	1	0.02	0.02	0.002	.97	< 0.01
Time x Group	1.00	1	0.52	0.52	0.04	.85	< 0.01
Error		22	293.96	13.36			

CHAPTER 5

DISCUSSION

In this study, I investigated the effectiveness of a near-death experience (NDE) learning module on adult grief in six specific areas: despair, panic behavior, personal growth, blame and anger, detachment, and disorganization. Specifically, I examined the effect of an NDE learning module treatment on decreasing scores on Despair, Panic Behavior, Blame and Anger, Detachment, and Disorganization subscales of the Hogan Grief Reaction Checklist (HGRC) and increasing scores on the Personal Growth subscale of the HGRC. Treatment outcomes for participants' scores on the HGRC were measured by self-report. A total of 24 participants completed the study. Statistical analyses revealed no statistical significance when comparing groups across time for any of the dependent variables.

Effect size calculations are an important indicator of counseling intervention effectiveness and, moreover, are at least equally as important as significance testing (Armstrong & Henson, 2004, 2005; Henson & Smith, 2000; Wilkinson & APA TFSI, 1999) in counseling intervention research. Therefore, I also hand calculated univariate eta squared effect sizes to assess and to recognize the magnitude of difference between the two groups and practical significance (Kazdin, 1999). Cohen's (1988) guidelines were used to interpret eta squared effect sizes for each dependent variable. Effect sizes indicated small improvement in the form of reduced panic behavior and increased personal growth for adults who participated in the NDE learning module over adults in the waitlist control group. Additionally, effect sizes indicated large improvement in the form of reduced blame and anger and detachment for adults who participated in the NDE learning module over adults in the waitlist control group.

Negligible effect sizes were found for despair and disorganization. Thus, results of this pilot study provide initial evidence that participating in an NDE learning module may benefit bereaved adults in some areas of their grief but not others.

Despair

Results of Research Question 1 analysis indicated that from pretest to posttest, adults who participated in the NDE learning module did not score statistically significantly higher ($p > .05$) on the Despair subscale of the HGRC when compared to adults who were placed on a waitlist no treatment control group. Additionally, treatment effect size for the NDE learning module intervention was negligible.

However, treatment effect size for both groups over time was small according to Cohen's (1988) guidelines, indicating that all participants in the study demonstrated some decrease in despair. All participants reported experiencing decreased indicators of despair, including feelings of sadness, loneliness, yearning, and hopelessness, over the 3-week time period between pretest and posttest. This result may indicate that participants' initiation of membership in a supportive intervention alone contributed in a small way to decreases in feelings of despair. Perhaps the hope offered by getting help offered a modest reduction in sadness and loneliness. Although a decrease in symptoms related to despair seems as though it could be considered a positive outcome for bereaved adults, results did not support the NDE learning module in particular as a source of this relief.

Results of this study call into question the effectiveness of learning about NDEs in decreasing despair of adults who are grieving. However, the results also directly contradict with at least one bereaved mother, who stated that learning about NDEs provided relief by

diminishing the “bottomless, black despair” (Sutherland, 1996, p. 6) she experienced after losing her son. Even a single contradiction seems to support further research in this area.

Panic Behavior

Results of Research Question 2 analysis indicated that from pretest to posttest, treatment effect size for the NDE learning module intervention was small, indicating the practical significance of the study’s results. Additionally, results indicated that from pretest to posttest, adults who participated in the NDE learning module did not score statistically significantly lower ($p > .05$) on the Panic Behavior subscale of the HGRC when compared to adults who were placed on a waitlist no treatment control group. Effect size findings provide evidence to support future controlled studies measuring the impact of an NDE learning module on panic behavior related to grief of bereaved adults. Although treatment effect size for both groups over time was medium, it may be noteworthy that the experimental group had a larger, but non-significant, difference between pretest and posttest means than the control group (see Table 2).

Bereaved adults who participated in the NDE learning module had a minor improvement in their feelings of fear, panic, and associated physiological reactions including headaches, fatigue, and stomachaches as a result of the intervention. This result seems to correspond with Drumm’s (1992) assertion that learning about NDEs gave her greater “peace of mind” (p. 69) in coping with her grief. Based on practical significance findings, the NDE learning module had a beneficial effect on participants’ self-report of panic behavior when compared to control group participants.

All participants reported moderate decreases in panic behavior over the 3-week time period between pretest and posttest. This result could be similar to participants' decreases in despair over time: the hope offered by participation in a supportive environment may have had a calming effect, reducing feelings of fear and anxiety for all participants.

Personal Growth

Results of Research Question 3 analysis indicated that from pretest to posttest, treatment effect size for the NDE learning module intervention was small, indicating the practical significance of the study's results. Additionally, results indicated that from pretest to posttest, adults who participated in the NDE learning module did not score statistically significantly lower ($p > .05$) on the Personal Growth subscale of the HGRC when compared to adults who were placed on a waitlist no treatment control group. Effect size findings provide evidence to support future controlled studies measuring the impact of an NDE learning module on personal growth related to grief of bereaved adults. Also, when combined, adults in both the experimental and control groups reported a statistically significant difference between pretest and posttest on the Personal Growth subscale. Although the treatment effect size for both groups over time was large, it is noted that the experimental group had a larger, but non-significant, increase from pretest to posttest means than the control group.

