AURORA@ COVID19-EU

ARTICULATING A UNIFIED RESPONSE TO THE COVID-19 OUTBREAK
RECONSTRUCTION AFTER LOSS IN EUROPE

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INDHOLD

FOREWORD

About this manual

This manual was created in 2022 in a collaboration between University of Maia – UMAIA (ISMAI/Maiêutica, Portugal), Universita Del Salento (Italy), Universidad Pontificia Comillas (Spain), Centro Hospitalar e Universitário de São Joao Epe., and The Danish National Center for Grief (Denmark). The collaborative process was led by the Danish National Center for Grief.

The development of the present manual constitutes a sub-project of the Research-Intervention Project "AURORA@COVID19-EU: Articulate a Unified Response to the Covid-19 Pandemic Reconstruction After Loss in Europe", funded by the European Union – ERASMUS+ (2021-1-PT01-KA220-VET-000033092). The primary objective of the manual is to strengthen efforts to prevent the development of complicated grief reactions in adults following the COVID-19 pandemic which swept across Europe, and indeed the entire world, at the beginning of 2020 and onwards. Furthermore, the aim of this project is to stimulate more compassionate and better equipped communities when it comes to accepting and supporting bereaved people in Europe. Raising general public awareness and strengthening education and information about bereavement in a grief literate and compassionate society.

Professional prerequisites for using the manual

The manual is not an introduction to psychotherapy in general. Rather, it gives a description of how an experienced clinician can approach interventions aimed at preventing the development of complicated grief reactions in adults, specifically, in relation to bereavement during the COVID-19 pandemic. Inspired by, and adapted from, recent work documenting effective treatments for complicated grief reactions (Johannsen et al., 2019), the manual offers guidance on how to support and work preventatively with bereaved people by means of using three different therapeutic approaches. To use the manual, you need to be a qualified/certified psychologist. Furthermore, it is advised, that you have at least two years of experience with psychotherapeutic work and have a supervisor or a professional peer group that you can consult when facing challenging situations.

How to use this manual

This manual is a starting point for psychologists interested in an introduction on how to work with bereaved people in the aftermath of the COVID-19 pandemic. The manual provides a framework for working with the bereaved, using one of three methods. As a reader, you are first introduced to relevant information on bereavement during COVID-19 in Southern Europe and the implications of losing a loved one under such extraordinary circumstances. The manual goes on to providing a short introduction to cultural aspects in Portugal, Spain and Italy of particular relevance to the specific challenges and effects of COVID-19 in each respective country. The manual then gives a brief introduction to grief theory and how you can use contemporary grief theory in your daily practice. Finally, it provides guidance on how to conduct an assessment interview and what to look for when clinically assessing complicated grief reactions.

This manual has been developed by researchers and practitioners from four European countries. The intervention described in this manual therefore reflects different theoretical stances and methods aimed at preventing complicated grief reactions. Readers of this manual will be introduced to cognitive behavioral therapy, emotion focused therapy and an eclectic approach using letter writing in the context of

bereavement therapy. The manual introduces different tools and strategies, in order to appeal to clinicians with different therapeutic backgrounds and experiences. Further, it seeks to facilitate providing personalized treatment to each bereaved individual with a view to support them in their specific needs and challenges. A brief section on the considerations on group therapy as well as a section of online therapy then follows. Finally, the manual offers reader's further resources and literature on grief intervention and working with bereavement.

Reading this manual you will be introduced to:

- Bereavement in the context of COVID-19 in Southern Europe
- Grief theory
- Natural versus complicated grief reaction
- Important aspects when assessing client therapeutic needs
- Three different therapeutic methods which can be applied in the prevention of complicated grief reactions following COVID-19
- Aspects worth considering when working with bereaved online or in a group setting

1.INTRODUCTION

The COVID-19 pandemic (SARS-CoV2) outbreak raised huge societal challenges for Europe. Besides the risks to life itself, it represented a major threat to mental health, social dynamics, and social justice (World Health Organization, 2020). Human capacity to face bereavement and loss under extreme circumstances were challenged during and after this pandemic crisis (Moreira et al., 2020).

In Europe, countries were hit differently during the COVID-19 outbreaks. The death toll due to COVID-19 has been particularly high in the southern axis of Europe, e.g. Italy, Spain, and Portugal. Yet, authors such as Morgan et al. (2020) argue that the real death toll includes not only deaths due to COVID-19, but also indirect deaths registered during the pandemic, for example, due to lack of access to health care as a result of the global disruption of health care services, increased levels of stress and mental health problems.

Furthermore, the social practices surrounding care to the terminally ill, death, funeral services and even the disposal of bodies were disrupted by a framework of emergency restrictions (Lowe et al., 2020; Stroebe & Schut, 2021). These emergency restrictions are likely to have impacted grieving processes negatively. Also, the pandemic has affected the most vulnerable people, in particular, worsening their already limited access to proper (mental) health care and exposure to socio-economic risks (Morris et al., 2020). Dealing with grief and bereavement of loved ones in this context is considered particularly problematic, i.e. taking into account the added brutality of social isolation, diminished social support mechanisms and availability of health care services (Morris et al., 2020).

Across borders, we have witnessed a lack of national strategies and/or unified grief and bereavement responses. This may result in an increased number of people living with complicated grief reactions post-COVID-19. Furthermore, the lack of systematic training of healthcare professionals and other professionals is likely to have resulted in insufficient bereavement care services for bereaved people (Aoun et al., 2019).

Against this background, the Research-Intervention the AURORA@COVID19-EU project aims to facilitate a unified, articulated response to address the needs of bereaved people in the aftermath of COVID-19. This project partnership aims to develop training resources to facilitate practices and provide education of direct and indirect agents related to death and dying during the COVID-19 pandemic.

According to a four-tier grief intervention model (see page 23), training manuals are developed for different professionals to respond to different levels of needs, with a specific focus on bereavement support during the COVID-19 pandemic.

Partner organizations from Portugal, Spain and Italy were chosen for this Partnership of Cooperation, and they will be the main local disseminators and participants, when the pilot implementation phase is executed in Portugal, Spain, and Italy. The Danish National Center for Grief (DNCG) joined this consortium due to being a highly specialized organization conducting research, treatment, and training related to bereavement and grief issues.

Direct agents: All professionals other than psychologists and specialized grief counsellors, meeting bereaved individuals in their professional roles. For example nurses, doctors, priests, funeral directors, teachers, fire fighters.

Indirect agents: Family, friends, wider social network and community supporting bereaved individuals.

By combining knowledge and efforts, the AURORA@COVID19-EU project will strengthen local capacities for training, clinical treatment practices, research dissemination and, ultimately, contribute to establishing more compassionate communities for meeting the needs of bereaved people through local networks of professionals, volunteers, and institutions.

The present “Training Manual I for Psychologists” targets psychologists who intervene with people at risk of developing complicated grief reactions during or following the COVID-19 pandemic. Pre-pandemic, about 10-20% of bereaved people experience what can be called complicated grief reactions, in which emotions and grief reactions do not subside but remain at a high and debilitating level (Bonanno et al., 2008; Lenferink et al., 2020). Several studies have suggested that following the COVID-19 pandemic this number will increase significantly due to the high number of added stressors and complications surrounding bereavement during this pandemic (Albuquerque et al., 2021; Cipolletta et al., 2022).

Training Manual I for Psychologists will be produced in five languages - English, Italian, Portuguese, Spanish and in Danish – and made available for use not only in the participating countries, but broadly throughout Europe and the world where relevant.

The development of a Training Manual I for psychologists incorporates the recommendations of the European Federation of Psychologists' Associations for Continuing Professional Development.

In closing, developing and disseminating the Training Manual I for psychologists represents an ambitious goal to help improve bereavement care services, specifically in Southern Europe, following the COVID-19 pandemic. However, we humbly think of this as an initial step only. Continuous collaboration between educators, researchers, providers and bereaved clients will be necessary to improve our ability to understand and address the needs of bereaved people and to promote compassionate bereavement responses.

2.BEREAVEMENT IN A COVID-19 CONTEXT IN EUROPE

THE EXPERIENCE OF LOSS

Recent studies suggest that the COVID-19 scenario may complicate the grief process of the bereaved, confronting them not only with the pain of loss but also with other painful challenges which precede and follow the death of their loved one. This includes the inability to be near and assist the ill person or to reach information from the medical staff providing care for their loved one. Following the loss, other difficulties arise in the lack of access to needed support and death rituals due to social distancing policies (Eisma et al., 2020; LeRoy et al., 2020; Zhai & Du, 2020). A preliminary study (Eisma et al., 2021) suggested a higher risk of prolonged grief for people bereaved by COVID-19 and unnatural deaths (i.e. accidents), compared to natural bereavement (i.e. deaths from chronic illness). A more recent study (Breen et al., 2022) compared the grief reactions of people bereaved by COVID-19-related deaths and people bereaved due to other natural or violent causes during this same period, highlighting that they do not differ in their levels of dysfunctional grief symptoms, disrupted meaning, risk factors, and functional impairment. Furthermore, regardless of the cause of their loved one's death, the levels of functional impairment of the bereaved people in the COVID-19 scenario were found to be equal to or greater than bereaved groups with complicated grief reactions or prolonged grief disorder before the pandemic. Similarly, another study (Eisma & Tamminga, 2020) started before the COVID-19 outbreak and carried out during its spread, showed that experiencing a loss during the pandemic elicited more severe acute grief reactions than before the pandemic.

Evidence of this kind suggest that dealing with loss during this ongoing health crisis may lead to negative and persistent consequences for the bereaved. Deaths at the time of COVID-19 may be considered traumatic losses since they occurred in a sudden, violent, and unexpected condition, not differently as in cases of suicides, homicides, and natural disasters (Kristensen et al., 2012); such a traumatic loss increases the risk of a traumatic bereavement process (Cipolletta et al., 2022), with people facing difficulties in accepting the death and beginning to grieve (Torrens-Burton et al., 2022), the high level of uncertainty (Freeston et al., 2020) and feelings of anger and despair (Selman et al., 2021). Such aspects together with the enforced social distancing and restrictions in visits to health care facilities and funerals, seem to have posed the basis for another epidemic, that of Prolonged grief disorder (Albuquerque et al., 2021).

Studies from Southern Europe (e.g. Aguiar et al., 2020; Cipolletta et al., 2022; Farinha-Silva & Reis-Pina, 2020; Fernández & González-González, 2020; Menichetti-Delor et al., 2021) seem to highlight three aspects adding to the traumatic bereavement experience following COVID-19. Namely the inability to say goodbye, the unknown character of the death, the physical isolation and the lack of social support, which, amongst others, may cast light on why we can expect to see a rise in the number of individuals suffering from grief complications as a result of the COVID-19 pandemic.

NOT ABLE TO SAY GOODBYE.

Not being able to say goodbye to a loved one who dies, before and/or after the loss, was found to be a risk factor for complicated bereavement in the COVID-19 scenario (Hernández-Fernández & Meneses-Falcón, 2021). Previous research discloses that a sudden and unexpected death (Kersting et al., 2011; Lundin, 1984) as well as not having the possibility to see the body (Chapple & Ziebland, 2010; Merlevede et al., 2004) can make it difficult to realize that someone is dead and, consequently, to accept the loss and "let them go". For instance, in a multicenter study conducted with a large number of relatives of patients who died in the Intensive Care Unit (Kentish-Barnes et al., 2015), it was found that the relatives who were unable to say

goodbye presented symptoms of complicated grief, post-traumatic disorder as well as depressive symptoms to a greater extent than relatives who had an opportunity to say goodbye. During COVID-19 health emergency, people lost their lives quickly and unexpectedly with the virus also affecting citizens under 80-70 years old, whom social media had wrongfully described as not being at risk. Sometimes the fast progression of the virus made relatives feel like they were not properly informed about the gravity of the situation and were unprepared when the death occurred (Menichetti-Delor et al., 2021).

Furthermore, in the hospitals and other health services, visiting policies were revised in the healthcare environments and visitor attendance was discouraged: family members and relatives, thus, could not provide comfort and emotional healing to the dying loved ones. The passing process occurred in unprecedented, traumatic conditions with people dying in hospitals and nursing homes without their families by their side. (Cipolletta et al., 2022). The physical distance from the patient when they were dying or dead made families feel like they had not done enough, creating feelings of guilt and deprivation (Hernández-Fernández & Meneses-Falcón, 2021; Menichetti-Delor et al., 2021). Contrary, the possibility to communicate with their loved ones in the hospital thanks to nurses holding the phone close to the bed made a difference in people's capability to make sense of their loss and shape the experience of having said goodbye (Wakam et al., 2020). Not being able to see the body of the deceased increased the feeling of disbelief and difficulty in accepting the reality of death. Hernández-Fernández and Meneses-Falcón (2021) refer to how families asked healthcare workers for concrete details about the moment of death and/or proof of the death (e.g. a photo or a personal item, the death certificate) so that they could structure a logical narrative of the facts and accept what had happened.

Also, the absence of funerals or rituals to mark the death contributed to the notion of not saying goodbye and marking the death. Funerals represent a crucial cultural and religious component of the grieving process (O'Rourke et al., 2011): historically, they provide an opportunity to convey love and respect for the deceased and to say 'goodbye'; they mark a transition in which the death can be fully realized but constitute also a moment where the bereaved give voice to their emotions and receive social and psychological support by their close networks (Mortazavi et al., 2021). In Italy, the lockdown measures decreed forbidden funeral ceremonies and closed cemeteries everywhere (Ingravallo, 2020). In Spain and Portugal, funerals were limited respectively to three and ten people plus the officiant (Aguiar et al., 2020). Similar measures have been taken worldwide (Burrell & Selman, 2022). In many cases, families could not embalm and choose the clothing envisaged, there was no viewing of the body, no holding of a proper funeral as would have been desired, namely as a cultural practice allowing the overall community to honor the life of the lost loved one and provide social support to the bereaved. Funeral wakes – another important death ritual in countries with a strong Christian heritage like Portugal, Spain and Italy – were not possible for prolonged periods of time, so family members lacked also the related meaning of doing justice to the departed, recalling their lives, their doings, and their tales (Aguiar et al., 2020; Burrell & Selman, 2020; Fernández & González-González, 2020).

THE UNCERTAINTY SUROUNDING THE DEATH.

Uncertainty can be defined as 'the inability to determine the meaning of illness-related events' (Mishel, 1988, p. 225). Hebert et al., 2009, identified four kinds of uncertainty: *medical*, which concerns diagnosis, prognosis, and clinical course; *practical,* involving tasks that need to be completed before the death or to concerns related to the bereavement period (e.g. from an economic/financial point of view); *psychosocial* uncertainty, which reflects concerns about how family dynamics and relationships will be modified as a result of the illness and death; *religious/spiritual* uncertainty, referred to existential concerns and issues of meaning. According to the authors, the most important instruments to help families and relatives to face all these forms of

uncertainty are good communication and trusting relationships between caregivers and health professionals. In this way, caregivers can be "prepared". Conversely, the uncertainty surrounding the death can enhance the risk of complications in the bereavement process: difficulties in managing the uncertainty have been associated with a major risk of prolonged grief, posttraumatic stress, and depression (Boelen et al., 2016). The more the loss remains unclear, the more people have the feeling of not really knowing if the loved one is dead or alive, absent or present, so they may not be able to process the death (Boss et al., 2021).

Such feeling of uncertainty is recognized as one of the main causes of distress in bereaved during the COVID-19 (Cipolletta et al., 2022; Freeston et al., 2020; Mortazavi et al., 2021). The unpredictability of the symptoms and course of illness, the lack of clarity about, for example, diagnosis, treatment options, but also the ambiguous information from different sources, and communication gaps with the hospital, upraised feelings of unfairness and need of clarity of what happened to the deceased (Menichetti-Delor et al., 2021). In particular, the absence and/or inefficacy of communication between health care workers and caregivers is reported as a critical aspect in the management of death during COVID-19 emergency: for instance, a study conducted in Italy by Testoni and colleagues, 2021, aimed at considering the death notification process among physicians (notifiers), patient relatives (receivers) and those who work between them (nurses). The authors found that if at one side physicians and nurses reported relational difficulties in supporting patients' relatives, the relatives reported suffering related to health care professionals' inefficacy in communication before and after the death.

Not having the possibility to give meaning to a sudden, unexpected, and traumatic loss, makes the death an open issue, leading to preoccupation and rumination (e.g. trying to reconstruct the events in order to understand what went wrong (Testoni et al., 2021) and "freezing" the bereavement process. Preoccupation with the deceased is one of the key symptoms in the PGD diagnosis (Killikelly & Maercker, 2017). This again supports the notion that bereavement during the COVID-19 pandemic increased the risk of developing complicated grief reactions over time.

PHYSICAL ISOLATION AND LACK OF SUPPORT.

The role of social support as a moderator of the impact of bereavement on psychological health and well–being is well-known in scientific literature (for a review, see Burke & Neimeyer, 2012; Stoebe et al., 2005). Studies conducted one year after the death showed how having social support from family and friends allows enduring the grieving process without experiencing depression or physiological illness (Benkel et al., 2009; Bonanno & Kaltman, 2001).

During the COVID-19 emergency, the measures of physical distancing and home quarantine have largely forced families to face the grieving process alone, without the support of their social networks, also for non-cohabiting family member and friends. Therefore, some of the most important protective factors for adapting to bereavement and coping with the death of a loved one, like family involvement, physical presence, mourning with others and receiving social support (Lyons & Chamberlain, 2006), have been denied people grieving in the COVID-19 scenario (Fernández & González-González, 2020). In some interviews conducted among psychologists offering support to the bereaved family in Northern Italy (Menichetti-Delor et al., 2021), it was reported that a great cause of suffering was the impossibility to mourn together with others: sometimes the feeling was that the lack of body contact and hugs blocked the physical experience of grieving, hampering, for instance, to important aspect of cry altogether. Furthermore, families may also have experienced social stigma regarding COVID-19 losses (Albuquerque et al., 2021) that made them feel even more abandoned and lonely and unable to reach for social support from a distance and imposed setting.

EMOTIONS HIGHLIGHTED IN COVID-19 BEREAVEMENT

As we have seen, the lack of goodbye, the uncertainty surrounding the deaths, together with the physical isolation that impacts the farewell and the grieving processes, suggest that people may have difficulties in finding closure for grief. The above-mentioned specific circumstances of the losses, such as the rapid and unexpected character of the dead, a lack of clear understanding of how the loved ones died, and the unseen body, made the departure similar to **ambiguous loss**: as said, in a suggestive way, by a mourning family member interviewed in Madrid (Fernández & González-González, 2020), "I felt like it was a kind of kidnapping". Indeed, as it happens in the case of the disappeared, about whom there will never be the absolute certainty of their death, bereaved people during COVID-19 may have difficulties to believe that their loved one is dead, since uncertainty, suddenness, unpredictability, and no rituals, make their loss ambiguous as well (Bertuccio & Runion, 2020; Fernández & González-González, 2020; Testoni et al., 2021).

Others refer to this kind of loss as a **disenfranchised grief** (Albuquerque et al., 2021; Kaur et al., 2022; Kokou-Kpolou et al., 2020), as a not recognized or legitimated pain, which was not acknowledged and socially validated by others due to the isolation and lack of social support in the aftermath of the death. Others explain the bereavement in terms of **traumatic grief**, where the traumatic circumstances of the death, as well as the fear for the loss of others and their own life, complicates the bereavement experience. For example, the qualitative studies from the Southern Europe context, based on the narratives of the bereaved, highlight how often the narratives presented typical traumatic traits which freezed the mourning process and complicates the responds (e.g. Cipolletta et al., 2021; Hernández-Fernández & Meneses-Falcón, 2021; Menichetti-Delor et al., 2021; Mortazavi et al., 2021; Picardi et al., 2021; Testoni et al., 2021).