The NDE learning module contributed to a modest increase in participants' personal growth. Personal growth refers to "spiritual and existential awareness" and "a sense of having become more compassionate, tolerant, forgiving, and hopeful" (Hogan et al., 2001, p. 14). These results support Drumm's (1992) assertion that her experience of learning about NDEs provided her and other bereaved adults she knew with a "renewed purpose" and "allow[ed] life

to move ahead” (p. 69). Another personal account indicative of the effects of learning about NDEs on bereaved adults’ personal growth was illustrated in the account of a woman named Maria who had lost her son (Sutherland, 1996). Maria stated that after learning about NDEs, “a wonderful new hope was born somewhere deep within” (p. 6) her. Effects of the NDE learning module may account for changes in two sources of hope related to personal growth: participants’ hope that their deceased loved ones still exist in a spiritual or transpersonal form and participants’ hope that they would eventually be reunited with their loved ones in an afterlife. NDEs may have provided participants with increased confidence that they not only could continue a spiritual relationship with deceased loved ones, but would also “see” them again in an afterlife. This increased confidence may have increased participants’ hope.

Additionally, the International Association for Near-Death Studies (2007) suggested that by learning about NDEs, bereaved people could have the opportunity to “continue [their] own process of psychospiritual development” (p. 5). The education about NDEs provided to adults in this study may have promoted increased spiritual awareness, leading to modest gains in personal growth. Based on practical significance findings, the NDE learning module had a beneficial effect on participants’ self-report of personal growth when compared to control group participants.

Furthermore, results indicated large effect sizes for all participants over time in the area of personal growth. Therefore, all participants reported experiencing increased indicators of personal growth over the 3-week time period between pretest and posttest. It seems that this result may reflect a characteristic of the concept of restoration-orientation within the dual process model of coping with bereavement as an inherent grief process. Restoration-

orientation represents what an individual copes with after a loss and how that individual copes with it. Personal growth may represent attempts of participants to “accept the reality of the changed world” (Stroebe & Schut, 1999, p. 215). Items in the Personal Growth subscale of the HGRC such as “I reached a turning point where I began to let go of some of my grief” and “I have learned to cope better with life” appear to strongly support this conceptualization. As discussed previously with the concepts of panic behavior and despair, the anticipation of engaging in bereavement support may have been a source of hope for all participants, providing them with an impetus for personal growth.

Blame and Anger

Results of Research Question 4 analysis indicated that treatment effect size for the NDE learning module intervention was large, indicating the practical significance of the study’s results. Additionally, results indicated that when controlling for pretest scores, adults who participated in the NDE learning module did not score statistically significantly higher ($p > .05$) on the Blame and Anger subscale of the HGRC at posttest when compared to adults who were randomly assigned to a waitlist no treatment control group. Thus, effect size results provide favorable evidence to support future controlled studies measuring the impact of an NDE learning module on blame and anger related to grief of bereaved adults.

Based on practical significance findings, the NDE learning module had a beneficial effect on participants’ self-report of blame and anger when compared to control group participants. Bereaved adults who participated in the NDE learning module reported a statistically non-significant but substantial decrease in their feelings of hostility and bitterness. It seems likely that some participants may have felt angry with their deceased loved ones, a common

experience in normal grief (Worden, 2009). The NDE learning module may have facilitated increased confidence about ongoing spiritual relationships with participants' deceased loved ones, allowing participants to release feelings of resentment to a great degree.

Additionally, participants' resentment and anger may have been directed toward other sources, including God or other spiritual figures from their respective belief systems. The nature of the information about NDEs that I taught in the learning module indicated spiritual beings as loving and compassionate; furthermore, NDEs may have facilitated increased confidence that an afterlife is a beautiful, peaceful, and unconditionally loving environment. This knowledge may have contributed to reduction of participants' blame and anger.

Detachment

Results of Research Question 5 analysis indicated that treatment effect size for the NDE learning module intervention was large, indicating the practical significance of the study's results. Additionally, results indicated that from pretest to posttest, adults who participated in the NDE learning module did not score statistically significantly lower ($p > .05$) on the Detachment subscale of the HGRC when compared to adults who were placed on a waitlist no treatment control group. Effect size results provide favorable evidence to support future controlled studies measuring the impact of an NDE learning module on detachment related to grief of bereaved adults. Although the treatment effect size for the NDE learning module intervention was large, it is noted that whereas the experimental group had an decrease in mean detachment from pretest to posttest, the waitlist control group had a decrease in mean detachment from pretest to posttest.

Based on practical significance findings, the NDE learning module had a beneficial effect on participants' self-report of detachment when compared to control group participants. Detachment refers to avoidance of intimacy, withdrawal from interpersonal relationships, and confusion about one's sense of self. The support group format of the NDE learning module may have decreased participants' detachment. Through the support group format, I facilitated a safe environment with the intention that participants could connect emotionally with others through discussion of their experiences of grief. The nature of this kind of supportive, caring environment likely lead to adults in the groups confronting rather than avoiding intimacy and engaging in rather than withdrawing from interpersonal relationships, especially with peers in the group.

Furthermore, a major component of one's sense of self is one's relationship to and with others (Rogers, 1961). Therefore, it seems likely that participants considered their relationships to their deceased loved ones as part of their senses of self. Learning about NDEs may have changed participants' view of the nature of their relationships with their deceased loved ones to reflect a continuing bonds perspective (Silverman & Klass, 1996). From this perspective, participants may have integrated their changed, continuing relationships to their deceased loved ones into their senses of self. Becoming more confident in a new sense of self may have lead to decreased feelings of detachment.

Disorganization

Results of Research Question 6 analysis indicated that from pretest to posttest, adults who participated in the NDE learning module did not score statistically significantly higher ($p > .05$) on the Disorganization subscale of the HGRC when compared to adults who were placed on

a waitlist no treatment control group. Additionally, treatment effect size for the NDE learning module intervention was negligible. These results cast doubt on the utility of future controlled studies measuring the impact of an NDE learning module on disorganization related to grief of bereaved adults.

Disorganization refers to “difficulty with concentration and problems learning new information and recalling familiar previously remembered information” (Hogan et al., 2001, p. 17). Neither previous anecdotal evidence nor this study indicated any effects of learning about NDEs on cognitive functioning in bereaved persons. Therefore, it appears unlikely that learning about NDEs has any measurable impact on concentration, memory, or other cognitive tasks.

Conversely, it is possible that these findings reflected a ceiling effect among participants. Participants in both the experimental group and waitlist control group reported low levels of disorganization at pretest, indicating that there may have been no room for reduction in disorganization among participants. Based on findings in regard to this research question, the NDE learning module did not have a beneficial effect on participants’ self-report of disorganization when compared to control group participants.

Subjective Observations

Worden (2009) asserted that in addition to formal assessment and measurement of changes in grief symptomatology, observing the subjective experiences of bereaved clients was an important indicator of change in grief interventions. To assist in observation of participants’ subjective experiences, I videotaped all sessions of the NDE learning module. Throughout this intervention, participants reflected upon their experiences of the intervention and about their grief. As a result of these discussions, I observed several themes possibly important to provision

of bereavement interventions using this NDE learning module with bereaved adults: (1) connection with the material presented about NDEs; (2) participants' experiences of change resulting from the NDE learning module; and (3) specific components about this intervention that participants found helpful. In this section, I discuss these themes and provide direct examples from individual participants.

Connection with Material Presented about NDEs

In the first session of the NDE learning module, participants watched an educational DVD about NDEs that I produced and most of *Round Trip* (O'Reilly, 1996), a documentary about NDEs. One of the major themes present in many participants' responses immediately following the videos was that of connection to the actual material presented in the videos.

One of the participants, a widow in her 70s who had lost her husband less than a year prior to the intervention, stated that she connected to the common aspect of peacefulness in many NDEs. Her husband of more than 50 years had been sick with several illnesses for several months before he died. Toward the end of his life, her husband was in the care of a local hospice. She reported that she was present at his time of death. She went on to say that

I can definitely agree with that [the material in the videos], because my husband was so sick. But in those last few minutes, his eyes became – he had hazel eyes – they became more blue. And he had such a peaceful... He was so at peace. It was like he was welcoming it [death].

Her adult son, through sheer luck of random assignment, also participated in the same group. He also reported feeling a sense of connection to the material in the NDE videos. He stated that "I was there with him the night before and there was this sense of, uh... He was ready... It was a very reassuring experience."

Another participant, an adult male who lost his adult brother less than a year prior to this intervention, also reported feeling a connection to the material about NDEs presented in the videos. This participant stated that after his brother was admitted to the hospital following an auto accident, his brother fell into a coma and was on life support. The participant described sitting next to his brother's hospital bed for several hours at a time. Immediately after the second video ended, he stated that

I wish I had seen that about 8 months ago, you know, just to know, you know, because... that's showing that death isn't something to fear, I guess. It would have, if I would have seen that then [when his brother was in the hospital], it would have been a lot different when I sat there in the hospital room with him.

Another participant's response that exemplified a theme of connection with the material that I presented about NDEs came from a young woman whose fiancé died just 3 months prior to the intervention. According to this participant, her fiancé died suddenly from undetermined causes only a day after she gave birth to their child. In response to the NDE videos, she reported that "It's comforting to me, at least, to know that they [the loved ones she has lost] are with us every day."

Participants' Experiences of Change

Another theme that appeared consistent throughout participants' discussions was that of experiencing change resulting from participating in the NDE learning module. The 70-year-old widow discussed above expressed her experience of feeling less emotionally detached and less avoidant of her grief:

I think I have spent time since we've been having these sessions together, um, maybe accepting my grief and tried to deal with it instead of trying to put it in a closet, put it in a drawer, not look at it.