Overall, the specific circumstances of the loss appear to have amplified negative emotions such as anger, guilt, and sadness, very frequent in the accounts of bereaved individuals in the context of COVID-19 (Albuquerque et al., 2021; Chopra & Arora, 2020).

ANGER.

Anger was one of the main reactions to the loss and it may be connected to a series of circumstances characterizing COVID-19 scenario (Cipolletta et al., 2022). Bereaved refer to an intense feeling of being abandoned by the health workers, unable to offer clear communication on what happened to the deceased and to provide care and a compassionate attitude toward the patients. They describe a feeling of being simply a number when communicating with the health authorities as well as in the ways of treating the body, creating a sense of dehumanization. Someone blamed the doctors for having misdiagnosed the patient, suggested hospitalization or having provided improper care. The complaint is expressed also toward the health administration who were unable to provide timely recovery. Anger is also directed at the government, unable to contain the spread of infections and manage the health emergency (Marinaci et al., 2021).

DISBELIEF AND CONSTANT RUMINATION.

Disbelief came with losses during COVID-19, that is the feeling that 'I cannot believe they are dead' (Hernández-Fernández & Meneses-Falcón, 2021). The sudden character of death, the imposed lack of contact with the person right before the passing and the lack of a farewell ritual with the body have formed a complex set of circumstances enhancing ambiguity (Imber-Black, 2020) and hampering the rationalization of the loss. Rumination relates to questions such as 'what went wrong', 'whether all the possible was made to save the loved one', 'what they felt and thought while facing dying alone' (Testoni et al., 2021).

GUILT.

Guilt reported by bereaved people (Albuquerque et al., 2021; Cipolletta et al., 2022; Mencacci & Salvi, 2021; Testoni et al., 2021) is related to not being by the loved one's side, thus, to not being able to offer help and emotional comfort and feeling as having abandoned the loved one. In some cases, guilt may emerge from the regret for having underestimated the virus' lethality or the fear/confirmation of having personally infected the deceased.

SHAME.

The stigma of possible contagion surrounding a COVID-related death drives people to hide the illness of their loved ones or the cause of death to avoid discrimination; as a result, the possibility to receive social and practical support was further impaired (Albuquerque et al., 2021).

ANXIETY, DISTRESS, AND COPING STRATEGIES.

At a general level, the pandemic seems to have challenged emotion regulation strategies, posing a high risk of developing psychosocial distress (Di Blasi et al., 2021). Difficulties with regulating emotional distress have been related to managing the uncertainties due to their fear of COVID-19 which, jointly, enhanced the risk of psychological distress (anxiety, depression, and stress) (Gullo et al., 2022). More specifically, it has been argued that the presence of pandemic-related stressors, such as social distancing and constraints in the availability of and access to a social network, makes it harder for individuals to implement adequate coping strategies to deal with the loss, with the consequence of higher levels of psychological distress and poorer mental health outcomes (Fisher et al., 2022). Anger, denial, guilt/blame, shame, as well as depression and anxiety, are all feelings of grief that typically come with every loss, including actual deaths (Buglass, 2010). It can be assumed that such feelings have been experienced more intensively in the context of COVID-19 pandemic.

Implications for interventions

From the above, some implications for therapeutic interventions may be drawn. In addition to more general grief intervention, a specific awareness should be focused on the meaning attached by each individual to the following aspects: Not being able to say goodbye; the unknown character of the death and the lack of social support, which may require specific attention in therapy.

As an example of how this type of intervention has been approached, it is helpful to look at the qualitative study by Menichetti-Delor et al. (2021) for inspiration. This study focused on bereavement follow-up calls offered by a clinical psychology unit to families of COVID-19 patients who died at the hospital. The following needs expressed by the families during the calls were identified. First, the need *to give meaning* to what happened in order "to put the pieces together". Meaning-making is a central process in healing in response to the trauma of both death and non-death losses and involves a struggle to understand what has been lost and how to build new lives (Neimeyer & Sands, 2011). To this aim, it is determinant for bereaved to share and narrate their loss, so that the recounting of one's experience may facilitate the search for meaning and coherence in such experience (Neimeyer et al., 2010). Second, the need to *express emotions* (such as sadness, anxiety, anger, but also emotional anesthesia) was frequently reported. Such a process was made difficult by the isolation and, thus, by the absence of relational containers. Third, the need *to say the last goodbye* and searching for alternative ways to accompany the loss and the grieving when a traditional funeral couldn't be organized (e.g. lighting a candle, holding a ceremony outdoor, or collecting songs, photos, and stories linked to the deceased and/or also digital experiences as for example online memorials; see for instance the

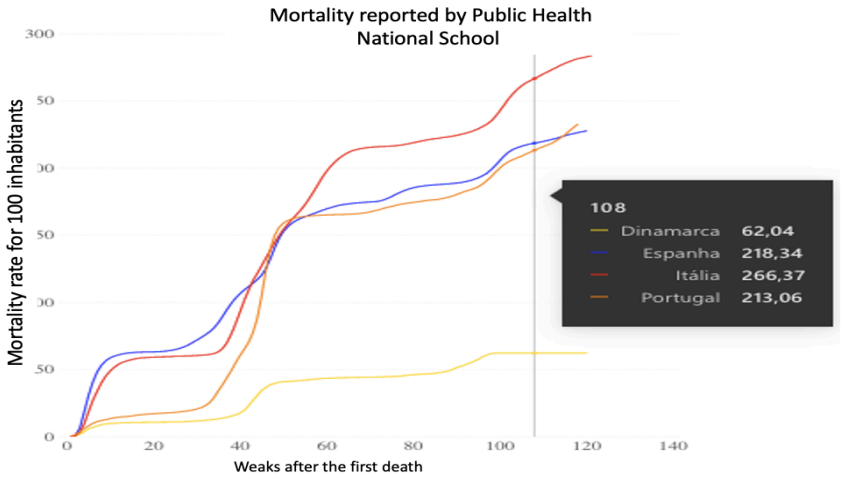
Coronavirus Memorial promoted by the Spanish national broadcaster *Radio Televisión Española:* rtve.es/coronavirus/memorial). The fourth main need identified was *to remember* the deceased together with other family members and to share with them memories of the past. Again, such a process was hampered by the isolation due to COVID-19 leading the family members to experience a solitary grief.

This offers an example on how to address the specific aspects, that have shaped bereavement under the COVID-19 pandemic. This will be further elaborated on in the intervention sections below.

CULTURAL CONTEXT

The distinct COVID-19 situations in European countries in terms of direct deaths, justify accurate intervention and motivated the development of this strategic Partnership for Cooperation between four countries. While Portugal, Spain and Italy have had more than 280 deaths per 100.000 inhabitants, Denmark has experienced less than 65 deaths. In the following section, we outline the overall scope, trends and target groups impacted in each context.

Figure 1 – Comparative Covid-19 Situation among the partnerships countries from AURORA Project



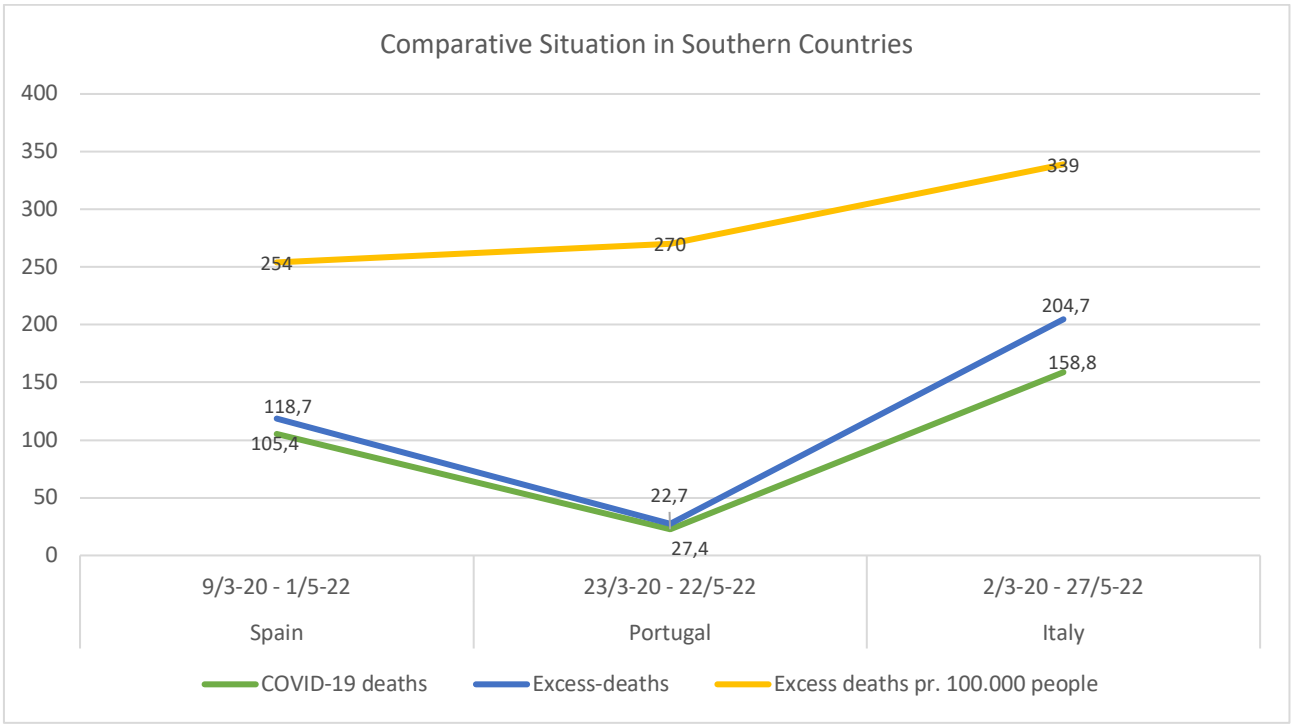
Source: https://barometro-covid-19.ensp.unl.pt/epidemiologia-da-covid-19/letalidade-e-mortalidade-entre-paises/

Many of the restrictions imposed to mitigate the COVID-19 pandemic conflicted with the collective, cultural practices and responses provided in moments of death and end-of-life situations, as also described above. The COVID-19 restrictions add to the risks of developing complicated grief reactions following a loss, and it is expected that they will impact the mental health of bereaved people (Stroebe & Schut, 2021).

In order to provide an overall comparative perspective across the below national COVID-19 data, we refer to the most recent global overview in an Economist article “Tracking COVID-19 death across countries”; with a

focus on the excess deaths and not on death tolls as they undercount the total number of fatalities, thus providing an overview of the real impact in terms of lives lost caused by the pandemic.[1]

Figure 2 - *Excess death per country*



Source: ec.europa.eu/eurostat/statistics-explained

Based on Portuguese research and the statistical model (Albuquerque et al., 2021; Carvalheiro et al., 2021) that calculates nine bereaved people per death (Albuquerque et al., 2021; Carvalheiro et al., 2021), the approximate number of bereaved during the COVID-19 pandemic in the three countries are the following:

Figure 3 - *Approximate number of bereaved*

Country	Population total 01/2020	Excess-deaths	Approx. total of bereaved
Spain	47,332,60	118,740	1,068,660
Portugal	10,295,90	27,440	246,960
Italy	59,641,50	204,710	1,842.390

Source: ec.europa.eu/eurostat/statistics-explained

[1] "Tracking covid-19 excess deaths across countries: In many parts of the world, official death tolls undercount the total number of fatalities", The Economist Oct 20th 2021 (Updated May 13th 2022), HTTPS://WWW.ECONOMIST.COM/GRAPHIC-DETAIL/CORONAVIRUS-EXCESS-DEATHS-TRACKER

Italy

Demographics of COVID-19 in the Italian context

Italy was the second country in the world, after China, to be hit by the COVID-19 pandemic and to experience a dramatic, record number of COVID-19 fatalities. Italy has suffered a total number of 183 138 COVID-19 deaths according to the **WHO Coronavirus (COVID-19) Dashboard**[1] (December, 2022). The procession of army trucks that drive through the city of Bergamo[2] transporting bodies from hospitals probably remains among the most eloquent and symbolic image of the loss, grief and pain lived during the Italian COVID-19 experience, that also became an image of the fear felt globally.

Photo: Procession of army vans transporting dead bodies in Bergamo

The elderly population was the age-group most affected by COVID-19 fatalities, with an average age of 80 years (43.6% women, 56,4% men) (Istituto Superiore di Sanità, 2021a; Polidori et al., 2020). Nursing homes experienced most outbreaks with a high mortality rate, especially at the onset of the pandemic. A total of 9154 residents in nursing homes died from 1 February to 5 May 2020 according to data from a national survey initiated by the Minister of Health (Gnasso et al., 2022).

The under-50 age group is next with 1743 deceased COVID-19 positives, including 440 women under 40 (273 men and 167 women aged 0-39) (Istituto Superiore di Sanità, 2021b). As high as 82.3% of deaths occurred in hospitals with nearly 500 deaths recorded among healthcare professionals (Istituto Superiore di Sanità, 2021b).[3] Mainly at the beginning, but also throughout the pandemic, there was a lack of health care staff, intensive care units and personal protective equipment. This happened within a health system already

[2] A city of Northern Italy, the geographical area first affected.

[3] Deaths among health care professionals between February 2020 and ??? [add here the time frame?]: 216 general practitioners, emergency care physicians, medical guards, outpatient specialists, private physicians, 30 dentists and more than 90 nurses. (Istituto Superiore di Sanità, 2021b).

suffering from a lack of resources. The psychological impact on the health care profession directly involved in the COVID-19 response still remains to be uncovered and addressed.

Although, there are no studies in Italy on the number and characteristics of the bereaved during the COVID-19 pandemic, it is likely that the high incidence among the elderly population has left mainly elderly spouses, adult children and grandchildren bereaved.

Families of the hospitalized patients were deprived of caring for their sick relatives, of being present during the time of death, of seeing and taking care of the body of their deceased relative and of performing catholic funeral rites or other ceremonies. All of these exceptional conditions - often put together or multiplied due to more losses in the same family – fostered very strong emotional and psychological impact (Menichetti-Delor et al., 2021; Alberto Vito, 2021). Read more in the sections above.

Bereavement care – pre and post COVID-19

Pre and post COVID-19 emotional and practical grief support is generally provided by the family and network of friends in Italy. In part due to cultural constraints related to the image of the psychologist profession, it is generally not very common in Italy to seek professional help for grief reactions. There is no nationally coordinated bereavement care response nor national guidelines for psychologists, and the scientific focus on grief and bereavement is relatively limited.

Several voluntary associations, pre and post COVID-19, exist to support the bereaved through mutual self-help groups distributed throughout the national territory. They represent a valuable possibility to share emotions, promoting self-efficacy, avoiding social withdrawal, and fostering meaning-making (Cipolletta et al., 2022), but they do not have the expertise/skills to provide an intervention response to help bereaved individuals at risk or with complicated grief reactions.

The pandemic gave rise to several, but local, initiatives to support people to cope with the general psychological impact of COVID-19. Free services of psychological support reachable online or by phone were offered by individual psychologists in private practice, professional associations, and academic psychological services (e.g. Parolin et al., 2021), of which many are no longer active. The actions taken during the pandemic seemed to be short, fragmented, locally organized, and not specifically focused on bereavement.
The COVID-19 ordeal has not brought significant change to bereavement care nor lead to a strategy at the national level. Little attention is also paid to the psychological impact following the physical distancing measures. This is the current situation despite the scale, impact and exceptional conditions of COVID-19 in Italy, and despite the fact that professionals recognize a general need for more systematic bereavement care in the aftermath of COVID-19 (Costantini et al., 2020).

Thus, at the forefront remains the need for a nationally coordinated bereavement strategy in conjunction with a professional response to bereavement care following the COVID-19 pandemic in Italy.

Portugal

Demographics of COVID-19 in the Portuguese context

Portugal has suffered a total number of 25.714 COVID-19 deaths according to the **WHO Coronavirus (COVID-19) Dashboard** (December, 2022), mostly men (52,6%, and 47,4% women). The elderly people were the most affected by the disease and the death toll was highest among people in their 80's.

Bereavement care - pre and post COVID-19

Prior to 2019 in Portugal, as is the case in many countries in Europe, there was a lack of an integrated public health response to attend to bereaved people and also an absence of volunteer structures to (in)formally assist and provide support to bereaved people to bridge the health care gaps and promote a more compassionate society.

In 2019, the Portuguese government represented by the Health Director Department, proposed and passed important legislation to the effect of the "Implementation of the Differentiated Intervention Model for Prolonged Grief Disorders". This entitles bereaved people who suffer from prolonged grief disorder the right and access to needs-based bereavement care to be identified and implemented by health care professionals in the National Health Service. This represents the Portuguese adoption of WHO's formal inclusion of "prolonged grief disorder" in the 11th revision of the ICD-11 International Classification of Diseases.

Five national institutions were assigned as reference centers to provide specialized care for bereaved people with complicated grief reactions. Furthermore, the clinicians were given tools of assessment and guidelines for the adequate intervention to be granted. Despite this national improvement of service provision, this framework was prior to COVID-19 and was not yet being adequately implemented in the public health system due to a lack of human resources in these pilot units.

In addition, around 60% of the Portuguese palliative care teams offer a formally structured grief support program to the family caregivers who have lost a family member (Carvalheiro et al., 2021).

However, the fundamental problem of clinical psychology subsidized by public budgets remains - also post COVID-19 - in the limited availability of clinical psychologists in the public system (5.14/100.000 inhabitants, ten times lower than the Danish system – and the consequent delays in referral (1-9 month depending on the province).

COVID-19 brought an unimaginable and abrupt change to standard practices in the health care system. Despite all the constraints and limitations imposed by COVID-19, the community at large became more alert and sensitive to the importance of mental health, but also more attentive to the importance of care and assistance to the bereaved, and many of the professionals have been able to reinvent themselves and think of creative ways to overcome these obstacles.

One example of creative re-invention and coming together as a united profession of clinical psychologists was the introduction of the psychological emergency hotline, created as a COVID-19 response by the National Health System with the collaboration of the OPP - Portuguese Association of Psychologists. This board has also developed many guidelines and important materials for the intervention of psychologist in different contexts, and also a brief Guideline to address the grief and bereavement particularities in the pandemic context https://www.ordemdospsicologos.pt/ficheiros/documentos/covid_19_luto.pdf

Nevertheless, and not least given the high number of newly bereaved, there is a need for the education and training of more professionals to be able to respond to this high and huge post-pandemic demand.

Data on COVID-19 bereavement

An online study conducted among the general adult population with 929 participants (Aguiar et al., 2020) stated that 17,9% have lost a loved one since the beginning of the pandemic, and the impact on their mental health is shown by the prevalence of 30,7% of clinical anxiety symptoms, 10,2% of depressive symptoms, and 16,8% with high score on the prolonged grief scale.

The preliminary results of the Portuguese bereaved sample of the "Grief and Bereavement in face of COVID-19 Pandemic: Transnational Study on its impact on well-being" (Barbosa et al., 2022), reporting an online data collection on the period between January and October 2021, with a total of 127 bereaved participants , also point to similar indicators.[4] Data on the **mental health of the bereaved** participants are as follows: **75.6% present clinically significant scores of anxious symptomatology** (of these 59.1% at a mild to moderate level and 16.5% with severe symptomatology). **30.5%** of the participants present clinically significant symptomatology **reactions of post-traumatic stress.** As for depression, **66.9% show clinically significant levels of depressive symptomatology** (47.6% mild to moderate and 19.3% severe to severe). Finally, the data on complicated grief reactions, **23.8%** of the bereaved manifest symptomatology indicative of the onset of a possible prolonged grief disorder. Despite the bias of the data collection (exclusive online) and also the timing of the collection during the pandemic, these numbers are indicative of how we must be prepared to address the difficult times we are facing ahead.

Spain

The Impact of COVID-19 in the Spanish context

According to data from **WHO Coronavirus (COVID-19) Dashboard**, 116.658 people died in Spain due to COVID-19, from March 2020 to December 2022.

As was the case in Italy and Portugal, also in Spain the elderly age group were most severely impacted by COVID-19 mortality and data during the first and worst wave reveal increments of 55.4% of death rates among 65-74-year-old people, and 75.9% increase among the 74-year-olds.

Grief in a Spanish context pre and post COVID-19

COVID-19 brought the obligation of solitude in grief, in a Spanish society that especially values social support from close friends and family members (Fernández & González-González, 2020). Health professionals were especially impacted by traumatic grief processes (Gilart et al., 2021).

There has been no professional assessment of the need for therapeutic bereavement interventions for bereaved with complicated grief reactions in Spain, but there have been some adjustments from Health Public Institutions and Private Societies to deal with those needs.

The public response to loss and grief after COVID-19 continues to be supported by primary care, in which the physician focuses primarily on symptoms of anxiety and depression, rarely using the diagnostic criteria of

[4]Respondents are mostly women (83.6%) with an average age of 31 years. The average age of the deceased family member was 71.8 years, and the main causes of death were: cardiorespiratory diseases: 19.5%; oncologic disease 36.7%, and COVID-19 disease: 10.2%. Only 10% of the participants admit not having participated in the funeral rituals of their loved one.

complicated or prolonged grief. The prescription of psychoactive drugs (i.e., anxiolytics and/or antidepressants), and less frequently, the referral to clinical psychology are the main response.

The fundamental problem of clinical psychology subsidized by public budgets lies in the limited availability of clinical psychologists in the public system (5.14/100.000 inhabitants, ten times lower than the Danish system[3]), and the consequent delays in referral (1-9 month depending on the province).

Although there has not been a fundamental change in the overall bereavement care response post-Covid, there has been a significant increase in the presence of clinical psychologists in some regions of Spain. During the first year of the pandemic, grief and bereavement received special attention. For example, the Official Association of Psychology in Spain, offered several editions of training courses to work on grief[5].

The Official Colleges of Psychology have made different resources available to society to deal with the discomfort and grief created by the pandemic guides to be disseminated for the general public and some professionals (e.g.https://www.copmadrid.org/web/files/comunicacion/GUIA%20Duelo.pdf).[5]

The Spanish Ministry of Health created a working group of people with different backgrounds: psychologists, family medicine and community health specialists and medical specialists in preventive medicine and public health, as well as specialists in bioethics and grief management who treated people who had just lost loved ones to COVID-19. As a result, some infographics were disseminated to help the population to deal with the loss of a loved one[6].

The Ministry of Health and the General Council of Psychologists offered a helpline for relatives of people ill or deceased as a result of the coronavirus. The Red Cross also created a service ("Cruz Roja te escucha"), to offer support and psychosocial accompaniment, particularly to relatives and friends of people who were very seriously ill or died from the disease caused by COVID-19. An important proportion of the response to the needs of people in Grief came from Charities such as “Fundación Mario Losantos del Campo[7]” or “Centro de Humanización de la Salud[8]”.

Despite the efforts that were made to address the needs of bereaved in this unprecedent times, in all these southern countries much more needs to be done.

3.GRIEF THEORY, GRIEF REACTIONS AND LEVELS OF SUPPORT

The purpose of this brief introduction to the field of grief and bereavement research is to offer basic knowledge of the key theoretical explanatory models and theories that have helped to shape or represent the current understanding of grief and intervention.

GRIEF THEORY: A BRIEF OVERVIEW

Over the last hundred years, there have been fundamental changes in the psychological-scientific understanding of grief. This has important implications for the development of contemporary grief treatment. This manual presents an overall and therefore simplified picture of the development of grief understanding (for a fuller theoretical account, see for example Stroebe et al., 2001).

Since the early 1900s, the most crucial psychological models of grief have consisted first of the psychoanalytic grief work hypothesis, then of the phase theories of grief and the task theories of grief from the late 1960s to the late 1980s. The 1990s saw a paradigm shift in grief understanding and intervention research with the Continuing Bonds Model and the Dual Process Model of Coping with Bereavement. These explanatory models have offered different theoretical ways of understanding grief, thereby not offering one unified theoretical explanation, nor are they all empirically supported (Guldin, 2010; 2019). The field has been the subject of significant academic discussions on how to understand grief.

Classical understanding: about separation from the deceased

Detachment was the central keyword in classical psychoanalytic understanding of grief (Freud, 1913). Sigmund Freud's understanding of grief was based on his theory of operationalism and economizing with 'energy'. According to this model of grief, it was thought that the energy of the mourner was tied to a loved object that no longer existed - but that the mourner had to release energy to live on by separating, detaching and freeing his or her feelings, memories and expectations from the lost one. This theoretical understanding of the psyche led to the therapeutic approach of catharsis - confronting emotions as a necessity to resolve grief - that dominated grief understanding for decades (Freud, 1917; Guldin, 2019; Klass & Steffen, 2018). This approach has been met with considerable criticism: empirical studies of the grief work hypothesis have failed to find evidence that confronting the emotions of grief is necessary to recovery (Archer, 2008 in Guldin, 2019). As grief consists of multiple problems, this understanding and methodology of grief becomes too one-sided. The focus of the grief work hypothesis on detachment and separation from the deceased through confronting the emotions of grief has changed radically in the past three decades.

Grief as phases and tasks

From the 1960s came a series of psycho-dynamically grounded theories about the stages and tasks of grief, called stage theory and task theory. Stage theories include John Bowlby's grief phase theory (Bowlby, 1980), Elisabeth Kübler-Ross's five stages (Kübler-Ross, 2006), Johan Cullberg's four phases (Cullberg, 2008), and James William Worden's task model (Worden, 2018). The understanding of Freud's model of detachment and catharsis lies just behind the phase and task models, which basically consider that grief requires working through emotions and towards a reorganization of the relationship detachment from. As in the stage theories, the tasks are based on an understanding of grief as an internal process in which the bereaved must actively confront and process the emotions of grief through a series of tasks, in order to detach from and adjust to life without the deceased (Guldin, 2019; Mogensen & Engelbrekt, 2013; Stroebe et al., 2001).

Probably the most significant grief phase theory is Bowlby's model, which is based on attachment theory (Bowlby, 1969; 1973; 1980). Attachment theory is strongly empirically grounded in observational studies of the bond between young children and their mothers as well as patterns in grieving. Bowlby (1980) described four phases in the course of grief (shock & numbness, longing & searching, disorganization, and reorganization) that as an individual process reflect changes in everyday life after the loss. According to Bowlby, the goal of the mourner's work is a reorganization of the attachment to the lost. That is, the inner working models of self/other that the loss has shaken are altered in a way that the mourner remains attached to the deceased, while the bereaved begins to turn to the altered everyday life. Bowlby thus further develops the grief-work hypothesis's idea of detachment, which is no longer the end goal but something the mourner relates to in the process of reorganizing inner working models and attachments to the lost (Bowlby, 1980).

The critique of the phase and task models is primarily directed against the understanding of grief that has become the field's overriding legacy since Freud, namely the requirement for confrontation and active working through/releasing of emotions in order to detach from the deceased. According to Archer (2008), the phase and task models have limited empirical support (Archer, 2008), and Guldin (2010, 2019) points out that there is no evidence that 'confronting loss through redemptive grief tasks promotes adjustment in all bereaved. It is thus a problem for the field of grief that it is debatable whether and when 'working through with a view to detachment' is conducive to a grieving process (Guldin, 2010; 2019).

Phase and task models are also criticized for being too schematic in their view of the mourner, too rigid in their clinical recommendations for grief processes and grief therapy, and too narrow in their etiological understanding of complex grief reactions. Not all bereaved go through the stages and tasks in the suggested order. Grief cannot always be empirically described and observed in terms of particular stages or on the basis of particular theoretical assumptions that, for example, there must be 'a particular acceptance' or working through of the loss. Finally, models do not account for cultural differences in grief (Guldin, 2019; Klass & Steffen, 2018; Stroebe et al., 2001).

The importance of attachment theory for understanding grief

Bowlby's attachment and grief phase theories (Bowlby, 1969; 1973; 1980), as described above, have had a major impact on the general understanding of grief. According to Bowlby, attachment consists of the human tendency to form close, enduring emotional bonds with particular persons who can provide protection, security, comfort and peace (Bowlby, 1988; Broberg et al., 2008). When the bond with such a particularly important attachment figure is broken in the context of a death, it can have a major impact on the person left behind.

Bowlby emphasized that the four stages in his theory of grief follow an individual process, the order of which depends on the individual (Bowlby, 1980). However, to move well through grief, the internal representations of the lost other, of the bereaved self and the bond between them must be reorganized. This means that the attachment to the deceased must be transformed and adapted to the new reality in which the physical presence of the lost one no longer exists. It is therefore not detachment, but reorganization of the relationship with the deceased.

Attachment theory has helped to turn the field's understanding towards seeing grief as unique in the light of the relationship with the one lost as well as in the light of the quality of the relationship, i.e. the theory contributes to the understanding of the expression of grief in relation to the meaning of the one lost for the

individual. In this way, Bowlby also develops a particular view of the impact that can be had when the quality of the relationship with the deceased is not optimal.

Continuing Bonds: on maintaining the emotional bond

Recent understanding of grief follows the paradigm shift of the Continuing Bonds (CB) model (Klass et al., 1996; Klass & Steffen, 2018) and the Two-Process Model of Coping with Bereavement (Stroebe & Schut, 1999). In the CB model, grief is seen as a lifelong process in which the connection to the lost is maintained and becomes part of the inner life of the bereaved, i.e. the relationship is internalized. The theory became a rebellion against the grief field's interpretation of Freud's idea of separation from the dead as necessary. According to this theory, the bereaved does not need to disengage, but simply reshape the attachment to the deceased. One maintains the emotional bond with the one lost in order to integrate it into one's personal life narrative and consciousness and take the meaning of the relationship with one's life. This can be done, for example, through inner dialogues, memories, visualizations and personal rituals. In this way, a living inner connection with the deceased helps to facilitate grief and adjust to the loss (Guldin, 2019).

The theory emerged as a result of both clinicians and researchers beginning to notice that bereaved people who maintained an inner, perhaps spiritual, contact with the lost did not develop complicated grief reactions. Across research groups, a series of concurrent findings showed positive links between maintaining a continuing bond with the lost and better social adjustment to loss in bereaved people. From there, the CB model evolved as a counter-reaction that overcame decades of advocating for the need to detach and disengage from the attachment to the person one has lost. The theory is inclusive, broad and strives not to simplify grief processes or the specific ways in which people work with grief (Klass et al., 1996; Klass & Steffen, 2018).

Two decades after the new understanding of grief broke through, Klass and Steffen (2018) in a new publication on directions for future grief research and intervention argue that the bond with the lost is intersubjective: that grief is a relationship between the bereaved and the lost that is both present and absent. Missing and longing is itself a relationship with the one who used to be there. Thus, grief is seen as a situated and communicative activity, where grief therapy can provide access to the background history of the relationship, enabling the mourner to restore attachment and reconstruct a 'world' whose meaningfulness is challenged by grief. In therapeutic work, the bereaved must create and integrate a balanced inner representation of the emotional bond with the lost, which can result in individual ways of having the lost loved one with them. It is a clinical task to assess when the bereaved's relationship with the lost is appropriate and when it is not, but as long as maintaining the emotional bond seems helpful to the bereaved, leads to adjustment and does not complicate the grief, one is on the right path (Klass et al., 1996; Klass & Steffen, 2018).

The theory has been the subject of extensive research (see more in Klass et al., 1996; Klass & Steffen 2018) and the maintenance of the emotional bond undoubtedly plays an important role in the grieving process.

The Dual-Process-Model

The Dual-Process-Model of Coping with Bereavement identified two critical processes, or stressors, associated with loss: the loss-oriented process and the recovery-oriented process. Stroebe and Schut (1999) argued for a crucially important, dynamic and regulatory oscillation between the two processes. Thus, according to the model, appropriate, adapted grief-coping consists of the bereaved, alternately and in doses, facing the reality of loss and difficult emotions, and at other times postponing, avoiding and distracting

themselves from grief, in order to concentrate instead on the tasks of re-establishing life without the lost one. Similarly, the model perceives pathological ways of grieving, for example the absence of balanced oscillation between avoidance and confrontation or involuntary intrusion as a result of a traumatic loss, as a disturbance in the pendulation process (Stroebe & Schut, 1999). According to Guldin (2019) the Dual-Process Model emphasizes that grief is an individual, dynamic and adaptive process that is in constant movement within the person and in relation to the outside world. Thus, external circumstances influence the grief process inwardly, just as internal cognitive processes modulate grief outwardly.

The bereaved must be able to alternate and flexibly switch between the two processes, which are regarded as equivalent. How much is going on in one process compared to the other is individual and dependent on the specific loss, and this possibility for nuanced, individual grief understandings is the model's great strength. In the process of loss, bereaved people are distracted from the restorative and relate emotionally and cognitively to the recognition of the irreversible relational loss. This can be with reactions such as longing, meaninglessness, despair, acceptance of finitude and reshaping the attachment to and meaning of the deceased in the inner representation. In the restorative process, the painful emotions are paused, and the bereaved person relates in a problem-focused way to concrete life changes and functional aspects of the loss, for example, learning new skills in relation to tasks the lost person previously took care of, changing roles, finding new confidants after the loss and creating closer ties with other loved ones. The ongoing meaning-making about the loss guides the bereaved understanding and coping with grief. The overall grieving process is directed at integrating the loss into the self-understanding, and when grief is complicated, it is understood in terms of the lack of oscillation between and activation of both processes. If the bereaved move only in one process, something will be neglected in the other process.

Contemporary stance: Meaning Reconstruction & Integration Models in a grieving context

Emerging literature seeks to incorporate the idiosyncratic nature of bereavement comprehension, with an emphasis on the meaning-making processes entailed in the experience of grief which may facilitate the possibility of posttraumatic growth after the loss has been integrated (Tedeshi & Calhoun, 2004). In this sense, Neimeyer (2000; 2001; 2022) based on a constructivist perspective, states that bereavement is an active process of meaning reconstruction that has been challenged by the loss. These models use several narrative, rituals, and expressive procedures/strategies to promote the retelling of the traumatic loss to foster the integration of the new identity of the survivor allowing, at the same time, that the bereaved personal story may move on (Neimeyer, 2022). The Meaning Reconstruction Therapy for Grief is a theoretically consistent constructivist therapy that integrates the contribution from the attachment theory, the continuing bonds, the dual process that is technically eclectic (see Neimeyer and Sands, 2022).

Alba Payàs and Adrian Chaurand (2019) proposed a specific intervention method in grief counseling through facilitating the continuing bonds with the deceased by favoring the activation of memories about the lost relationship. They start from an integrated process of reconstruction of meaning from which a new personal vision of the world emerges after the trauma. At the genesis of the model is the principle that relational memories awaken more balanced and less distressed states by defocusing the bereaved from intrusive thoughts related to the circumstances of death, emotional numbing, somatic activation and traumatic symptoms (Boelen & Huntjens, 2008). These overwhelming death-related memories should be addressed through specific trauma-oriented interventions to increase the client's self-regulation abilities (Shear et al., 2011). To design her integrative model of focusing on meaning reconstruction, the authors draw

from cognitivist models and social constructivist models, seeking for the bereaved to find meaning for their experiences of loss in search of the benefits to relocate the bereaved loss within a structured narrative that seeks to make the world predictable and coherent (Folkman, 2001; Janoff-Bulman, 2010), to accommodate the new meanings of change in their identity (Gillies & Neimeyer, 2006), to experience growth and transformation (Calhoun & Tedeschi, 2014), to maintain a sense of purpose in life, and to assign values to the experience of life after loss (Hershberger & Walsh, 1990). All these different theoretical viewpoints, underpin the model and operationalize into specific techniques useful for clinicians seeking to facilitate their client´s change process with their idiosyncratic experiences.

This brief overview on the conceptual evolution of the grief process and its respective models is not an exhaustive review of all the approaches and authors who have developed work in this field, however our choice intended to give voice to the approaches that mainly support the intervention we will present in further sections.

GRIEF IN PRACTICE: WHEN PEOPLE ARE AFFECTED BY GRIEF

After an introduction to past and contemporary understandings of grief and the theories behind them, we move a step closer to practice by shifting the focus to look at how grief can manifest itself, how natural grief reactions unfold, and what can happen when grief reactions become complicated and in need of specialized treatment.

Bereavement care model - levels of support & competences

We start by introducing what in more informal language is referred to as the 'Grief Pyramid' or 'Grief Triangle' depending on country. It is a model that illustrates needs-based, stepped bereavement care which is already being applied and promoted in some European organizations and countries.

The model is inspired by the evidence-based public health approach to bereavement care as advanced by NICE (2022), and applied to bereavement context by Aoun (2020), Aoun and others (2017; 2018; 2019). The four-tiered approach recognizes that while grief reactions vary from person to person, in general, bereavement care needs can be conceptualized as ranging from a need for basic information and support, through to additional support and guidance and to a high level of specialized care. A similar approach is currently being used by the European Association for Palliative Care (Guldin et al., 2015).

The bereavement organization in Dublin, the Irish Hospice Foundation has conducted a national dialogue and developed a complete national framework in the form of an adult bereavement pyramid that outlines needs, services and competences. As they state: "It places bereaved people's needs at the center and shows the appropriate support/services and competence required to meet basic through to complex bereavement needs".

The European network, Bereavement Network Europe has further expanded on the work of the Irish Hospice Foundation and has added a fourth and additional level of "society" to the grief pyramid in recognition of the importance of societal grief literacy, de-stigmatizing grief and policy work that need to be developed and implemented in the grief/bereavement arena. The base of the pyramid model identifies the importance of general public awareness, education and information about bereavement leading to a more compassionate society. For reference go to: https://bereavement.eu/

The four-tiered, needs-based model of bereavement care was promoted and applied as a structure around the first European Grief Conference hosted in Copenhagen in 2022 by the Danish National Center for Grief in Partnership with Bereavement Network Europe, Irish Hospice Foundation and Institute of Psychology of Aarhus University in the hope that this model in time could develop into a broadly accepted standard by bereavement practitioners, educators and policy makers etc. to appropriately assess and address bereavement needs, services and competences in Europe. For reference go to: https://egc2022.dk/

Figure 4 - *The grief pyramid presented at EGC*

This tiered approach to conceptualization of bereavement care needs, provides an effective structure for organizing and presenting information about bereavement intervention needs and resources. The grief pyramid terminology "all, some and few" also refers to research-based estimates of different bereavement needs. Read more on this in the following section about grief reactions.