Similarly, a young woman who lost her grandfather several years ago to natural causes stated that “I found myself thinking about him more.” She further discussed that her family members encouraged an atmosphere of avoidance, one that discouraged talking about her grandfather’s death. She stated that the workshop helped her to feel encouraged to experience her grief.

Conversely, the male participant discussed above who lost his father expressed his confusion about the benefits of constantly revisiting his feelings of grief. He stated:

It’s been a little bit difficult because I feel like, um, I’ve put these things out there before. I’ve felt these things before. And every time I go there again, it pulls me down for a period of time. I mean, on the one hand it feels good because you get it out there. But on the other hand you feel like it’s this cycle you keep going through. And you want to move on, and you want to get back to something that feels more like normal. So, I don’t want to pour water on anything, because I think this has been good.... It’s good to share and talk about these things. But I don’t know how many times going back there and thinking about this helps.

His mother, also in the group, spoke similarly about her shifting between engaging in and avoiding directly experiencing the thoughts and emotions associated with her grief. She added that one of her coping mechanisms that came up in the weeks between intervention sessions was that “I tell myself a hundred times a day: ‘He’s in a better place. He’s not hurting. It’s okay, I’ll go be with him someday.’”

Some participants expressed that they felt changes within themselves but could not necessarily pinpoint the nature of the changes. One participant stated during Session 2 that “This week I’ve probably felt a little better than I have in the past.” As the group’s discussion progressed, he continued to explore what had changed for him, stating that “I think it’s given me a little more positive outlook now, instead of just, like... dragging all day with no energy.”

By the third session, many of the participants could more explicitly outline what they believed had changed for them as a result of participating in the intervention. The 70-year-old

widow, discussed above, stated that she found herself communicating to her deceased husband in the week leading up to the final workshop, remarking that “There’s been robins behind the house the past couple of days... I’ve been finding myself saying, ‘Honey, look, the robins are back!’”

The young woman who lost her fiancé, discussed above, stated that she felt more confident in her changing notions of spirituality. She reported that “I guess on the video... it’s believable. I kind of believe it [an afterlife] now and I probably didn’t before.”

Finally, the male participant who lost his adult brother talked about his increased sense of compassion toward others. He stated that previous to his brother’s death, he would react in an apathetic way toward others who told him about their losses. However, since the workshop, this participant reported that “I find myself now... [when someone tells me they’ve lost someone], I’ll sit down and listen to them, you know, and hear their story, you know, and soak it in, I guess.” This statement adds support to the finding in this study that participants experienced increased personal growth.

Specific Components about this Intervention that Participants Found Helpful

A final theme that seemed consistent throughout many participants’ statements surrounded specific components of the intervention that appeared helpful to them. Two components of the intervention seemed particularly helpful to participants: the support group modality and the NDE videos.

One participant remarked that he had attempted to process his grief with others in the past, especially his family. However, he stated that he found the supportive, nonjudgmental nature of this group more helpful:

I've talked about it with people but, you know, they'll sit there and they'll listen, but I don't know if you understand it as much until you've been through it.

He continued by stating that "I think just talking about it, you know, with other people that have been through it – I think that helps a lot." Many other group members were in agreement with the helpful nature of the support group format.

The second component of this intervention that many participants explicitly discussed as helpful to them was the NDE videos. One of the participants, a female whose young son had died, stated that "I just got lost for awhile. And I think just coming and watching the tapes put me on track." Some of the participants were more specific about how the NDE videos helped them. For example, a male participant whose father died expressed that

I think it was helpful to hear about people who have come close to passing away, and that, that experience is a welcoming, gentle, um, not painful, uplifting sort of experience. It makes it easier to think about, um, what he [dad] might have gone through as he was moving on. I guess I hadn't given that part of it as much thought. It's a nice additional way to have as a way of coping.

Similarly, another male participant found solace in the peaceful nature of NDEs as described by NDErs in *Round Trip* (O'Reilly, 1996). He added that

The video was kind of good for me, because I liked how all the people talked about, you know, they didn't want to come back when they were seeing the light, you know. So, to know that that's a good thing, you know, to go ahead and pass on – because a lot of the problems I've had and what really bothered me when it [his brother's hospitalization] started, with my brother especially, was like: What is he going through? What is he thinking, you know? Like, when we disconnected the life support, was he thinking: Why are you doing this to me? You know, but, now, after seeing that [the video], I know that he was going to a better place. It kind of brought me to ease a little bit.

Finally, another member of the group found confidence in her notions of an afterlife because of the NDE videos. She stated that

I feel like I've always know that there's life after death and that you go to a better place. And I knew that as soon as my grandpa died, he was in heaven looking down on us or

whatever. And, uh, watching the near-death experience [video] just kind of solidified that. I feel like... I always go to church and you hear about it, but there's always that little doubt that's like, what if nothing happens and it's just emptiness after we die? So, I feel much better.