Natural grief reactions

Grief is a natural, adaptive process. It is a necessary process of adjustment following the loss of a loved one with whom emotional ties have been formed. Empirical studies have shown that grief is complex and can manifest itself in a wide range of emotional, cognitive, behavioral and physical reactions, as well as existential thoughts. Examples of these are shown in Table 3.

Figure 5 - *Examples of common grief reactions*

Emotional reactions	Physical reactions	Behavioural reactions	Cognitive reactions	Existential aspects
Shock Longing Sadness Anger Guilt/relief Fear Anxiety Insecurity Numbness	Sleep problems Change in appetite Headaches Stomach ache Heart palpitations Physical restlessness Fatigue	Social isolation Dependency on others Avoidance Agitation Anxiety Hyper activity Ritualization	Difficulty concentrating Sensory disturbances Confusion Rumination Suicidal thoughts	Feelings of meaninglessness Identity loss and confusion Isolation Experience of injustice "why me?"

Source. Stroebe et al.(2001b) Guldin, 2019

In the immediate aftermath of a loss, it is natural that the acute grief is marked by strong emotions, including longing, sadness and loss. At the same time, people can experience a range of other emotions and reactions that may seem overwhelming and strange, but are typical responses to loss, such as anxiety, palpitations, and sensory disturbances. The experience of grief changes over time, i.e. the painful feelings and overwhelming reactions decrease in both intensity and duration. The bereaved begin to understand (and accept) the finality of the loss and to settle into the new life without the deceased. The bereaved also find a meaningful way to maintain the relationship with the deceased. It can be said that the bereaved individuals manage to integrate the loss and the deceased into their life. Most people would say that grief does not disappear, but that it changes and becomes integrated in a person's life story. About 80% of bereaved people experience such a natural and healing grief process (Bonanno & Malgaroli, 2020; Lenferink et al., 2020; Nielsen et al., 2019).

It's important to note, that the grieving process is expressed differently from person to person. The response will depend on personality, life history, cultural context, who one has lost and how one has lost.

Grief in the acute stage

The time immediately after a death is typically marked by intense emotions such as longing, sadness, emptiness, hopelessness, anger, etc. The intensity of these feelings can be alien to both the bereaved and those around them and therefore this experience can feel frightening and out of character. For some, acute grief feels as a violent and chaotic state of being perhaps best likened to a state of shock or crisis. Grief in the acute stage does not follow a certain pattern. Some will feel overwhelmed with emotions and others will be unable to feel anything due to the unfathomable loss they have endured (Dyregrov & Dyregrov, 2009).

Immediately after a death, there are often many simultaneous demands, tasks and considerations for people in mourning. It is a time where many decisions need to be taken and for some, it becomes a time where different emotional responses and interests need to be managed. When we as professionals meet people in the acute stage of grief, clients can feel overburdened and consumed by the practical task that the bereaved are required to manage.

SUPPORT RATHER THAN THERAPY IN THE ACUTE STAGE

Therapeutic intervention typically has a development goal in mind. A process that often requires the client to move into peripheral areas of the safe and familiar and where existing defense and coping mechanisms

and understandings are challenged. In acute grief, self-protection is needed in order to slowly approach and adapt to the unbearable new reality. Avoidance of the reality of the death as well as inaction towards understanding the finality of the loss are appropriate defense mechanisms in acute grief in order to prevent oneself from being overwhelmed. Therefore, the more confrontational aspect of grief intervention will be unhelpful at this stage of the grief process. Moreover, at this stage we don't know whether the bereaved is in a natural grieving process, which will be the case for about 80% of the bereaved (Bonanno et al., 2008; Lenferink et al., 2020). For bereaved with a natural grief reaction there is evidence of the importance of support rather than outright therapeutic intervention with confrontation and verbalization (Guldin, 2014).

Therefore, the main task when we as professionals meet bereaved in the acute stage, is that of support rather than therapeutic intervention. Bereaved can find themselves in a chaotic state of being, feeling out of themselves and in free fall. A professional can here be assisting the bereaved in finding back to a safer place. A way of doing this is by offering the following (Inspired by Dyregrov, 2011; Guldin, 2014):

1. Psychological first aid; sleep, eating, reducing additional stressors, who does what, etc.
2. Curious about the context and social support around the bereaved
3. Presence, compassion and care
4. Listening - not acting or fixing
5. The psychoeducational element and normalizing the experience

The bereaved in the acute stage of grief is often marked by a sense of unreality. It is a natural and healthy defense mechanism to require the loss and its implications to be understood gradually. For many it will simply be too overwhelming if everything has to be taken in at once and as a professional we need to work with this in mind.

During the first six months after the death, the range and intensity of emotions and reactions will slowly begin to find a more natural level. Grief changes gradually over time as the majority of bereaved slowly begins to understand, and accept, the finality of the loss (Bonanno et al., 2008).

Complicated grief reactions

However, not all bereaved people experience a healing grief process. About 10-20% experience what can be called complicated grief reactions, in which emotions and grief reactions do not subside but remain intense and debilitating (Bonanno et al., 2008; Lenferink et al., 2020). It is as if the bereaved person is trapped, and the grief response does not evolve and change over time. Based on the Dual-Process Model (DPM), this can be seen as an indication that the bereaved person does not oscillate between the two adjustment processes in an appropriate and adaptive way, but is primarily in one of the processes. As a result, grief does not enter in appropriate doses that would otherwise help with acceptance and integration of the loss, but instead the bereaved is overwhelmed by emotions (remains exclusively in the loss-oriented process) or has completely shut off grief and other emotions (remains exclusively in the rehabilitative process).

A complicated grief process can contribute to poor well-being, impaired functioning and social/relational problems, as well as psychological disorders such as prolonged grief, depression and PTSD (Lenferink et al., 2020; Zisook et al., 2014).

Risk and protective factors

There are factors that can increase the risk of complicated grief reactions (Guldin, 2018; Thomas et al., 2014; (see Table 4). First, bereaved people may have individual vulnerabilities, for example an insecure attachment style, mental illness, poor self-esteem, previous loss or childhood neglect. In addition, it may matter if the

relationship with the deceased was conflictual or highly dependent. The circumstances of the death may also play a role, for example if the loss was sudden and unpredictable or traumatic (accident, suicide or homicide). There may also have been a long and grueling course of illness, with the survivor, for example, taking on extensive care responsibilities. Finally, major social changes and network support (or lack thereof) are an important factor after the loss (Boelen et al., 2006; Burke & Neimeyer, 2013; Larsen et al., 2018).

Figure 6 - *Examples of risk factors for the development of complicated grief*

Pre-loss factors	Loss-related factors	Post-loss factors
• Gender Men: higher risk of suicidal behaviour after loss. Women: higher risk of developing depression and other mental illness after loss • Age: Younger adults and older people are generally at higher risk • Previous mental illness • Previous significant loss, trauma or neglect • High level of grief symptoms before death • Other concurrent losses or stressors	• Very close relationship with the deceased (e.g. child, spouse) • Quality of the relationship: relationship was important for the well-being and functioning of the bereaved, involved a degree of dependency • When the loss was experienced as traumatic • Suicide, murder, accidents • When the reaction to the loss was violent, with high arousal, fear or avoidance • After high burden of care, for example towards ill partner or parent	• High vulnerability • Lack of self-efficacy • High level of grief symptoms at 6 months after the loss • Experience of lack of support from others • Emotional loneliness after the loss • Other concurrent stressful events

Source. Guldin (2018); Thomas et al. (2014)

Fortunately, there are also protective factors. Research suggests that a secure attachment style, the experience of having a supportive network, and seeking out and being receptive to support can be protective (Heeke et al., 2017; Levi-Belz & Lev-Ari, 2019). In addition, studies show that if the dying person and their family received palliative care/support (for example, in hospice), this can be protective (Levi-Belz & Lev-Ari, 2019; Mason et al., 2020). Similarly, coping strategies that focus on problem solving and include active planning of positive/relaxing activities, as well as coping with a spiritual purpose, may be helpful in preventing a complicated bereavement process (Parro-Jiménez et al., 2021).

Grief requiring specialized treatment

For the 10-20% of bereaved adults who experience a more complicated, persistent and debilitating course of grief, there are serious and long-lasting negative consequences for the bereaved's overall quality of life, well-being and functioning (Shear, 2015; Stroebe et al., 2007). Bereaved in this group may need psychotherapy to unblock the factors that inhibit the natural and healing process of grief (Boelen et al., 2007; Shear, 2017). Prolonged grief disorder (Killikelly & Maercker, 2017) is an example of a grief reaction, but there are other types of grief requiring treatment. These include disorders such as depression, anxiety and post-traumatic stress disorder. The loss of a loved one can also cause an existential crisis so strong that people lose their courage to live and need help. For bereaved with these grief reactions, a safe and meaningful life seems out of reach (Neimeyer et al., 2010). Some bereaved people exhibit inappropriate cognitive and behavioral patterns that tend to keep the bereaved person in grief, for example in the form of thoughts that constantly revolve around the deceased, or behavioral avoidance of anything that reminds the bereaved of the reality

of the loss (Boelen et al., 2007). It is not possible to demonstrate whether these mechanisms cause or maintain a stuck grieving process. However, they seem to be associated with emotional overwhelm, difficulty in problem solving and in making sense of the loss and of life afterwards. As discussed above, it is not always the event itself - the death - that determines whether grief becomes treatment demanding.

Despite the huge discussion in the last 40 years about the pathologizing of love and grieving processes, the WHO and the APA (American Psychiatric Association) have recently included in their respective (ICD-11[8] and DSM-5-TR[9]) health treatises Prolonged Grief Disorder as a new clinical condition (Boelen & Lenferink, 2022; Prigerson et al., 2021). Independently of the discussion, and since this condition is now represented in the respective textbooks that are part of the basic training of psychologists, we will refer to the respective diagnostic criteria in appendix 2, as well as provide the sources for further consultation. Furthermore, as stated before, this training manual focuses more in a preventive role of psychologists dealing with complicated grief reactions more than in a remediated context to treat this new condition where specialized psychologists must act, assuming that psychologists are already familiarized.

[8] https://www.psychiatry.org/patients-families/prolonged-grief-disorder

[9] https://icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/1183832314

4.THERAPEUTIC CONSIDERATIONS AND PROPOSALS

Psychotherapy research has shown that the client, the therapist, their relationship, and the treatment method and context all contribute to effective treatment (Norcross & Lambert, 2019). In this section, we focus on the therapeutic alliance between the client and the psychologist, and the therapeutic stance of the psychologist.

Alliance

The therapeutic alliance consists of three parts: 1) agreement on the therapeutic goals, 2) consensus on the therapeutic tasks, and 3) the bond between client and psychologist. The alliance can be said to constitute a collaboration that is active and consensus-based (Horvath & Greenberg, 1989; Norcross & Lambert, 2019). The alliance may fluctuate within and between sessions in relation to what is happening in therapy. To maintain an alliance, it is crucial that the psychologist maintains a positive attitude towards the client's honest evaluation of the alliance and responds non-defensively to negativity, but perceives disagreement as a marker that it might be helpful to talk about the therapeutic interaction. Both psychologist and client contribute to the alliance, but the ability to create an alliance is a therapist characteristic, and those who manage to form better alliances with their clients achieve better outcomes (Norcross, 2011; Norcross & Lambert, 2019).

The alliance is not the same as the therapeutic relationship, although these terms are often used synonymously. The therapeutic relationship is also important and consists of many other elements, for example empathy, which can be used to foster and nurture the alliance. A safe therapeutic relationship, or a secure bond, between psychologist and client is a necessary condition for exploring painful experiences in order to reorganize and revise mental representations and facilitate a grieving process (Mikulincer et al., 2013). In the processes of grief therapy, the psychologist works to establish the relationship/bond by paying particular attention to their role as an attachment 'safe base' and 'safe haven'. The psychologist lets their grief interventions be guided by the client's specific type of attachment pattern and supports the client's affect regulation and mentalization.

The therapeutic relationship is not a technical therapeutic approach, but is an expression of a specific way of meeting and relating to the bereaved. The psychologist is interested in understanding the bereaved as an experiencing, intentional human being on their own terms, in understanding the material related to grief, and in understanding and relating to what takes place in the therapeutic space, including the psychologist's own experiences and reactions.

Relational stance and mentalization

The therapeutic relationship is a fundamental aspect of any psychological intervention. However, the therapeutic relationship is particularly relevant – and can become particularly challenging – for therapists working with bereaved clients because of the suffering and anguish the clients experience. Moreover, establishing a therapeutic relationship may become even more complicated if the therapist has a personal history with loss and bereavement.

To adequately develop and manage the therapeutic relationship with bereaved clients, therapists should cultivate a relational stance characterized, among others, by the following:

- *authenticity* and *congruence* in the sense of being freely and deeply receptive to all aspects of the own flow of experience within the relationship with the client;
- *empathic understanding* and *sensing* of the inner states (experience) of the client;

- *unconditional positive regard* and *acceptance* for who the client is and what they are experiencing;
- ability to minimally *communicate* the above-mentioned authenticity/congruence, empathic understanding, and acceptance to the client (Abass & Town, 2021).

Cultivating such a relational stance requires adequate levels of therapist mentalizing which is fundamental for self- and co-regulation and which could be defined as the capacity of perceiving oneself and others as characterized by mental states i.e., assumption, beliefs, intentions and hopes (Bateman & Fonagy, 2012). This notion places a great emphasis on the representability of affects, even more so than of cognitive beliefs, which create an intersubjective relationship (Bateman & Fonagy, 2012). It recognizes the here and now of the intersubjective transactions taking place in the clinical intervention as the main instrument of change (Karterud, 2015).

However, mentalization may not always be easy for the therapist because of the high distress and sense of fragility a bereaved client may experience. To the extent this latter may become affectively threatening for the therapists, they might face a drop in their mentalization abilities, with the consequence of self-deception, distancing themselves affectively and emotionally. When this is the case, relational ruptures might occur which will need to be repaired. To this aim, therapists should pay particular attention to the following:

They should consider that relational ruptures represent an essential opportunity for change for the client (i.e. corrective emotional experience) to the extent the therapist can sufficiently repair them (Abbass & Town, 2021). For this to happen, therapists should be able:

- to acknowledge that a relational rupture has taken place by being sensitive to rupture markers (for confrontation ruptures, for example, the client complains about lack of progress or is devaluating; for withdrawal ruptures, for example, the client is verbally disengaged, presents incoherence between affective expression and narrative content, or makes use of self-esteem-enhancing operations);
- to concurrently focus and explore both their own and the patient's experience of rupture (attempting to move from the feeling of anger to the feeling of disappointment and hurt in the case of confrontation ruptures; from the feeling of discontent, rejection, and vulnerability to the self-assertion and self-agency in the case of withdrawal ruptures);

The above may provide the client with a corrective emotional experience. However, since a relational rupture is essentially due to a breakdown in the mentalizing abilities of both client and therapist, to repair it is a very delicate task and requires therapists to recover adequate levels of mentalization:

- in case of mild to moderate (in terms of the intensity of) relational ruptures, this means improving the ability (i) to notice the rupture markers in the here-and-now of the session and (ii) to activate the episodic memory of past relational rupture in the here-and-now of the session;
- in case of moderate to severe relational ruptures, this means to (i) activate explicitly reflection during/through (i) clinical reporting and (ii) the need to receive supervision.

How are we as psychologists affected when working with the bereaved?

As mentioned in the section above, creating and maintaining a therapeutic relationship can be particularly challenging when working as a therapist with the bereaved. This is expressed in the quote below:

*"There is a cost to caring. Professionals who listen to clients' stories of fear, pain and suffering may feel similar fear, pain and suffering because they care. Sometimes we feel we are losing our own sense of self to the clients we serve" (*Figley, 1995, p.1).

There is a risk from working with clients, where the work is considered meaningful, that exactly *because* the work is meaningful, it is difficult to set aside. Compassion Fatigue, a term put forward by Figley in 1995, started a line in psychological research intended to better understand and highlight the psychological vulnerability of people caring for others, who had undergone trauma and suffering.

The aspect of compassion fatigue became particularly relevant during the COVID-19 crises, where professionals where exposed to an enormous amount of distressing work (Frenza et al., 2020; Serrão et al. 2021, Gilart et al. 2021; Franza et al. 2020). Research has been conducted into the impact of COVID-19 on health professionals which highlights the emotional distress they have experienced and its influence on professional work. For example, an online survey of Italian health workers showed that the COVID-19 had a negative impact on their mood and lifestyle, characterized by higher levels of restlessness, worry, loneliness, negative mood, and lower levels of happiness (Mansueto et al., 2021). There is still scarce literature on the implications of such conditions on the quality and efficacy of professional work. However, these preliminary considerations suggest the need to adequately monitor healthcare workers' psychosocial condition and its effects on their professional work. In Spain for example, in response to this, a free initiative was launched to listen to and support healthcare professionals (https://sanitarios.noestassolo.es/).

Another aspect which needs to be taken into consideration when working as a therapist in the aftermath of the pandemic, is the role that the therapist has been given in some societies. In a study by Cipolletta et al. (2021) the researchers explored how intervention from health professionals may become hampered by the variedness of perspectives that individuals have towards the health system in Italy. The conclusion was that therapists should use this actively when working with individuals bereaved during COVID-19. For example, by being aware of this as a possible barrier for the client in starting therapy and addressing this openly and curiously.

The COVID-19 pandemic has had a deep impact on the life of everyone, including professional therapists. The aspects presented in this section highlight, that working as a therapist with individuals bereaved under the pandemic, requires a particular stance and awareness on monitoring both the alliance, therapeutic relationship and the personal effects of this work. Clinical supervision and monitoring an adequate case load are important aspects at work, which can support the therapist and assist them in balancing this role successfully.

5.THERAPEUTIC METHODS

As described in the previous sections, research indicates that a large proportion of people who loses a loved one re-establish a daily life with support from their family and social networks, while a smaller proportion of bereaved experience that grief does not ease over time and that they need professional treatment following the loss. In order to determine whether the client has a grief requiring treatment and is motivated for a therapeutic process, it is recommended that an assessment interview is conducted prior to entering therapy.

ASSESSMENT INTERVIEW

In the assessment interview, a psychological assessment is carried out, in which the therapist enquires into the client's life story, and the client's current level of symptoms and functioning is assessed through information given by the client, as well as through the clinical impression of the client and/or through the use of objective measures (please see appendix 1). Questions are asked specifically about who is lost, what relationship they had, grief reactions, current and habitual level of functioning: function in everyday life, at home, in close relationships, in social activities, at education/work. Please see appendix 1 for an example of an assessment interview and a suggestion of possible outcome measures to assess grief complications.

The assessment interview is usually held at the earliest four to six months after the loss, as it can be difficult to assess the need for preventative therapeutic intervention before. If the bereaved is referred immediately after the loss, a crisis intervention can be initiated, or referral to crisis intervention elsewhere can be made and the need for grief treatment assessed later.

As mentioned above, the assessment interview helps the therapist to determine whether a client is at risk of developing - or has developed - a complicated grief and needs professional grief therapy, or whether the client has a normal grief which can be adequately supported through help from family, networks and possibly other voluntary communities.

A literature review on risk factors by Burke and Neimeyer (2012) highlights that an individual grief process is influenced by the availability of appropriate support in the network. In practice, we see that the quality of network support, including support from family or other significant relationships, has a significant impact on the client's ability to cope with grief. Some of the factors are, therefore, family and network. Other factors are the extent of external changes in everyday life, which also influence the client's grief process. And still other factors are resources and vulnerability, symptoms, and personal characteristics of the client.

The following factors, drawn from the research, are included in the overall assessment:

Risk factors

In the clients' history:

- Attachment problems both early in life and in the relationship with the deceased
- Abuse and neglect
- Highly dependent relationship with the deceased
- Previous losses

In the context of illness/death:

- Over-involvement through a long preceding illness of the deceased and no help along the way
- Lack of preparation time prior to death
- Lack of support in the network after the loss
- Major changes in everyday life after the loss
- Intensity and duration of grief reactions
- Traumatic experiences and ambivalent circumstances

As explained in section on acute grief, expected reactions in the first months after the loss may be distressing for the client, but are not in themselves indicative of grief complications. Therefore, we look at the intensity and duration of the reactions.

Intensity

If the grief reactions fail to decrease over time and so pervasive that re-establishing oneself in everyday life after the loss becomes difficult, this may indicate complicated grief at six months after the loss.

> *Example: a young adult may find it difficult to or socialize with peers in the immediate aftermath of the loss. If, several months after the loss, the young person is still unable to attend school or has withdrawn completely from social interaction with peers, this may indicate need for professional help for.*

Duration

If intense grief reactions persist beyond six months after the loss, or are persistently intense for more than six months, this may indicate complicated grief.

> *Example: it is common for a bereaved individual to feel sad or angry on a regular basis in the period immediately following the loss and experience trouble sleeping. If, six months after the loss, the bereaved feels still sad or angry several times a week and has difficulty falling asleep, this may indicate complicated grief.*

In the assessment interview, the psychologist will thus make a qualified assessment of the bereaved individuals need for professional grief therapy. The clinician will do so by using knowledge of risk factors, assessing intensity of grief symptoms over time, the need for suicide assessment and mental flexibility around the loss as well as a clinical impression of the client's emotional distress and motivation for entering therapy.

INTERVENTIONS FOR THE PREVENTION OF COMPLICATED GRIEF REACTIONS

In recent years more knowledge on effective intervention for complicated grief reactions have been made available. Recent systematic reviews and meta-analyses have found support for psychological intervention for bereaved adults with prolonged or persistent grief responses (Johannsen et al., 2019; Maass et al., 2020; Wagner et al., 2020). In 2020, the DNCG completed a review of existing national and international knowledge from research (e.g. Johansen et al., 2019) and practice on psychological interventions for adults with complicated grief reactions (Larsen et al., 2020). The review resulted in several recommendations and suggestions for psychological interventions for adults suffering from grief complications. It found grief-specific psychological treatment to adults with complicated grief reactions (i.e. with a high level of grief symptoms) to be indicated. "Grief-specific" meant treatment that (a) focuses on grief symptoms, (b) includes psychoeducation in relation to grief; and (c) addresses challenges associated with the loss such as avoidance, lack of acceptance and existential themes. Consistent with these recommendations, this manual will present a number of theoretical approaches and methods focusing on reducing grief symptoms in adults following COVID-19. That being an Emotion Focused Therapy approach, A Cognitive Behavioral Therapy approach and an Eclectic approach. The methods presented here specifically address aspects such as lack of acceptance, avoidance and existential challenges in bereavement. All the methods are described here with a view to conducting individual therapy. However, the eclectic approach is applied in group therapy as well but it is beyond the scope of this manual to explore further.

This manual has been developed with the objective of preventing complicated grief reactions in adults following the COVID-19 pandemic. To focus the intervention on the specific aspects of bereavement following the pandemic, this manual is inspired by what we have learned about effective grief therapy in general (as described above) and the recent qualitative study by Menichetti-Delor and colleagues (2021) (see section 'Implications for intervention' on page 9). This study highlights four aspects which may be especially important to address with bereaved people, who have lost during the pandemic.

- First, the need *to give meaning* to what happened in order "to put the pieces together".
- Second, the need to *express emotions* such as sadness, anxiety, anger but also emotional numbness.
- Third, the need *to say the last goodbye* and searching for alternative rituals to facilitate closure for example in place of a traditional funeral.
- Fourth, the need to identify ways *to remember* the deceased together with other family members and to share with them memories of the past.

This offers an example on how to address the specific aspects, that have shaped bereavement under the COVID-19 pandemic. This will be further elaborated in the intervention sections below.

EMOTION FOCUSED THERAPY FOR BEREAVEMENT FOLLOWING COVID-19

Emotion-Focused Therapy (EFT) incorporates principles, processes and techniques from the tradition of experiential therapy that embraces the legacy of Carl Rogers and Fritz Perls' deeply humanistic understanding of human change (Elliott & Greenberg, 2021; Greenberg & Goldman, 2019). This perspective conceives emotions as a fundamentally adaptive signaling system that provides people with important information about their needs and goals (Elliott & Greenberg, 2021). Emotions are ultimately symbolized with narrative meaning making in a dialectical-constructivist idiosyncratic view of the self (Greenberg et al., 1993).

EFT proposes different principles of emotion change (Greenberg, 2011): Emotion awareness, emotion expression, emotion reflection, emotion regulation, and emotion transformation (changing emotion with emotion, changing emotion with an interpersonal experience) that can be defined as productive emotional work. Greenberg (2002) highlights "how painful and unpleasant emotions can promote healing since they propel the client on a healthy self-organizing trajectory that reaches its completion as a meaningful, emotionally differentiated, and integrative experience" (p. 10).

Grief is a developmental transition in the wake of death and loss, where narrative processes and meaning reconstruction play an important role in healing. In fact, losses can facilitate personal growth and it assumes a central role in therapeutic change (Sayar & Hjeltnes, 2021). EFT helps clients to productively process sadness and emotional hurt (Paivio & Pascual-Leone, 2010; Rosner et al., 2011; Sharbanee & Greenberg, 2022; Kramer & Pascual-Leone, 2015). The fullest form of grieving involves integrating the good aspects of the relationship so as to be able to carry the love for the other after the loss (Elliott & Greenberg, 2021).

According to Larson (2020) this approach with the bereaved helps to explain the "paradoxical clinical reality that the pain of loss actually helps to process the loss, in other words, to change grief, you must experience grief" (p. 246). Therefore, as the EFT model proposes that "the only way out is through" [the pain] (Pascual-Leone, & Greenberg, 2007, p. 875), the nature and principles of this empirically supported approach matches the needs of bereaved facilitating the integration of the loss.

Despite this adaptive but painful experience, a complicated grief reaction stems from the interruption of sadness and pain. Clients might be unable to cope with an important loss and unable to move on. Often, they need to learn to express unresolved anger or guilt to be able to move forward. They may also need to develop a stronger sense of themselves so that they believe that they can cope without the other person (Greenberg, 2009).

Sometimes, grief may be blocked by other emotional states, such as guilt (e.g. in self-evaluative processes), fear or avoidance/block of emotion (e.g. in self-interruptive processes). Sometimes, during grief and bereavement work, other emotional core pain (i.e. primary maladaptive emotions) are accessed (Sharbanee & Greenberg, 2022) and need to be healed. In those therapeutic processes, the deceased played a role in the schematic emotional memories (e.g. being the only person that soothed some deep shame) that can now be accessed and transformed. Thus, shame, fear or sadness can be accessed and transformed (Timulak, 2015) and help to integrate the loss.

Although there has been developed EFT approaches to work with grief (see a recent review in Sharbanee & Greenberg, 2022), this is a specific innovative and tentative proposal that can be adapted with specific bereaved clients in a specific context of the covid pandemic and the emotions that it triggers. The access and symbolization of emotions is the core therapeutic process in EFT, but we will address those emotions with specific experiential tasks that can be adapted to specific clients' process. The intervention follows the

module approach proposed in transdiagnostic EFT (Timulak & Keogh, 2022), helping the clinician to structure a brief treatment for grief in the pandemic context.

Types of emotion expression

EFT works differentially with different types of emotions. Distinction is made between primary adaptive, primary maladaptive, secondary, and instrumental emotions (Elliott & Greenberg, 2021).

1.1. Primary adaptive emotions

Primary adaptive emotions are the first reaction to a situation, and mobilize the person with action tendencies that help them to meet their needs in the present situation. For example, sadness at loss that reaches out for comfort, grief that let's go of what is irrevocably lost, loneliness that reaches out for the other, pain/hurt that expresses a wound or a sense of brokenness, fear at threat, anger at violation or hopelessness that let's go of a need that no longer can be met (Kramer & Pascual-Leone, 2015).

The therapeutic aim with these emotions is to help clients to use the information they bring to guide their action. Next, we will look at some of the most common adaptive emotions in bereavement work.

SADNESS

The most important and dominant emotion in bereavement work is sadness/grief in the face of loss (Paivio & Pascual-Leone, 2010b; Pinto et al., 2021; Rosner et al., 2011). This cognitive-affective state is qualitatively different from the sadness related to the hopelessness (usually secondary), or the sadness related to loneliness (primary maladaptive), being more linked to the feeling of loss and its object of pain being clearer. As we said, this type of sadness is understood to arise from separation or loss and allows us to elaborate on this by pointing to the cause of grief (Greenberg & Paivio, 1997; Pinto et al., 2021). Processing grief and living the reality of loss is intimately related to the two sequentially ordered action tendencies (Paivio & Pascual-Leone, 2010; Pascual-Leone & Greenberg, 2005). The first tendency is to cry for help, to seek comfort and to search for the lost object. When crying for help does not work, either because of a poor response from the context or an inadequate expression of it (Timulak & Keogh, 2021), or because the search for contact clashes with the absence of what is lost. The second action tendency is to withdraw and conserve energy for the hard times ahead. It is important to understand that, although relatively linear in character, it is natural and to be expected that there will be movement between these two tendencies and what they imply.

In the pandemic context Manicheti-Delor and colleagues (2021) highlighted how families needed the possibility to express sadness in these extraordinary contexts of relational and emotional barriers and containments due to physical isolation. A survey to the UK bereaved during the pandemic reports intense feelings of sadness for not being able to visit or say goodbye to their dying relative (Selman et al., 2022). Breen et al. (2021) add that the sadness that emerges from the pandemic loss contexts will probably impair the functioning of the bereaved, particularly for those who manifest separation distress, and post-traumatic stress.

ANGER

Anger is a very important emotion in grief since it might be a primary adaptive emotion that can facilitate grief resolution (Sayar & Hjeltness, 2021): once activated, it can promote assertiveness and avoid the intense and conflicting feelings by finding a balance between them.

Sometimes anger takes the form of rejection of the other (Pascual-Leone & Greenberg, 2007). For example, the person may blame the loved one for not having taken protective measures against COVID-19, or may

blame the doctors for not trying enough or not providing adequate care to prevent the loss (Selman et al., 2022). In these cases, it is common for this anger to be secondary and blur other primary emotional experiences, such as the sadness of loss or fear of the lack of control in the face of death.

On other occasions, anger is manifested as an assertive or protective anger before a transgression of the limits. In this case, anger defends autonomy, one's own limits, when there has been poor treatment by doctors, or health regulations that are experienced as profoundly unfair. This anger, typically primarily adaptive, when affirmed and validated, guides the person and enables them to strengthen the sense of self (Rosner et al., 2011) and experience the benefits of setting boundaries and defending their needs (Sayar & Hjeltness, 2021).

NOSTALGIC JOY

Addressing now the change processes related to good outcome cases of grief, it is common for patients to start feeling nostalgic joy when remembering their loved one, recalling meaningful and special moments that capture the unique characteristics of the person and the relationship. These emotional expressions of joy have been found as a predictor of recovery from grief sadness (Bonanno & Keltner, 1997).

This adaptive emotion has a sweetness quality to sadness, and expressions of joy and amusement, such as smiling and laughing, are common (Sharbanee & Greenberg, 2022). These memories of past positive experiences bring a sense of vitality to the self and celebration of the lost self.

GRATITUDE

The emotion of gratitude is common in the grieving process, expressing an appreciation of the good received from the deceased. Expressing gratitude allows living the connection to that of the relationship, enduring the bond through savoring and being grateful for what has been received (Sharbanee & Greenberg, 2022). While mourning allows one to accept the loss, gratitude allows one to live the new forms of the inner relationship by feeling that aspects have been incorporated into oneself that endure.

COMPASSION

Compassion is a key emotion in emotional work, it is the adaptive response to vulnerability (Neff, 2003; Timulak, 2015). Bereaved experience compassion from others in their interpersonal environment and from the therapist, but in many occasions, compassion arises from the self, when expressing painful emotions, such as grief. Compassion promotes the tendency to the action of comforting, reaching out to nurture the damaged and vulnerable part, being a key emotion in the transformation (Timulak, 2015) and helping process grief (Harris, 2021; Sayar & Hjeltnes, 2021; Sharbanee & Greenberg, 2022). Some research highlights the protector role of self-compassion in grief complicated reactions since it promotes the quality of continuing bonds and an overall global functioning (Bussolari et al., 2021).

Primary maladaptive emotion

They are described as painful core emotions, which are felt in a familiar and somewhat rigid way by the person during their life, constituting a habitual vulnerability, and which construct a deteriorated sense of self (a sense of being inadequate, or fragile, typically).

In therapeutic work, we seek to access, symbolize and transform these types of emotions. The most common primary maladaptive emotions are shame ("I am not worthy, I am not worth it"), fear of unprotection ("no

one is there for me, I am alone and unprotected"), sadness/loneliness ("I long for contact that never comes") (Timulak, 2015).

ABANDONMENT/SADNESS-LONELINESS

In grief work, sometimes old painful core emotions appear, which are exacerbated and triggered by the loss and need and can be transformed. For example, the person may have historically been missing greater appreciation, greater protection, or greater affection from the deceased. These emotions of sadness and loneliness linked to those needs have a history prior to death, and they may need longer treatment.

At other times, the deceased person was the only source of appreciation, protection, or contact, leaving the bereaved person in profound helplessness. In other processes, the deceased was the only source of comfort when the person felt their chronic nuclear pain, so that the grief process is blocked by the activation of this pain that no longer feels regulated (Gamoneda & Jódar, 2022).

SHAME/GUILT

Inadequacy, self-depreciation and shame may be experienced whenever bereaved internalize the society's unspoken assumptions about grief and bereavement regarding what is expected in terms of the “adequate” form for expressing feelings, its duration or even its legitimacy. If these feelings last may lead the bereaved to the isolation and subsequently increase of complicated grief reactions. Harris (2021) states that shame creates the need to withdraw, jeopardizing the process of significant connection that was most needed. Another important aspect about shame is the inner sense of safety that is inhibited and threatened when a harsh critic self and excess perfectionism leads to a feeling of not worthy, or that they are lacking in some way.

In the pandemic context shame and guilt were usually present due to the fact that people were unable to visit, to comfort, and support their dying relatives (Selman, et al., 2022).

FEAR/ANXIETY

Fear (in present) and anxiety (in the future) embodies danger signaling, telling us that we or someone that we love is threatened (Elliott & Greenberg, 2021). Even though the unknowing nature of the COVID-19 pandemic at early stages as long as the number of deaths caused by the illness did propel this fear based adaptive reactions, the general and ongoing/chronic sense of threat became, for some individuals, problematic. While fear motivates us to escape from the threat or to freeze in order to not attract attention, anxiety motivates us to avoid behavior steamed with preoccupation. The underlying need is safety and is clearly at risk for the caregivers that anticipate the attachment bonds threatened by physical separation by loss. Although anticipatory anxiety might have a protection role since it prevents the contact with pain and suffering, it also prevents successful and healthy emotional processing (Timulak & Pascual-Leone, 2014) which may intensify the complicated grief reactions.

The death of a loved one may be experienced as not meaningful and sometimes can be felt as a traumatic experience (Harte et a., 2020), and occurring in the pandemic context can potentially increase the sense of traumatic loss (Reitsma et al., 2021). An experience of trauma-related fear can trigger emotional avoidance and even block the access to the painful emotions (see below how to deal with self-interruptive processes), which can disturb the grieving process. These traumatic fear based schemes can be framed as maladaptive emotions that should be addressed in complicated grief reactions.

Secondary Emotions

Secondary emotions are emotions that obscure in consciousness the experience of other primary emotions. They cover up previous emotions, and the person is not able to perceive what they feel and need primarily. These emotions are validated in therapy, but instead of facilitating the elaboration and expression of these emotions, the therapist seeks to deepen them in order to access the underlying primary emotion, in other words, facilitating the experience of the emotional transformation (Elliott & Greenberg, 2021).

Hopelessness, anxiety, irritation that blames others (covering up the nuclear pain) like a rejecting anger, are common secondary emotions (Timulak, 2015). These secondary emotional processes need to be validated and symbolized, but also bypassed to access core pain. Guilt, hopelessness, anxiety, disbelief and constant rumination, a "sense of unfairness and 'meaning protest' stemming from a belief that things should have been different" (Sharbanee & Greenberg, 2022, p.5) are common secondary emotions in the grieving process. Those secondary symptoms and the avoidance strategies to deal with them are a very great source of discomfort that the person needs to address before being able to delve into the more core emotions described above (Timulak & Keogh, 2021).

Instrumental Emotions

Instrumental emotions are expressed to achieve relational goals, such as sadness that is expressed to seek comfort, or anger that the person expresses to achieve intimidation and obedience in others. When these emotions appear in the therapeutic process, the therapist facilitates the substitution of these expressions by honest and direct requests for the goals that the person is trying to achieve (Greenberg, 2011).

Emotion processes in complicated grief

The different symptomatic psychological difficulties are understood in EFT by different emotional processes: lack of emotional awareness, lack of regulation, presence of maladaptive emotions or inadequate expression of emotions in interpersonal contexts (Greenberg, 2011). EFT distinguishes between types of grief based on the underlying emotional etiology, rather than on the expression of symptoms (Sharbanee and Greenberg, 2022). Thus, in the typical or uncomplicated process, grief is an adaptive emotion around the loss (Sharbanee & Greenberg, 2022). However, in the complicated grief reactions, other emotional processes, such as guilt (e.g., in the self-evaluation process) or fear/blocking emotion (e.g., in the self-interruption process), appear and block the natural bereavement. Sometimes, during grief and bereavement work, other core emotional pains (i.e., maladaptive primary emotions) prevail and the grieving process is also blocked.

Emotion change

EFT proposes different principles of emotion change (Elliott et al., 2004; Greenberg, 2011) designed to help people to accept, express, regulate, make sense of, and ultimately transform difficult emotions. Another hallmark of EFT is the facilitation of these emotional processes through tasks that are proposed when a specific problematic state appears in the client (e.g. the self-critic state would be approached with the suggestion of the two-chair dialogue task).

Emotional change requires both that the primary maladaptive emotion is aroused (Warwar, 2005) and it is attended in a productive manner. Productive processing involves that client experiences mindful attention and acceptance of the emotion, expresses it in a congruent way, symbolizes it in words, and the experience is differentiated, regulated and lived with a sense of agency (Auszra & Greenberg, 2007). Primary adaptive emotions are experienced as a result of this productive processing, and transform previous maladaptive emotions, through memory reconsolidation (Greenberg, 2021). As a final process of consolidation, encoding

the emotions into narrative has a strong function of *making-sense-of*, and inherently regulating the pain and making it less disorientating (Sharbanee & Greenberg, 2022; Kennedy-Moore & Watson, 1999).