Conversely, some of the participants discussed components of the NDE learning module that were not helpful. One specific component that many participants in one group pointed out was an NDEr on the video *Round Trip* (O'Reilly, 1996) who was holding a cigarette throughout her interview. Several of the participants in one particular group expressed their anger that this NDEr was given a second chance at life, yet decided to participate in an unhealthy and risky behavior. A female participant in her early 20s expressed anger about this NDEr on the video and stated that

I'm not sure if the lady [in the video] was holding a cigarette in her hand, but I think she was. And, I mean, that was amazing to me. I was like, so she had this near-death experience, she gets to come back to Earth, life, whatever... She's still smoking, but this person over here has been smoking and they have to die. You know?

Another female participant who lost her husband over a year ago had a similar reaction that carried across all three sessions. In the third session, she stated that "I can't believe that lady was still smoking!" This feedback about this particular component of the NDE learning module seems to indicate that it might be useful to change some parts of the video on NDEs.

Limitations

This study contained several methodological limitations that may have affected the results. One of these limitations is the small sample size of 24 participants. A small sample size can be a limitation in bereavement intervention studies (Stroebe, Stroebe, & Schut, 2003), but is also quite common in counseling outcome research (Armstrong & Henson, 2005).

Additionally, participants in this study represented a limited geographical area, limiting the

ability to generalize the results from this study to other areas. Moreover, the majority of participants in this study were female, further limiting generalizability to males. A replication of this study with a larger, more diverse sample size is suggested in order to increase generalizability to a greater proportion and representation of bereaved adults.

As a pilot study, this study was the first of its kind. Because no other empirical studies existed on the current research topic, I had no way to replicate even parts of another study. Therefore, this study was a test of both the design itself and the intervention, which may have limited interpretation of the results.

Additionally, participation in this study may have been attractive to adults who were particularly open-minded regarding near-death and other transpersonal experiences. Because all recruitment efforts included mention of near-death experiences as a component of this study, some participants may have been more interested in this topic than the general population of bereaved adults. Although in future studies it would be difficult to recruit on this topic without mentioning NDES in recruitment materials because of research ethics, efforts should be made in future intervention studies to recruit participants who may have no specific interest in NDEs or related phenomena.

Furthermore, the use of a no treatment control group was a limitation in this study. It is possible that any differences observed between the experimental group and the waitlist control group were simply due to use of an intervention, without regard to the specific components of the NDE learning module. It is also possible that any differences observed were due to being in a therapeutic and supportive counseling group. In future replication studies, I recommend that researchers use a treatment comparison group rather than or in addition to a control group.

The use of a treatment comparison group could support the assertion that particular characteristics of the NDE learning module were the source of changes in the experimental group.

Recommendations for Future Research

Based on the results and limitations of this study and prior anecdotal evidence, I suggest several recommendations for future research:

1. The present study had a small sample size of 24 participants. Replicating the study with a larger sample size could not only affect statistical significance findings but also allow for greater generalizability.
2. The present study did not include a treatment comparison group. Future research investigating the effect of learning about NDEs on adult grief could compare this intervention to other treatment interventions, such as other forms of bereavement support groups.
3. The present study did not restrict the amount of time that had to have passed since participants' loved ones died. Some research findings support the notion that interventions designed to moderate this variable may indicate greater benefit to participants (Stroebe et. al, 2008; Worden, 2009). Therefore, focusing on adults who have lost loved ones within a specific time period could add to these postulations.
4. The present study focused on several symptom sets related to grief. In future studies, targeting specific sets of symptoms, such as personal growth or blame and anger, could distinguish which parts of adult grief are impacted the most by learning about NDEs.

5. Finally, the present study utilized *Round Trip* (O'Reilly, 1996) as one of its teaching tools. Rather than focusing specifically on bereaved adults, *Round Trip* was designed for a general audience. Future researchers could produce their own videos specifically for use with bereaved adults, focusing on features of NDEs that may be most impactful.

Implications and Conclusions

Grief resulting from loss of a loved one is an almost universal experience that can result in a multitude of both painful and growth-promoting internal experiences. Without intervention, normal grief can often resolve over time; however, in some cases, grief can matriculate into complicated sets of emotional, cognitive, and behavioral symptoms that can intrude on one's ability to function in a healthy manner on a daily basis (Worden, 2009). Even more concerning is when normal grief matriculates into complicated grief, leading to overwhelming emotional states and maladaptive behavior. Therefore, it is vital to identify effective grief counseling services that benefit bereaved adults emotionally and behaviorally.

Although none of the results reached statistical significance, it is likely that the sample size was a major limitation and contributor to this outcome. Additionally, findings did not indicate benefit to bereaved adults in the areas of despair and disorganization. However, results of this study indicate that an NDE learning module can have a beneficial impact on adult grief, specifically in the areas of panic behavior, personal growth, blame and anger, and detachment. Collectively, these results warrant further investigation, as the findings indicate that learning about NDEs can emotionally and behaviorally benefit bereaved adults by decreasing some distressing aspects, such as feelings of anxiety, resentment, and emotional

and interpersonal withdrawal. The findings also indicate that learning about NDEs can emotionally benefit bereaved adults by increasing and promoting aspects of personal growth, such as compassion, hope, and spiritual awareness.