Emotion sequences in complicated grief

It is important to note that although we will now speak of sequences, these are not equivalent to the stages or tasks that other models of grief propose. Emotional sequences occur moment by moment, immersed in the work of the different tasks in the session and following the dynamic flow emotional processing that is characteristic of client experiencing (Sharbanee & Greenberg, 2022). These sequences are presented in a linear way, because some emotions usually precede and give rise to others. However, we must not forget that the natural course of the emotional processing sequences evidenced by client experiencing usually occur in a recursive way, as clients usually oscillate between emotional states, and sometimes there are steps backwards, to allow for subsequent steps forward (Pascual-Leone, 2009).

We can understand two types of sequences in complicated grief (see figure 7): In the first sequence, the central process consists of overcoming the emotional blockage and secondary emotions, in order to be able to fully process the grief. After the elaboration and expression of sadness and the differentiation of anger and sadness (if necessary), other adaptive emotions may appear, such as compassion, gratitude, nostalgic joy. In this first sequence, the access to grief is the main process of change, a process widely observed in clinical experience ("Many people benefit from grieving by opening up and letting the tears flow" in Sharbanee & Greenberg, 2022, p. 5).

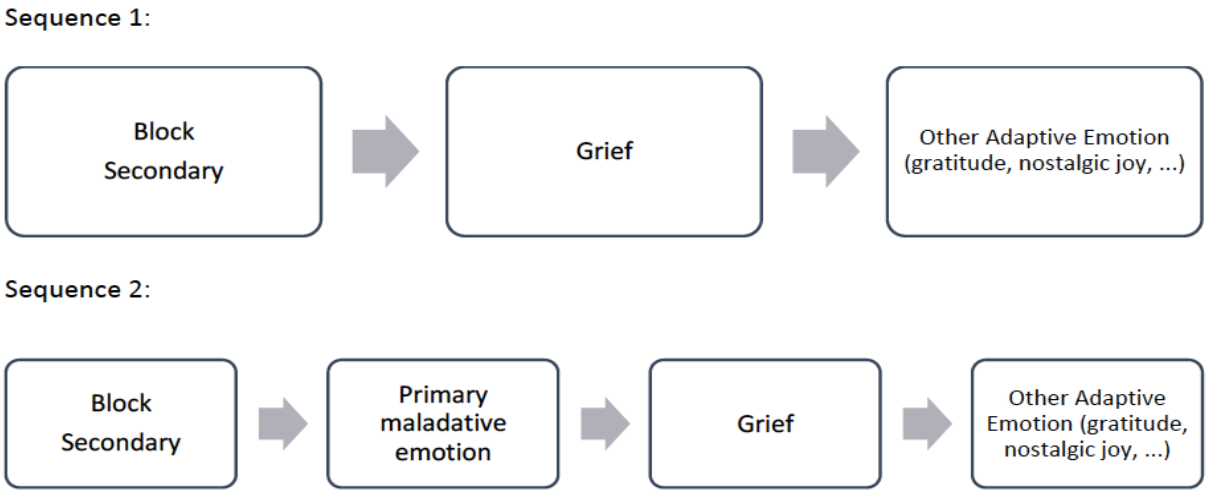


Figure 7. Two emotion sequences in complicated grief work (Sharbanee & Greenberg, 2022)

In the second sequence, the grief usually is accessed after working with historic wounds (i.e. primary maladaptive emotions) in which the lost loved one played a role. In these sequences, after the validation and overcoming of blocks and secondary reactions it is necessary to work with core shame, fear-based

vulnerability or loneliness/abandonment. After the access and symbolization of these primary emotions, grief, and other adaptive emotions are likely to appear (Timulak, 2015), since "it is that pain that elicits the compassion and holds the memories of joy and the resulting gratitude" (in Sharbanee & Greenberg, 2022, p. 8).

Thus, "productive processing of complicated grief requires that clients are guided from their secondary reactions, to their primary maladaptive emotions, such as shame, unworthiness, insecurity and vulnerability, and then on to the full expression of both the assertive anger at past failings and their grief at the loss, and their compassion and nostalgic-joy" (in Sharbanee & Greenberg, 2022, p. 10). Progress through this sequence of emotional processing has been associated with deepening in-session experience (Pascual-Leone & Greenberg, 2007) and associated with positive clinical outcomes across several clinical disorders and therapies (see Pascual- Leone & Kramer, 2019, for a review). Pinheiro et al. (2021) in a comparative study of a good outcome case and a poor outcome from a constructivist therapy clinical trial for complicated grief reveal the therapeutic facilitation of the emotional processing during therapy. Emotional processing is associated: a) with changing maladaptive grief related emotions, b) the ability to adapt to the new life without the deceased based on the healthy inputs gave by their emotions, and c) the overall symptoms improvements in the good outcome case (Pinheiro et al., 2021).

Working with grief with EFT in times of COVID-19 pandemic

Although there have been EFT approaches developed to work with grief (Sharbanee & Greenberg, 2022), our aim here is to present an innovative and tentative proposal adapted for bereaved clients in a specific context of the covid pandemic. The intervention follows the modules approach proposed in transdiagnostic EFT (Timulak & Keogh, 2022), helping the clinician to structure a brief treatment for grief in the specific challenges of the pandemic context.

Constructing a productive working alliance: compassionate, rooted in therapeutic presence, empathic attunement. These are the basic relationship principles built on a genuinely prizing relationship with an accuracy in attending and decoding the client's experience (Elliott & Greenberg, 2021).

Case formulation of grief process in emotional terms: guide the therapy toward the central block to adaptive grief (Shabernee, & Greenberg, 2022, p.10). "...an unresolved blocking emotional process is what distinguishes a complicated grief process from a normal grief process" (p.5). Therefore, understanding the emotional blocking and transforming it will be the crucial point for the case formulation (see the sequences outlined above).

Listen to the markers (signs of problematic emotional states in the client):

Self-critic: sometimes the emotional blocking may be an internal form of criticism (self-criticism). This self-critic may emphasize the fear of having contaminated the deceased, of not having removed the family member from the nursing residence, not being able to say goodbye, not being able to participate in the rituals, etc.

Self-interruptive process: The process of interrupting the experience, through thoughts like "it's no use feeling this pain" or avoiding scenarios "I'm not going to go to his neighborhood, I don't want to have a bad time, it's beyond me".

Unfinished business markers: A sense of incomplete or unexpressed grief, or unresolved issues towards the deceased.

Meaning protest: The person is stuck, unable to process an experience that has broken core beliefs.

Problematic reactions: The person does not understand the meaning of their reactions and is perplexed by their emotions.

Narrative pressure related to the traumatic loss: There are traumatic elements that a person needs to address.

LISTEN TO THE THEMES AND EMOTIONS: THE EXPERIENCE OF GRIEF IN COVID-19 THROUGH THE LENS OF EFT

A) THE UNKNOWN CHARACTER OF THE DEATH

Different aspects related to the unknown character of the death (such as the inability to determine the meaning of illness related events, the unpredictability of symptoms, lack of clarity about the treatment options or big general misinformation), might trigger a lot of anger and meaning protest markers (e.g., towards the medical doctors and towards the government policies). This calls for the meaning reconstruction task, to help clients to express the specificities of their loss and the meanings attached to it, access and specify cherished beliefs that were violated and re-create meaning when cherished beliefs are shattered by the circumstances involved in the loss.

A lot of anger and fear need to be processed. Empathic attunement is key to help differentiate these strong and important emotions, that may appear forming a complex mixture of fear and anger.

B) NOT ABLE TO SAY GOODBYE

Some of the deep pain in the loss during COVID-19 comes from not being able to say goodbye. Some clients show a kind of shock and fear/anxiety related to disbelief. Not knowing how the body was buried or not having a memory of the contact with the body, may trigger those emotions that need to be symbolized and deepen while activated. This process will promote the acceptance of the death (Sayar & Hjeltnes, 2021; Sharbanee & Greenberg, 2022).

Some aspects of the experience are more traumatic and overwhelming (e.g., the sudden death, with no coffins available). Thus, it will be key in helping people to retell the story and at the same time focusing and clearing a space (Elliott & Greenberg, 2021) to help people regulate under-regulated emotional reactions and access the experience with a sense of agency.

C) PHYSICAL ISOLATION AND LACK OF SUPPORT

Some of the most unique experiences in loss during COVID-19 are related to the physical isolation and lack of support of the bereaved person. Vulnerability markers will be expected (Elliott et al., 2004; Elliott & Greenberg, 2021), when clients express distress over strong negative self-related feelings (usually with hopelessness and a sense of isolation). Empathic affirmation and compassionate self-soothing are available tasks to facilitate the process.

Some clients may express hurt and pain imagining the physical isolation and lack of support in the deceased loved one. This process can be understood as an unfinished business, and chair work will help clients to process this hurt and pain (Elliott et al., 2004; Elliott & Greenberg, 2021)

Understanding and co-constructing the main blocks of grief

Sometimes the deceased is linked to the primary maladaptive emotion, having been the person who was dismissive, abandoning or humiliating. On other occasions the deceased was the only person who was a source of comfort in the face of chronic painful emotions. In this case, grief is complicated because the person feels more unprotected in the face of their own family pain.

FACILITATING EMOTION REGULATION

It is very important to consider emotional regulation abilities, since active emotional work must be facilitated only when we know that the person possesses adaptive regulation skills. In case of substance abuse, self-injury, or very fragile processes, it is very relevant to work on emotional regulation beforehand (Greenberg, 2011). The therapeutic alliance is the fundamental tool that will generate an increase in the client's emotional regulation competence. In addition to the relationship, we have different tasks that promote an increase in emotional regulation, in the face of specific problematic states:

1. Empathic Affirmation for vulnerability states
2. Self-soothing
3. Clearing a space

WORKING WITH GUILT AND OTHER COMMON SYMPTOMS

If through empathic attunement we cannot overcome secondary emotions and blocking processes, we have active tasks at our disposal that can facilitate the process. We work with the two-chair dialogue to work on guilt and other symptomatic processes, which block the elaboration of grief (Elliott et al., 2004; Elliott & Greenberg, 2021). In this task, the client is invited to enact the internal voice that blames, induces anxiety, interrupts or launches obsessive thoughts or ruminations. One of the gains that this task brings is the experience of agency that the client has in the process of generating this symptomatology. By inviting the person to change chairs, primary maladaptive experiences can emerge, be symbolized and expressed. In this process the expression of experiential needs to the voice is very important. This allows the process of transformation in the voice that previously blamed, interrupted or frightened. Transformative adaptive emotions may emerge in this process. EFT offers different chair work for each process:

4. Guilt: two-chair work
5. Self-worry (Anxiety splits)
6. Self-Interruption
7. Rumination/obsessive process (see Elliott et al., 2004; Elliott & Greenberg, 2021)

WORKING WITH PRIMARY EMOTIONS

Chair work with the significant other is the most emblematic task for complicated grief work in EFT (Sharbanee & Greenberg, 2022). In an empty chair, the presence of the significant other is facilitated, so that the client can access and express the emotions that emerge when in contact with the deceased (Elliott & Greenberg, 2021). The aim is to access and differentiate adaptive emotions, and if necessary, to work with primary maladaptive emotions. For this purpose, if congruent with the formulation of the case, moment-by-moment, it is usually suggested to the client to occupy the other's chair, and from this position, enact the negative other by pouring their message (e.g. shaming or leaving alone) to the experiential self of the other

chair. This facilitates, when the client changes chair, the access of chronic nuclear emotions. At this point it is crucial to symbolize and express these emotions, so that they can be processed productively. In the later stages of this task, we facilitate the emergence of adaptive emotions (Elliott & Greenberg, 2021).

CONSOLIDATION IN NARRATIVE:

The therapeutic process of accessing adaptive primary emotions and transforming maladaptive primary emotions can be consolidated into narratives that bring together elements of personal history, past and anticipated future, resulting in a new sense of identity (Cunha et al., 2016). But the reflection and narrative reconstruction previously require that the pain of the grief is felt, as we covered before.

When the person fully feels their primary emotion, is able to articulate the need embedded in it, and feel entitled to have that need met or discover what they have longed for. This articulation of needs allows us to feel new adaptive emotions, typically compassion and assertive anger. To say goodbye, we have to say and feel everything that was unarticulated and implicit in our emotions. All significant moments of change are anchored in experientially vivid encounters with self and others, rather than in therapeutic commentary, interpretations or instructions, even though these will have an important role in a posterior phase for the consolidation of a new, integrated self-narrative (Neimeyer et al., 2009).

In this process of consolidating the elaboration of grief, constructing new identity narratives, we can follow the meaning reconstruction task (Elliott & Greenberg, 2021) and empathic exploration task (Elliott et al., 2004).

Concluding remarks

As a humanistic, process-experiential model, the EFT approach requires the development of a specific relational environment, characterized by a therapist that is fully present to the other and attuned to the dynamic flow emotional processing that is characteristic of client experiencing. EFT helps bereaved clients to unblock interruptive processes and get in touch with primary emotions. In this process, therapists facilitate the access, symbolization, expression and regulation of clients' core emotions. Sometimes this process involves the transformation of core wounds such as fear of trauma, shame, or loneliness and abandonment. In most processes, the therapist witnesses the devastating pain of irrevocable loss that death brings. However, therapists also witness the resources of patients, which provokes deep adaptive emotions in the therapist as well: sadness and compassion in the face of vulnerability, joy in the face of healing, or admiration at the unfolding of the resources that clients put in place and guide them back to life.

COGNITIVE BEHAVIORAL THERAPY FOR BEREAVEMENT FOLLOWING COVID-19

Fundamental to the cognitive model is that humans are governed by cognitive processes. A cognitive-behavioral conceptualization of complicated grief (CG) presents three *core processes* as crucial to the development and maintenance of CG: a) insufficient integration of the loss into the autobiographical knowledge base, b) negative global beliefs and misinterpretations of grief reactions, and c) the use of anxious and depressive avoidance strategies (Boelen et al., 2006b). These three processes are important as they each contribute to the different clinical outcomes that constitutes CG. An insufficient connection between the reality of the loss and the abstracted autobiographic knowledge base is assumed to generate key CG symptoms such as disbelief, involuntary recollection and searching behavior. Negative global beliefs are connected with yearning, anger, guilt and other emotions associated with CG and misinterpretations of grief reactions generates discomfort and fear. The last core process, anxious and depressive avoidance strategies, fuels numbness, detachment and difficulties imagining a meaningful life (Boelen et al., 2006b; 2007). This conceptualization of CG offers a framework for the generation of hypotheses about the mechanisms underlying CG which subsequently can inform a therapeutic intervention.

For the purpose of this manual, we will use this conceptualization of CG as well as the research conducted by the Dutch psychologist Paul Boelen and colleagues on Cognitive Behavioral Therapy for transdiagnostic complicated grief to treat adults in individual therapy (Boelen et al., 2006b; 2007). This work will form a starting point for elaborating on how CBT can be used to conduct therapy with individuals bereaved during the COVID-19 pandemic and where there is a need to work therapeutically to prevent complicated grief. As presented in chapter 2 of this manual, the specific circumstances and restrictions surrounding death and dying during the COVID-19 pandemic have impacted greatly on the experience of bereavement and grief in southern Europe. Therefore, a CBT approach to prevent complicated grief post pandemic, will need to take into consideration these specific aspects of bereavement in the COVID-19 era. Cognitive behavior therapy or CBT interventions, including exposure, cognitive restructuring, and graded activation has previously been found effective in alleviating complicated grief reactions in research conducted prior to the COVID-19 pandemic (see Johannsen et al., 2019; Bryant et al., 2017; Currier et al., 2010; Boelen et al., 2007).

Insufficient integration of the loss into the autobiographical knowledge base

A key feature of complicated grief is that the bereaved are constantly reminded of the person they have lost, yet the absolute separation and the finality of the loss seems unreal and reminders of this reality continues to create intense pain and distress (Boelen et al., 2006b). In CBT this phenomenon is explained by proposing that the separation is insufficiently understood and integrated in the autobiographic knowledge base. The information of the loss has not been incorporated into existing memory, which explain why the emotional pain don't subside over time. When working to prevent the development of complicated grief, helping clients understand, accept and integrate their loss into their existing knowledge base and life narrative may be helpful. This aspect could, however, be particularly challenging for those bereaved during COVID-19. For many bereaved people, uncertainty about the events surrounded the death was a key feature, making the loss narrative particularly difficult to understand and incorporate into existing knowledge (Boss et al., 2021). Furthermore, when the death is traumatic, the memories per definition are very difficult to incorporate into existing autobiographical knowledge (Boelen et al., 2006b), which again places bereavement during COVID-19 at risk of being particular difficult to process (Testoni et al., 2021).

A key aspect of patients suffering from complicated grief reactions are the use of avoidance as a strategy to keep the painful feelings and the reality of the loss at bay. Therefore, treating this aspect of complicated grief requires facing the reality of the loss and engage with internal and external cues connected with the reality of the death (Boelen et al., 2007). In CBT the method used for this purpose is exposure. When working to prevent the development of complicated grief, clients who seems to rely on the use of avoidance as a coping strategy, might benefit from a similar approach.

Exposure involves the (gradual) confrontation with specific internal and external loss-related stimuli such as memories, objects, and situations, which has been avoided by the bereaved (Boelen et al., 2021). The goal is to integrate the loss into the autobiographic memory and increase the connectivity in the person's life narrative. General exposure exercises include the bereaved retelling the circumstances of the loss, to articulate and elaborate on the consequences of the loss for the self, the future, and the relationship with the deceased, and to experience and express the separation distress connected with this reality (Boelen et al., 2021). Interventions and methods applied at this stage aim to help the bereaved relate to and understand, with both brain and heart, that the deceased is dead and not coming back. The aim here is to be able to come to terms with the finality of the loss. In therapy, it is of uttermost importance that the psychologist is empathetic and caring and creates a safe space which enables the bereaved to explore these painful and difficult aspects (Boelen et al., 2007)

STARTING THE INTERVENTION

Exposure therapy is based on the notion that avoiding reminders of the loss is a key contributor to and maintaining factor in complicated grief and that for recovery to occur it is important for patients to gradually confront these reminders and elaborate on the implications of the loss (Boelen et al., 2007). When starting therapy, it is important to explain this rational to the bereaved, so that the bereaved understand the purpose of the often painful confrontation. In some CBT grief intervention, the bereaved is asked to tell the story of their loss in the first sessions, so that the therapist can identify aspects of the loss that are particularly distressing. Both internal stimuli, such as memories and thoughts and external stimuli such as places and people, that they tended to avoid, are identified.

This initial telling of the loss story gives information about the three core processed

a) insufficient integration of the loss into the autobiographical knowledge base
b) negative global beliefs and misinterpretations of grief reactions
c) the use of anxious and depressive avoidance strategies

It enables the therapist to create hypotheses about what are the most critical aspects in the grief process and where the therapy should focus (Boelen et al., 2006b, Boelen et al., 2007).

In therapy imaginary exposure to relevant topics of conversation that can promote acceptance of the reality of loss may include:

THE BEREAVED CHANGED SELF-IMAGE AND IDENTITY

Conversations in therapy may focus on how the bereaved person now sees him/herself and what the 'new me' looks like. In order for the bereaved to accept that there is a new version of themselves, they must accept that they have lost an important person in their life and therefore accept the death. This could be conducted through exploring the changed self-image and identify in respect to the roles and responsibilities in the family

or in relation to the wider social network. What does it mean to go from being part of a couple to now being alone in a social context? Often, bereaved persons say they feel as if they have lost part of themselves - it can be helpful to put this into words as well as to validate that experience. For individuals bereaved during COVID-19, there may be a notion that the pandemic had a fundamental impact on their lives and identity. Through the loss of a loved one but perhaps also due to other losses e.g. their jobs, financial stability, trust in authorities and changes in social networks (Kokou-Kpolou et al., 2020), adding to the level of complexity in accepting a changed self-image.

PLANS AND EXPECTATIONS FOR THE FUTURE

In therapy the bereaved can reflect on broken dreams and plans for the future, possible changes in financial and practical circumstances, and situations in which the deceased will be "missing." Talking about the future means accepting that it will be a future without the loved one and therefore accepting the death. There may also be a need to talk about "what we didn't get to do," "what we weren't told," and/or unresolved conflicts. For bereavement during the COVID-19 pandemic, many lost loved ones without much warning or time to say goodbye. This aspect of 'unfinished business' may complicate the grieving process gravely, offering emotions of guilt for not being by the loved one's side or anger for being prevented to be so (Albuquerque et al., 2021; Cipolletta et al., 2022; Mencacci & Salvi, 2021; Testoni et al., 2021).

RELATIONSHIP WITH THE DECEASED

The therapy can address who the deceased was as a person, what is missed most, and what may not be missed. By talking about the person and memories in past tense, this confronts the bereaved with being in the present without the loved one. The therapist may ask about examples of everyday moments and how the deceased may have a role in the bereaved person's life, e.g. through rituals, memories, conversations with others about the deceased, etc. Restructuring the relationship requires some form of acceptance and this may be difficult, if the grief feels ambiguous due to, for example, not having said goodbye to the loved one because of pandemic emergency restrictions. This needs to be acknowledged and perhaps a ritual or ceremony to mark the death at this later stage, may be helpful for the client to in order to say the last goodbye (Menichetti-Delor et al., 2021).

THE PAINFUL EMOTIONS

Painful emotions can be avoided by bereaved suffering from Complicated grief because they are reminders of the loss. In therapy, conversations can focus on the feelings that are troubling the bereaved. How are they experienced and how can the bereaved deal with them? Is it possible for the bereaved to just "stay with" the feelings, wait and let them pass? Are there emotions that the bereaved person is afraid of or perhaps embarrassed by? Are the feelings linked to memories, fears about the future, perhaps existential themes such as loneliness and meaningless? Studies of bereaved under the COVID-19 pandemic found that higher levels of psychological distress such as anger, guilt and shame were intertwined with their view of the pandemic (Gullo et al., 2022). If the bereaved can gain a better understanding of their feelings and the opportunity to express them, rather than shutting them down, this may help initiate further adjustment process.

In order to work with external stimuli such as the avoidance of physical places, objects and people, in vivo exposure can be introduced along with the imaginal exposure through conversation. For those bereaved during the pandemic, this could be visiting the hospital where the loved one died or seeking knowledge from hospital staff who were with the loved one in the final hours. It could be visiting places that reminds the bereaved of the person they have lost and which they have been avoided. In vivo exposure can be

overwhelming for the bereaved, and a graded approach is strongly encouraged, whereby confronting the least troubling aspects first and gradually approaching the more distressing places and objects. Maintaining close contact and continually 'checking in' with the client to ensure, that the exposure is not causing too much distress (Boelen et al., 2006b). Gradually the exposure therapy should enable the bereaved to understand and confront the reality of the loss and incorporate the loss into their life story.

Negative global beliefs and misinterpretations of grief reactions,

Losing a loved one can feel like having your understanding of the world turned upside down - it no longer makes sense, and your existential foundations has been shaken. This can create negative global beliefs about oneself, others, and the future which are considered particularly critical in the development and maintenance of complicated grief reactions. When working to prevent the development of complicated grief reactions, exploring and addressing potential negative beliefs and misinterpretations may be helpful. Catastrophic misinterpretations of the grief reactions contribute to bereaved feeling loss of control, distress and as a result, those bereaved often use anxious avoidance strategies in order to minimize feelings and thoughts of the loss. These two cognitive processes in turn elicits strong negative emotions such has anger, guilt and fear (Boelen et al., 2006b). During the pandemic, adapting negative global beliefs may have been a particular challenge for those bereaved. Many suffered multiple losses and stressors. Not only did they lose a loved one, they may also have lost their livelihood, their faith in the authorities, their social network etc. (Cipolletta et al., 2022; Gullo et al., 2022). In order to adapt to these losses and to everyday life without the deceased, it is important to work on reestablishing a sense of self-confidence and trust in other people, life and the future by engaging with the loss and accepting the associated thoughts and feelings (Boelen et al., 2006).

Using CBT, one way of working towards re-establishing global confidence is through cognitive restructuring (CR). CR is aimed at identifying and challenging maladaptive cognitions that hinders confrontation with the reality of the loss and engagement with the future, and maintain negative emotions and unhelpful coping behaviors (Boelen et al., 2006b; Boelen et al., 2021). Maladaptive cognitions include negative cognitions about the self, life's meaning, and the future, as well as catastrophic misinterpretations of grief-reactions. Specifically, after traumatic losses (such as many of those that occurred during COVID-19 pandemic), one's sense of the world as a safe, predictable, and somewhat controllable place is challenged (Boelen et al., 2021). The aim in therapy becomes to increase trust in the bereaved person's abilities to cope with life and to master, for example, new tasks that the deceased used to do or establish new relationships. In addition, therapy can focus on encouraging the bereaved to seek comfort in relationships with others, as well as accept experiences of failure and disappointment from friends and family following the loss, so these negative experiences won't create withdrawal and social isolation. The aim of cognitive restructuring is not to help patients to think positively or to convince them that their cognitions are wrong. Instead, the aim is to help patients accept that the loss has shattered some aspects that previously were certainties and that, it is important to alter maladaptive beliefs into helpful beliefs, reflecting confidence, trust, and hope in order to accept the loss and move forward (Boelen et al., 2021).

In the first core process, imaginal exposure was introduced, whereby the bereaved starts by telling the loss story. Imaginal exposure is also an important aspect of targeting and treating negative cognitions. By listening to the bereaved loss narrative, important information on negative cognitions surrounding the event leading up to the death or an inability to cope with their new life situation is given (Boelen et al., 2006b). It could for example be a bereaved' inflated responsibility with a relative being affected with COVID-19 and subsequent guilt for proposedly causing their death (Boelen et al., 2021)

In therapy sessions, the bereaved and the therapist can explore and address negative cognitions and assumptions that contribute to problems with self-confidence, trust in others, and negative views of life and the future. This could for example be:

LACK OF SELF-CONFIDENCE AND NEGATIVE SELF-IMAGE

Some bereaved people think and fear that they will not be able to cope with their grief or with life without the deceased. They don't think they will be able to cope with living on, or that they will be able to be of service to others. In addition, they may struggle with feelings of grief that are too overwhelming for them to face.

LACK OF TRUST IN OTHERS

Lack of trust in others can be about blaming doctors and others in the medical profession for not doing their job well enough during COVID-19. It can also be about disappointing episodes with family members and the network. Feeling forgotten during the pandemic and their loss not acknowledged by their network after restrictions lifted.

LACK OF FAITH IN LIFE AND HOPES THE FUTURE

Some bereaved persons think that life is now meaningless and the future bleak and dark. The pandemic can have bought multiple stressors into their lives and it's difficult to see how their life can in any way be good and meaningful again. Hopes and plans for the future were linked to life with the deceased, and that life is no longer possible.

In supportive conversations, negative thoughts can be challenged and changed through Socratic dialogue, identification of negative distortions and change to alternative, more helpful thoughts.

SOCRATIC DIALOGUE

This is about questioning negative and unhelpful thoughts in a curious and probing way, in a way that promotes reflection on the extent to which these thoughts are true and helpful. For example:

Ask about evidence that supports the negative thoughts

> "What is it, exactly, that makes you think that it is your fault __ died from COVID?
>
> "You say you will never be happy again, is that thought true? What is the evidence for this?"

Ask about evidence that goes against the negative thoughts

> "You talk about it being your fault that __ died. Is there any evidence against that?"
>
> "Life has no meaning anymore. Is there anything that would contradict that thought?"

Ask questions about logic

> "You are convinced that you should have been with __'s when he died in the hospital alone. Tell me a little about how you could have done it."
>
> "You say that you can't count on anyone, but you also say that your son has been there for you all along. Am I right on both counts?"

NEGATIVE DISTORTIONS

Negative cognitive distortions are thought patterns that perpetuate misconceptions and assumptions that are not logical or helpful. In conversations with the therapist, the therapist and the client examine together whether these are present in the clients thought patterns:

Overgeneralization: making general conclusions on a flimsy basis

> "Nothing can make me happy now"

Personalization: explaining the outcome of a situation based on one's own faults or shortcomings

> "It's my fault she died"

Catastrophizing: Extreme negative evaluation of unpleasant situations

> "I will completely break down, if I meet someone I know"

If the therapist and the client become aware of negative cognitive distortions, these can be challenged using Socratic questions (as instructed above). It is important that the therapist continues to be probing, curious and reflective as well as supportive. The therapist must show acceptance for the negative cognitive distortions, as they were developed as a result of a life shattering experience which did turn previous certainties of life upside down (Boelen et al., 2006b).

IDENTIFICATION OF ALTERNATIVE THOUGHTS

Once negative, unhelpful thoughts or thought patterns have been identified and discussed, the next step is to help the client find alternative, more helpful thoughts. That is, thoughts that do not keep the bereaved stuck in a stagnant and suffering grief, but are more nuanced, and that manage to be both descriptive of how the client is feeling, but also hopeful. It is important that the alternative ideas are realistic and credible. Examples could be:

> Before: "I'll never be happy again."
>
> Alternative: "I am still very sad, but choose to believe I can be happy again one day"

> Before: "I should have prevented his death."
>
> Alternative: "I wish there was more I could have done."

> Before: "I can't bear to live without him."
>
> Alternative: "It will be hard to go on living without him. I'll do the best I can."

The alternative thoughts are constructed collaboratively by the client and the therapist. This can be a difficult task and it is important not to move too quickly. The goal is to find alternative thoughts that are less negative and more helpful. It is not a question of just thinking more positively, it is about finding thoughts that are realistic, logical and helpful in reducing negative feelings and giving hope for the future. With practice, the

bereaved learns to become aware of and able to challenge unhelpful thoughts and assumptions going forward.

The use of anxious and depressive avoidance strategies

Exposure procedures introduced in earlier sections are helpful in order for bereaved to engage with stimuli which make the loss a reality and thereby confront anxious avoidance strategies. When anxious avoidance strategies manifest themselves in an attempt to maintain an unchanged connection to the deceased, this can be brought up in conversation with the therapist. One hypothesis could be that the uncertainty surrounding the death, the lack of rituals and social support following a loss during the pandemic can make it seem unreal and increase anxious avoidance strategies (Fisher et al., 2022). Together with the therapist the bereaved person can examine, what the short and long term effects of avoiding the loss may be for the client. For example, short term the bereaved can avoid feeling the pain and long term, the bereaved fails to adjust to a life without the person they have lost, with all the implications this may hold (Boelen et al., 2006b). Slowly in a step-by-step approach, the bereaved is encouraged to reduce the compulsive behavior (e.g. not sleeping in the bed which was shared by a deceased husband). Reducing efforts to maintain an unchanged relationship to the deceased will most likely cause pain and suffering for bereaved, which the therapist needs to be aware of and accommodate in therapy (Boelen et al., 2006b).

For bereaved people suffering from depressive avoidance, behavioral activation which increases mood and quality of life are encouraged (Boelen et al., 2021). During the pandemic, social distancing interrupted social interaction and leisure activities, making it difficult for bereaved to access social support which is a key moderator on the impact of bereavement (Burke & Neimeyer, 2012; Stoebe et al., 2005). There may therefore be an even greater need for helping patients to gradually increase their engagement with usual activities that offered joy, meaning, and fulfillment before the loss occurred. In case the mutual dependency with the deceased was strong, emphasis should be placed on finding new activities and engage in new roles unrelated to the deceased. To help the bereaved in moving forward, they should be aided in becoming aware of personal values and subsequent goals, which they want to achieve, and set out steps to achieve them (Boelen et al., 2021).

Activities could include:

- Social contact with friends and family
- Getting back to work or education, finding voluntary work
- Sports and leisure activities (e.g. clubs and associations)
- Hobbies and other interests (e.g. reading, listening to music, playing music, going for walks, etc.)

The therapist can explain that activity and mood are linked. That is, if you engage in an activity that you enjoy, you will typically feel better and in a less bad mood than if you did nothing (e.g. just sit at home alone). The therapist may ask whether the client can recognize this from previous experiences.

In talking to the client about engagement in activities, it may be helpful to talk about some of the possible obstacles the client is experiencing in engaging in everyday life again. These can range from the experience of lack of energy, problems concentrating, lack of desire, worry about coping or feeling sad, to uncertainty about how others will react and fear of having to talk to others about the loss. These may reflect a lack of confidence and trust in others, as well as pessimistic assumptions about how beneficial it will be to engage in activities. Life can have changed dramatically as a result of the pandemic and encouragement needs to be

put in place by the therapist in order to support the re-engagement with the world. This is where going back to task two as well as focusing on taking a problem-solving approach to the obstacles. It can be good to start small with manageable activities and then see how it goes and whether it feels beneficial. For example, meeting with a friend alone before returning to the whole bridge club. Or start at work a few days a week before returning to a full work week.

Attempting activities in the face of a major loss can be seen as exhausting, pointless and trivial. Be understanding of this, but then try to motivate the client to try activities anyway, as a distraction from the grief and sadness, and in an attempt to integrate the grief into life going forward.

If the client has difficulty thinking of an activity or cannot quite face having to re-engage, simple questions like these may help:

What interests/hobbies did you have before __ died?
What activities used to make you happy?
What interests do you share with others in your network?
If you didn't feel so sad and tired, what might you want to do, do you think?
Is there anyone who could help you get going again?
What do you think ___ would encourage you to do?

Some clients think they need to feel better and have more energy before they can re-engage in activities, but it's actually often the other way around. Starting to do something i.e. engage in activity, no matter how small, can help them feel better.

As said, the strategy is to start small, thereby increasing the chance that the experience of the activity is positive. Then the client's self-confidence and trust in others is strengthened and the courage to engage further grows. If the experience is not positive, the reason for this can be discussed and another activity exercise implemented and tested.

Behavioral activation exercises take place between sessions and it may be helpful to ask the client to write down how it went. For example, the client can write down a brief description of the activity, when and where it took place, how it went, and how the client felt before, during, and after the activity.

Increasing healthy behavior targets all three core processes, as it confronts the irreversibility of the separation, generates experiences that run counter to negative global beliefs, and stops the downward spiral of depressive avoidance (Boelen et al., 2006b).

AN ECLECTIC THERAPEUTIC APPROACH TO BEREAVEMENT FOLLOWING COVID-19

Effective grief treatment methods are typically grounded in cognitive-behavioral theory, but often use an eclectic approach to choosing therapeutic methods and tools (for example, Boelen & Smid, 2017; Bryant et al., 2017; M. K. Shear et al., 2014, 2016; Wagner et al., 2006). These methods and tools include psychoeducation about grief, e.g., using the Dual Process Model of Coping with Bereavement (DPM; Stroebe & Schut, 1999, 2010), exposure, cognitive restructuring, behavioral activation, retelling the moment of death and imaginary conversation with the deceased.

This following section has been inspired by the therapeutic intervention as carried out in the Danish National Center for Grief (DNCG). DNCG has over 20 years of experience with conducting grief therapy with children and young people (through age 28). The center makes use of an integrated eclectic psychotherapeutic approach which consists of an integration of theoretical and therapeutic models that address different areas of a grief process. In practice, the therapy bridges the DPM, psychodynamic, attachment, narrative, cognitive and existential theoretical approaches. It also draws on key elements of mentalization-based and emotion-focused therapy and focuses on the therapeutic stance. This approach enables complex issues to be addressed and interventions to be matched to clients' individual needs.

The Dual Process Model (DPM) represents a cornerstone of the intervention's grief specific theoretical foundation. It is also actively used in the therapy through psychoeducation. How the DPM is used for understanding the individual grieving process and targeting treatment needs, will be presented in the following. After this section, a short introduction to some of the most central theoretical approaches will follow.

The Dual Process Model: Grief as a Dynamic and Complex Process

As mentioned above, the grief specific theoretical foundation for the treatment rests on the DPM (Stroebe & Schut, 1999, 2010). In accordance with this model, the psychologists embrace the notion that grief, at its core, is a dynamic and complex process. The grieving person needs to address both loss-oriented and restoration processes to be able to adjust to and integrate the loss into their life. That is, the bereaved needs to, on the one hand, confront and experience the difficult painful feelings associated with the loss; learn to accept that the deceased is in fact dead; and establish a new and different kind of continuing bond to the deceased – the loss-oriented work (Stroebe & Schut, 1999). At the same time, the bereaved must find a way to embrace and adjust to the everyday life changes associated with the loss. That includes, among other things, learning new things; finding solutions to practical challenges; establish new roles, identity and relationships independent of the deceased; and continuing their personal development – the restoration work (Stroebe & Schut, 1999). The DPM explains that, ideally, the bereaved person oscillates between the two processes. It provides a dosing mechanism that facilitates confronting the various processes and challenges in manageable portions, so that the overall adjustment can take place little by little. In the course of therapy, this important process of adjusting to loss is explained to the clients through psychoeducation. This tends to increase the clients' understanding of their own experiences, as well as point out where they may have gotten stuck in the grieving process. It also seems helpful for clients to learn that grief has no expiration date, but that their grief will become more manageable over time.

The fact that grieving takes place in a cultural context with norms and expectations for how one grieves, and that this impacts the bereaved experience, is also explicitly addressed in the course of our treatment. Obviously, the client's personal context, the bereaved adult's personality, attachment pattern, coping

strategies, defense mechanisms, as well as familial and social circumstances, also influence their work with both loss and restoration processes (Guldin, 2019).

Within this understanding of the grief process, psychologists work flexibly with the clients, using therapy techniques from various therapeutic approaches (see details in a later section) in order to, among other things, encourage acceptance of the death, facilitate the creating of a continuing bond with the deceased while helping the client function better in life and establish relationship with supportive others with a view to strengthen hopes for the future. In the following, some of the most central psychotherapeutic models will be briefly presented before introducing three important areas of grief working within this approach.

THE PSYCHODYNAMIC MODEL

When painful experiences and complex grief-related thoughts and emotions have been repressed and perhaps excluded from consciousness, it can have an arresting power that can create various intrapsychic and interpersonal problems for the bereaved (Rubin, 1999). The task of therapy is to make the unconscious related to the deceased and grief conscious, so that the bereaved gain greater insight and are able to better accommodate avoided feelings and accept the loss. In doing so, space is given to the grieving process. This is done, among other things, by focusing on the person's object relations, that is, the person's model of self/other, through attention to the transference experience in therapy, and by examining inner conflicts and defenses in the bereaved (Gullestad & Killingmo, 2007; Larsen et al., 2021;).