My original motivation to investigate the effects of an NDE learning module on grief was personal in nature. Approximately 3 years ago, my sister died from a brain aneurysm. I suffered greatly from the experience of my grief. A little over 3 months after my sister's death, I was an audience member during a discussion in which four near-death experiencers (NDErs) talked about their NDEs. I was emotionally moved during this panel; soon afterward, I realized that hearing NDErs' stories had a therapeutically beneficial effect on my grief.

Based on my subjective experiences, I believe that a live panel of NDErs is likely more effective than using a video such as *Round Trip* (O'Reilly, 1996). However, I also found that *Round Trip* had a healing effect on my grief as well. Therefore, it is my personal assertion that although psychoeducational NDE videos as intervention tools did not seem as effective as a live NDE panel, the content of NDE videos can be controlled and standardized. Additionally, psychoeducational NDE videos are easier to use – researchers and bereavement counselors alike seeking to use a similar intervention would not have the hassle of finding NDErs to talk live to a group of grieving adults. Therefore, the use of psychoeducational NDE videos as part of learning modules for bereaved adults seems like a beneficial intervention medium.

Prior meta-analytic studies (e.g., Allumbaugh & Hoyt, 1999; Currier, Holland, & Neimeyer, 2007; Currier, Neimeyer, & Berman, 2008; Fortner, 1999) can neither confirm nor deny the full spectrum of benefits or drawbacks to grief counseling interventions. A host of methodological issues in prior grief intervention research is at least partly to blame for recent

inconsistent conclusions regarding effectiveness of bereavement interventions. Therefore, I sought to design this study with methodological rigor in my use of random assignment and a classic pretest/posttest experimental design. Because the findings of this study indicated small to large benefits to bereaved adults in several areas of grief, it appears this study adds confirmatory evidence to the utility of bereavement interventions in general. Consequently, it is important to continue to investigate the effectiveness of learning about NDEs as a bereavement intervention.

In conclusion, the NDE learning module is a good prospect as a potentially effective intervention for use with bereaved adults to decrease some distressing aspects, such as panic behavior, blame and anger, and detachment, and increase growth-oriented aspects of their grief. The impact of this NDE learning module on distressing grief aspects such as despair and disorganization appears weak based on the findings of this study. Although several prior reports and case studies (e.g., Drumm, 1992; Horacek, 1997; McDonagh, 2004; Ring & Valarino, 2000; Sutherland, 1996) indicated similar anecdotal findings, based on my exhaustive review of literature, this study represents the first study of its kind to quantitatively analyze effects of learning about NDEs on adult grief. This study also represents a framework for future quantitative and qualitative studies investigating the impact of learning about NDEs on adult grief.

APPENDIX A
INFORMED CONSENT FORM

University of North Texas Institutional Review Board Informed Consent Form

Before agreeing to participate in this research study, it is important that you read and understand the following explanation of the purpose, benefits, and risks of the study and how it will be conducted.

Title of Study: Effects of a Near-Death Experience Learning Module on Grief

Principal Investigator: Ryan D. Foster, a doctoral candidate in the University of North Texas (UNT) Department of Counseling and Higher Education.

Purpose of the Study: You are being asked to participate in a research study that involves investigating the effects of learning about near-death experiences on adults who are grieving.

Study Procedures:

This study will provide you the opportunity to participate in an educational learning module on near-death experiences and discussion of this education on your reaction to grief. The educational learning module includes viewing two videos on near-death experiences and discussion of your reactions to the videos over three sessions of interaction. The learning module consists of three sessions I will provide weekly over three consecutive weeks on the campus of the University of North Texas in Denton or the University of North Texas-Dallas. The first session of the module will take three hours, the second will be two hours, and the third will be two hours. If you agree to participate in this study, you will participate in the three-week learning module sometime over the coming four months.

If you agree to participate in this study, I will ask you to complete four forms. The first, a Contact Information form, you will complete and return to me today. The next three you'll receive and return by mail. One is a Bereavement History Form in which you will provide personal information about yourself including gender, age, ethnicity, religious preference, and identification of the significant other whom you are grieving. It takes approximately five minutes to complete. Another form is the Hogan Grief Reaction Checklist to measure symptoms related to grief. This form takes approximately 20 minutes to complete. I will also ask you to complete the Checklist again at a later point in the study. The final form is a Meeting Time Availability form in which you will indicate your preferred meeting time(s) and location(s) (UNT in Denton or UNT-Dallas) from choices listed on the form. The forms you receive by mail I will ask you to complete and return in a pre-addressed and -stamped envelope within one week of receiving them.

Foreseeable Risks: This study may have potential risks for you. During group discussions, you may talk about topics that may be uncomfortable or emotionally distressing for you. If you experience distress or discomfort that concerns you, I will provide you with further referrals, such as counselors or related professionals, who can assist you with your unease.

Benefits to the Subjects or Others: We expect the project to benefit you by providing you an opportunity to learn about near-death experiences. In addition, this study may benefit others who

are grieving and may contribute to the field of grief counseling. However, we cannot guarantee any specific results or outcomes for you or others.

Compensation for Participants: No compensation is available for your participation in this study.

Procedures for Maintaining Confidentiality of Research Records: We will maintain signed consent forms and coded questionnaire results in separate locations. I will not have access to questionnaire results until the completion of this study, after you have participated in all group sessions. The confidentiality of your individual information will be maintained in any publications or presentations regarding this study.

Questions about the Study: If you have any questions about the study, you may contact me, Ryan D. Foster, at telephone number 940-565-2066, or my faculty advisor, Dr. Jan Holden, UNT Department of Counseling and Higher Education, at telephone number 940-565-2919.

Review for the Protection of Participants: This research study has been reviewed and approved by the UNT Institutional Review Board (IRB). The UNT IRB can be contacted at (940) 565-3940 with any questions regarding the rights of research subjects.

Research Participants' Rights: Your signature below indicates that you have read or have had read to you all of the above and that you confirm all of the following:

- Ryan D. Foster has explained the study to you and answered all of your questions. You have been told the possible benefits and the potential risks and/or discomforts of the study.
- You understand that you do not have to take part in this study, and your refusal to participate or your decision to withdraw will involve no penalty or loss of rights or benefits. The study personnel may choose to stop your participation at any time.
- You understand why the study is being conducted and how it will be performed.
- You understand your rights as a research participant and you voluntarily consent to participate in this study.
- You have been told you will receive a copy of this form.

Printed Name of Participant

Signature of Participant

Date

For the Principal Investigator: I certify that I have reviewed the contents of this form with the participant signing above. I have explained the possible benefits and the potential risks and/or discomforts of the study. It is my opinion that the participant understood the explanation.

Signature of Principal Investigator

Date

APPENDIX B
BEREAVEMENT HISTORY FORM

Bereavement History Form

- 1) Age: _____
- 2) Sex: M F
- 3) Relationship status? Circle one:
a. Single b. Committed Relationship c. Married d. Partnered e. Divorced
f. Widowed g. Other (please specify): _____
- 4) Religious or spiritual affiliation? Circle one:
a. Buddhist b. Christian c. Hindu d. Jewish e. Muslim f. Other religion: _____
g. Spiritual, not religiously affiliated h. Neither religious nor spiritual
- 5) What is your race or ethnic identity? Circle one:
a. African American b. American Indian c. Asian d. Latina/o
e. White, non-Latina/o f. Bi-racial g. Other: _____
- 6) Highest educational level achieved? Circle one:
a. Some high school b. High School Diploma/Equivalent c. Some College
d. Bachelor's Degree e. Graduate Degree
- 7) Current occupation? _____
- 8) For whose death(s) are you seeking bereavement support (please circle one or more)?
a. Grandparent b. Parent c. Child d. Spouse/Partner e. Sibling
f. Other (please specify): _____
- 9) How much time has passed since the death of the person for whom you're seeking support?
a. 0-3 months b. 3-6 months c. 6-12 months
d. 1 to 2 years e. Over 2 years

10) Have you ever had a near-death experience? Yes No

If so, what were the circumstances? _____

11) Other than your support group, are you currently participating in any other activity to

assist you in your grief? No Yes (please describe): _____

APPENDIX C

HOGAN GRIEF REACTION CHECKLIST

HOGAN GRIEF REACTION CHECKLIST
(reproduced by permission of N. Hogan, March 7, 2009)

*This questionnaire consists of a list of thoughts and feelings that you may have had since your loved one died. Please read each statement carefully, and choose the number that best describes the way you have been feeling during the **past two weeks, including today**. Circle the number beside the statement that best describes you. Please do not skip any items.*

- | | |
|-------------------------------|--------------------------|
| 1 Does not describe me at all | 4 Describes me well |
| 2 Does not quite describe me | 5 Describes me very well |
| 3 Describes me fairly well | |

- | | |
|--|-----------|
| 1. My hopes are shattered..... | 1 2 3 4 5 |
| 2. I have learned to cope better with life..... | 1 2 3 4 5 |
| 3. I have little control over my sadness..... | 1 2 3 4 5 |
| 4. I worry excessively..... | 1 2 3 4 5 |
| 5. I frequently feel bitter..... | 1 2 3 4 5 |
| 6. I feel like I am in shock..... | 1 2 3 4 5 |
| 7. Sometimes my heart beats faster than it normally does for no reason.. | 1 2 3 4 5 |
| 8. I am resentful..... | 1 2 3 4 5 |
| 9. I am preoccupied with feeling worthless..... | 1 2 3 4 5 |
| 10. I feel as though I am a better person..... | 1 2 3 4 5 |
| 11. I believe I should have died and he or she should have lived..... | 1 2 3 4 5 |
| 12. I have a better outlook on life..... | 1 2 3 4 5 |
| 13. I often have headaches..... | 1 2 3 4 5 |
| 14. I feel a heaviness in my heart..... | 1 2 3 4 5 |
| 15. I feel revengeful..... | 1 2 3 4 5 |
| 16. I have burning in my stomach..... | 1 2 3 4 5 |
| 17. I want to die to be with him or her..... | 1 2 3 4 5 |
| 18. I frequently have muscle tension..... | 1 2 3 4 5 |
| 19. I have more compassion for others..... | 1 2 3 4 5 |
| 20. I forget things easily, e.g. names, telephone numbers..... | 1 2 3 4 5 |
| 21. I feel shaky..... | 1 2 3 4 5 |
| 22. I am confused about who I am..... | 1 2 3 4 5 |
| 23. I have lost my confidence..... | 1 2 3 4 5 |
| 24. I am stronger because of the grief I have experienced..... | 1 2 3 4 5 |
| 25. I don't believe I will ever be happy again..... | 1 2 3 4 5 |
| 26. I have difficulty remembering things from the past..... | 1 2 3 4 5 |
| 27. I frequently feel frightened..... | 1 2 3 4 5 |
| 28. I feel unable to cope..... | 1 2 3 4 5 |
| 29. I agonize over his or her death..... | 1 2 3 4 5 |
| 30. I am a more forgiving person | 1 2 3 4 5 |

- | | | | |
|---|-----------------------------|---|------------------------|
| 1 | Does not describe me at all | 4 | Describes me well |
| 2 | Does not quite describe me | 5 | Describes me very well |
| 3 | Describes me fairly well | | |

- | | | | | | | |
|-----|---|---|---|---|---|---|
| 31. | I have panic attacks over nothing..... | 1 | 2 | 3 | 4 | 5 |
| 32. | I have difficulty concentrating..... | 1 | 2 | 3 | 4 | 5 |
| 33. | I feel like I am walking in my sleep..... | 1 | 2 | 3 | 4 | 5 |
| 34. | I have shortness of breath..... | 1 | 2 | 3 | 4 | 5 |
| 35. | I avoid tenderness..... | 1 | 2 | 3 | 4 | 5 |
| 36. | I am more tolerant of myself..... | 1 | 2 | 3 | 4 | 5 |
| 37. | I have hostile feelings..... | 1 | 2 | 3 | 4 | 5 |
| 38. | I am experiencing periods of dizziness..... | 1 | 2 | 3 | 4 | 5 |
| 39. | I have difficulty learning new things..... | 1 | 2 | 3 | 4 | 5 |
| 40. | I have difficulty accepting the permanence of the death..... | 1 | 2 | 3 | 4 | 5 |
| 41. | I am more tolerant of others..... | 1 | 2 | 3 | 4 | 5 |
| 42. | I blame others | 1 | 2 | 3 | 4 | 5 |
| 43. | I feel like I don't know myself..... | 1 | 2 | 3 | 4 | 5 |
| 44. | I am frequently fatigued..... | 1 | 2 | 3 | 4 | 5 |
| 45. | I have hope for the future..... | 1 | 2 | 3 | 4 | 5 |
| 46. | I have difficulty with abstract thinking..... | 1 | 2 | 3 | 4 | 5 |
| 47. | I feel hopeless..... | 1 | 2 | 3 | 4 | 5 |
| 48. | I want to harm others..... | 1 | 2 | 3 | 4 | 5 |
| 49. | I have difficulty remembering new information..... | 1 | 2 | 3 | 4 | 5 |
| 50. | I feel sick more often..... | 1 | 2 | 3 | 4 | 5 |
| 51. | I reached a turning point where I began to let go of some of my grief.. | 1 | 2 | 3 | 4 | 5 |
| 52. | I often have back pain..... | 1 | 2 | 3 | 4 | 5 |
| 53. | I am afraid that I will lose control..... | 1 | 2 | 3 | 4 | 5 |
| 54. | I feel detached from others..... | 1 | 2 | 3 | 4 | 5 |
| 55. | I frequently cry..... | 1 | 2 | 3 | 4 | 5 |
| 56. | I startle easily..... | 1 | 2 | 3 | 4 | 5 |
| 57. | Tasks seem insurmountable..... | 1 | 2 | 3 | 4 | 5 |
| 58. | I get angry often..... | 1 | 2 | 3 | 4 | 5 |
| 59. | I ache with loneliness..... | 1 | 2 | 3 | 4 | 5 |
| 60. | I am having more good days than bad..... | 1 | 2 | 3 | 4 | 5 |
| 61. | I care more deeply for others..... | 1 | 2 | 3 | 4 | 5 |

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APPENDIX D

SEMI-STRUCTURED GROUP DISCUSSION

Semi-Structured Group Discussion

Session 1

1. What are your initial thoughts or feelings after watching these videos?
2. In what way has today's presentation affected you?
3. Any additional thoughts or comments?

Session 2

1. Please take a moment to reflect on your grief process since we met last week to watch the video and discuss it. Have you noticed any difference that you attribute to what we watched and discussed? If so, what difference(s) have you noticed?
2. What elements of our viewing and discussion last week and/or this week affected you?
3. Any suggestions about the use of this video and discussion that might be more helpful to you and/or others who are grieving?
4. Any additional thoughts or comments?

Session 3

1. Please take a moment to reflect on your time here over the past few weeks. Have you noticed any changes or differences related to your grief process as a result of this workshop? If so, what changes or differences have you noticed?
2. What particular elements of this workshop affected you?
3. Any last thoughts or comments?

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