With respect to the object-relations perspective, the relational patterns the bereaved has entered into and the experiences with significant others are the focus of therapeutic understanding. In therapy the meaning the bereaved attaches to the relationship with the deceased as well as the thoughts and feelings associated with the loss. When people have complex emotions following a loss (for example, guilt, shame or anger), it is in the psychodynamic model that grief therapy goes beyond the normalization of these emotions, but allows for a more nuanced, deeper understanding of feelings of loss.

When therapy includes approaching avoided experiences, thoughts and emotions related to grief, it can be anxiety-provoking and therefore arouse defensiveness. The defenses, as well as the underlying conflicts and emotions, are addressed explicitly in the therapy sessions. The intention is to try to untie these, often relational, knots and help the bereaved to expand their awareness and narrative, in order to reduce the need for defense (Larsen et al., 2021; Rubin, 1999). Angry feelings directed at the inadequate governmental responds during COVID-19, for example, can be exacerbated in an attempt to defend against more underlying, longstanding feelings of powerlessness and helplessness that have been triggered.

As an example of working with transference experience in grief therapy, the psychodynamic approach will use the transference and counter-transfer experiences to understand the client's underlying personal dynamics and explore the impact of those on the client's response (adjustment) to the loss. For example, Rubin (1999) describes therapeutic situations in which the psychologist may experience being in competition with an idealized deceased person or may experience not 'existing' for the client, which can be used to understand the bereaved person's mental representation of the deceased, and the function of the deceased for the client's self-image – and response to the loss (as if to communicate "my mother was perfect, I can't live without her, and you can't help me, because you are not perfect").

UNDERSTANDING GRIEF FROM AN ATTACHMENT PERSPECTIVE

Adult attachment patterns can be defined as cognitive, affective and behavioral mental models that involve affect regulation strategies and that unfold in close intimate relationships (George et al., 1996; Main et al., 2003). This means that one's childhood experiences with attachment figures lead to certain unconscious patterns in one's attention, expectations, emotion regulation and action strategies in relation to close others.

People with attachment security are better equipped to deal with loss because this pattern allows them to tolerate separation. The process of grieving is also typically less complicated because they are likely to reshape the emotional bond with the deceased themselves in an adaptive way. In contrast, insecure attachment compromises the grieving process. It creates problems for the way the insecure attachment comes to maintain the emotional bond with the deceased (Kosminsky, 2018; Stroebe et al., 2010). Clients with insecure attachment are most often marked by distrust of the intentions of others and they have a more negative self-image. They either have a strong need for affirmation from others or are extremely wary of forming close relationships, making it much more difficult for them to build and maintain a therapeutic relationship and establish agreement on the goals and tasks of therapy (Diener & Monroe, 2011). Thus, an understanding of the bereaved' attachment pattern contributes an important key to how the person is likely to respond to therapy and the therapist (Levy et al., 2011; Larsen et al. 2021).

In attachment-informed grief therapy the psychologist serves as a transitional attachment figure to help the bereaved come to terms with and adjust to a significant loss. In the therapeutic process, the bereaved person is supported in exploring, experiencing and tolerating feelings of grief and separation from the deceased. Problems with mentalizing the loss are addressed, meaning the ability to understand the mental state of oneself and others. The therapy encourages flexible attention to both the loss and the life ahead, so that the bereaved begin to engage with life again without giving up bond to the deceased.

In general, attachment-based approaches to grief therapy address the bereaved person's life story and relationship with the lost person, in the context of a "secure base and safe haven" created by the psychologist. In addition, the psychologist allows therapy processes to be guided by the client's attachment pattern/affect regulation strategy and self/other models (Bowlby, 1988; Daniel, 2015; Mikulincer & Shaver, 2013; Stroebe et al., 2010; Larsen et al., 2021).

THE NARRATIVE MODEL

The narrative model focuses on the impact of loss on the identity and self-narrative of the bereaved person. Narrative processes create a sense of meaning for the individual and thus can assist in adjustment after loss (Neimeyer & Milman, 2020; Sayar & Hjeltnes, 2021). Neimeyer and Hooghe (2018) point out that it can be difficult to 'find meaning' in a loss, especially when a death occurs prematurely, or when it is frightening or violent, or if our identity and safety depended on the deceased – several of these risk factors could be relevant if the death occurred during the COVID-19 pandemic. The importance of meaning making following bereavement is supported by a study done by Menichetti-Delor et al. (2021) on the needs of families of COVID-19 patients who died at the hospital in Italy.

According to Neimeyer and Hooghe (2018), attempting to adjust to loss by affirming or reconstructing meaning occurs through two types of storytelling: first, the need to relate to the death itself and its meaning for the bereaved; and second, an effort to access the backstory of the bereaved person's relationship with the deceased – this in order to clarify unfinished issues and (re)create attachment security (Neimeyer & Hooghe, 2018).

Through storytelling, we construct our identity by putting parts of ourselves into a meaningful whole that defines who we are, who we were, who we want to become. The narrator attaches meaning to episodes and

links them together in a plot, but existential crises, loss or traumatic events can lead to narrative breakdown, such as for losing a loved one during COVID-19 (Riber & Lindvig, 2011; White, 2004). In relation to grief, the meaning of loss, and the way an identity or self-narrative has been affected by the death, can be explored through a series of questions that can be revisited many times in a grief process in order to integrate the loss experience into a coherent narrative: *How are you doing now? Can you tell me about when your partner died? Can you tell me about your partner's life story? What is it that you have lost? Who are you now? What do you need to hold on too? Has anything good come out of this experience for you? What does the future you want look like?* (Kosminsky & Jordan, 2016; Neimeyer, 2012).

Specific aims of the therapy

Based on the previous review of the theoretical basis of grief therapy, we can define concrete overall goals of the eclectic grief intervention. The aim of the therapy is to create:

- A better regulation of emotions and a better mentalization
- Awareness of and ability to describe feelings, thoughts, and actions
- An emotional coping – the ability to respond to strong emotions in adaptive ways
- Flexible oscillation between the loss-oriented and recovery-oriented coping processes
- Ability to explore and accept the reality of death
- A coherent narrative of loss and self/identity
- A reorganization of attachment - Continuing Bond
- Better relationships/relational skills

Now we turn to three examples which introduces more practical ways of working in therapy.

LETTER WRITING AS A METHOD IN GRIEF THERAPY

Since the 1980s, so-called expressive writing has been used and studied as a method for processing stressful and traumatic experiences (see Pennebaker et al., 1988, 1990). It has been shown to have a positive effect on both physical and mental well-being (Frattaroli, 2006), partly due to increased insight (Pennebaker, 1997), confrontation with what one has otherwise tried to avoid (Frattaroli, 2006; van der Houwen et al., 2010), and increased emotional acceptance of what has happened (Baum & Rude, 2013). The work with expressive writing is the precursor to using letter writing in grief therapy and involves describing deep feelings and thoughts associated with a stressful or traumatic experience and the death of an important person.

Letter writing as a method provides a simple, easy-to-use framework for grief work. It is a way of structuring therapeutic work that involves homework, i.e. contemplation in between sessions, and a method that gives the client a sense of control over the focus of the therapy, as they determine the content of the letters. It is also a flexible method which, through the specific focus of the letters, is adapted to the therapeutic needs of the individual.

The task of sitting at home and reflecting on experiences, thoughts and feelings around a theme and having to formulate a letter about it can help the client to work towards structuring experiences and feelings that have otherwise seemed chaotic and disorganized. Traumatic experiences from their loved one's last days can be broken down and addressed in small, less overwhelming portions by having the client write a series of letters about different themes. The letters make it possible to process individual experiences and smaller bits, rather than having to deal with the whole loss story at once. Over time, this focus on the sub-elements of experiences can help to create a better overview for the client and aid the felling of acceptance of the loss as well as control over their own story.

THE FRAMEWORK OF LETTER WRITING

The letters are written to the person the client has lost or to other important people when appropriate. It is not important how long the letters are, but that they are personal, relevant and meaningful to the client. The therapist explains that letter writing is used as a tool to process experiences with the loss and grief, and to evoke feelings and thoughts associated with having lost an important person in their lives and the grief that comes with it. The therapist can explain that letters can help to bring greater clarity and perspective to situations that have been overwhelming, confusing and traumatic. They can also help to separate the often tangled emotions of grief.

The letter is read out in the session and, subsequently, a dialogue develops between the client and the therapist, in which the therapist comments on, examines and asks questions about what the client has said. The therapist highlights parts of the letter that seemed particularly important. The therapist can talk about and mirror the emotional and bodily reactions of the client during the reading and in the dialogue that follows. It is here, in the conversation between the client and the therapist, that clinical grief work unfolds. At the end of the dialogue, therapist and client jointly decide on the focus of the next letter, a focus that is often agreed in the form of a heading for the letter for the next session.

CONSIDERATIONS WHEN USING LETTER WRITING IN A CLINICAL CONTEXT

Expressive writing can facilitate both the process and outcomes of psychotherapy as discussed above. It gives the clients the opportunity to work privately, controlling their own intervention dosage. It is low cost and easily implemented. Furthermore, expressive writing intervention has been shown to be feasible and tolerable in a variety of difficult situations, as seen in, for example, the WET program for persons with PTSD (Sloan et al., 2021), in the use of storytelling in newly bereaved caregivers (Barnato et al., 2017), in persons bereaved through drug-related deaths responding to writing prompts (Thatcher, 2021), and the brief “Writing for Recovery” program tested in bereaved Afghani adolescents refugees (Kalantari et al., 2012). Finally, although not expressively tested, using expressive writing in form of letters is feasible in the context of bereavement therapy, inferred by its repeated use across effective treatments for PGD (e.g., Boelen et al., 2013; Bryant et al., 2017).

However, using letter writing as a clinical tool has its limitations as well. For example, expressive writing may result in immediate distress and discomfort (Smyth, 1998). Thus, some clients may choose to stop and not complete the letter assignment, if they exceed their tolerance for emotional distress. Some clients may have trouble understanding the value in writing letters to the deceased about upsetting experiences. Here it might be helpful to review some of the potential benefits discussed above in this section.

Practical considerations also warrant consideration when determining if letter writing might be a good tool to use with a particular client. For example, clients who have learning, cognitive or physical disabilities or literacy issues may find letter writing difficult and may lack motivation to engage in writing activities. Clients, who struggle with limited self-awareness and for whom reflecting on experiences is difficult, may also not benefit from writing assignments as described in this paper, and focusing on exploring clinical material through traditional in-session conversation may be best. Finally, in some situations, the client may lack the

time, privacy at home, or the motivation to complete homework assignments. If the therapist is unable to help the client solve these problems, letter writing assignments are not feasible (Larsen, 2022).

TIMELINE

Another method used in DNCG, is creating a timeline of important events during the course of illness or surrounding the death. This is often used as a framework for letter writing and will be presented in the following section.

In therapy, a good starting point for the client is to complete a timeline in order to get an overview of the events surrounding the loss, and illness when relevant. This can be done at the start of therapy or later on during the course of treatment, when there may be a need for a greater overview of what has happened. As mentioned, suffering bereavement during COVID-19 is characterized by a sense of confusion, detachment and uncertainty (Cipolletta et al., 2022; Freeston et al., 2020; Mortazavi et al., 2021). Putting the pieces together intentionally will help to create an overview of what is known and what still remains uncertain. This will provide the bereaved with a stronger narrative of what happened and aid the rational acceptance of the loss. The timeline is further used for deciding on which letters the client should write, as events singled out on the timeline, which indicates particularly difficult episodes that are currently complicating the grief process. The timeline is used flexibly and according to the needs of the bereaved.

For some clients, their upbringing and life until the loss was marked by illness, family and/or personal stresses, which meant that memories could be fragmentary and incoherent, and the sense of identity itself was experienced as uncertain. During the COVID-19 pandemic, aspects and events surrounding the death may not be known, and dealing with this 'unknownness' is an important part of accepting the reality of the death (Cipolletta et al., 2022.) By opening up a dialogue about the time leading up to the death of the loved one or the death itself, new memories or details may emerge. The bereaved may also be encouraged to talk with someone close to them or seek knowledge from health professionals at the hospital or nursing home, where their loved one died under the pandemic, in order to help them with creating a more coherent narrative. The timeline allows the bereaved to put into words, reflect and reconsider experiences, feelings and actions that may provide new insights and explanations for their own actions and reactions to date.

With a better overview comes the possibility of being able to integrate a more complete representation of what happened while a parent was seriously ill or (suddenly) died. It is important that the person focuses on their own experiences of the loved one's illness when working with the timeline, rather than focusing on what the ill person went through. For many it has been natural to pay more attention to how the ill person was feeling, rather than how they were feeling.

The timeline is made in the individual's notebook or on a piece of paper. It can be designed in different ways. Some make a timeline as a line or an illustration. Others write points or make a list. Participants decide on the form, but are guided that the timeline can include specific events as well as their significance for the person. For example, concrete events can be written on one side of the line and the meaning of the events on the other side of the line. You can also choose to write concrete events on one side and on the other side a description of what happened in your life during that time, for example who were the most important people in their lives through social isolation, when they started to re-enter life after the pandemic etc..

After completing the timeline, perhaps as a homework assignment, the client talks through the timeline with the therapist. At first the client talks about the background for selecting points and what it was like to make

the timeline. It can be both eye-opening to recall the circumstances surrounding a death of a loved one, and it can reactivate emotions related to the period with illness and feelings leading up to and around the death.

Subsequently, the points formulated by the client on the timeline are worked on in more depth. It is important to keep the client focused on their own experience of stressful circumstances. There may be traumatic experiences that the client has not dealt with, severe feelings of powerlessness and inadequacy at not being able to do something when the loved one fell ill or a sense of guilt for not being present when their loved one died alone in hospital (Cipolletta et al., 2022; Testoni et al., 2021).

Working with the timeline does not necessarily have to be done in chronological order. There may be points of impact that have a particular weight and which prevent the bereaved from feeling the importance of other points of impact. Consideration should therefore be given to whether it would be more appropriate to start with what the clients finds most difficult and then work on the other points from there.

THE USE OF PHOTOS

Another approach when working with accepting the reality of the loss, is to work with photos of the deceased in therapy. Initially, the client introduces the person they have lost by showing and talking about a photo of the person to the therapist. The deceased person is the focal point of the therapeutic work, so it makes sense to "invite" them into the therapeutic space and to be visually present through photos. In connection with letter writing, the client is instructed to look at the photo of the deceased person before writing and reading the letter. The purpose of looking at photos is, among other things, to create a feeling of being "closer" and more connected to the deceased person. Working with photos can further help to stimulate feelings, thoughts and memories that are important for therapeutic work.

Some clients enjoy looking at photos and may experience good memories and positive feelings related to the deceased by relating from photos. Others have difficulty looking at photos of their deceased loved one. They find it difficult to confront the death and the emotions that come with it. When they look at a photo of the person that have died, they have to face the loss and they feel the significance of the fact that the deceased is now only in a picture and no longer a physical reality. Here, the client can be encouraged to look at the photo briefly at first, and then the therapist can help with a gradual exposure to and habituation of painful emotions that the client comes into contact with. Some people speak in the present tense when they look at the photo and talk about their dead loved one. Here the therapist can guide by saying "was" instead of "is". This is often experienced as a confrontation with a reality that the client resists, but can be helpful in acknowledging the loss.

USING PHOTOS IN CLINICAL PRACTICE

Working with photos is aimed at enabling clients to look at photos over time, so that they become more of a source of joy and connection rather than a source of despair and one-sided reminder of all that has been lost.

Now we turn to three common aspects in grief therapy and give examples on how working with letter writing can be used as a method in therapeutic settings when working with bereaved people.

ACCEPTANCE

Avoidance is often present in both natural and problematic grief reactions. As described above in the context of the DPM, bereaved alternate between the loss-oriented and the recovery-oriented process. Problems arise if the bereaved person focuses exclusively on one process and consciously or unconsciously try to avoid

the other process altogether. For example, when the bereaved person is so overwhelmed by difficult emotions that it becomes almost impossible to cope with everyday life. Or when the person is so busy "moving on" that feelings and thoughts associated with the loss are shut down and avoided. This is where avoidance and ultimately failure to accept the death can become problematic in the long run.

This difficulty in accepting the death can be caused by and maintained due to a number of factors. For example, the loss can feel so earthshattering, that confronting it is too painful and frightening. A bereaved person can feel unable to engage with these intense emotions, fearing losing control if they were to start to engage with the consequences of the death. Or, there can be sense of 'unfinished business' getting in the way of acceptance, relating to the experience that something was not accomplished or not completed or handled before the person died. It is something that many, if not all, bereaved are left with in some form after the death of a loved one. A range of complicated emotional reactions can accompany this, for example feelings of guilt, anger and regret, as well as overwhelming sadness at what was not achieved with their loved one. As previously explored in chapter 2, bereavement during the COVID-19 pandemic has been especially marked by 'unfinished business,' as many did not have the opportunity to say goodbye or have yet to come to terms with the loss because so many aspect of the death remains unknown. Avoidance may therefore be a significant complicating aspect following bereavement during COVID-19.

CREATING A COHERENT NARRATIVE THROUGH LETTER WRITING

One way of working with acceptance is through letter writing which enables the bereaved to gather a coherent narrative of the loss story, before and beyond. A persons' experiences of the deceased person's course of illness, when they were being taken to hospital, and the time surrounding their loved one's death are often described as chaotic, confusing and 'seeming unreal'. This is very much the case for those bereaved during the pandemic, where stories of a beloved family member, who was taken to hospital and then never seen again, are plentiful. Many aspects of their loved one's last days and hours can be unaccounted for, and clients may have difficulty putting together the sequence of events and what their experience was in relation to what happened. The fact that these significant experiences and events were so confusing and difficult to understand makes it difficult for a person to relate to, understand and ultimately accept what happened (Menichetti-Delor et al., 2021).

The letter writing method can be an effective way to work towards creating a more organized narrative around the loss experience. The person can be instructed to write a series of letters that relate to the time that seemed particularly chaotic. In this way, a narrative can unfold which becomes clearer to the bereaved enabling them to start understanding and accepting, that the person they love has died (Larsen et al, 2020).

A REORGANIZATION OF ATTACHMENT - CONTINUING BONDS

The concept of continuing bonds was introduced by Klass and collegues in 1996. With that came a paradigm shift in the understanding of grief. Grief is now understood as a lifelong process that does not end when the final stage is reached, the last task is solved, or the bond to the deceased has been severed. Rather, the loss, the subsequent grief, and a meaningful ongoing bond with the deceased must be integrated into the self and become part of the bereaved person's continued life. Therefore, the grieving process is not about breaking the bond with the deceased, but instead the relationship must be internalized, so that the bereaved can take the person imaginatively with them into the future (Klass et al., 1996; Worden, 2018). The idea of persistent ties is seen by many as an extension of the basic idea of attachment theory. Instead of maintaining physical

closeness to the attachment figure, a psychological closeness is created which can provide a sense of reassurance (Field et al., 2005). For example, it may be reassuring for a widower to think about what her beloved husband would have advised her to do when faced with a difficult situation, thereby continuing their bond in a new form.

When continuing bonds is a focus of grief, there is an attempt to encourage flexible attention to both the loss and the life ahead, so that the bereaved begin to engage with life again without giving up attachment to the deceased.

STRENGTHENING CONTINUED BOND THROUGH LETTER WRITING

Therapeutic letter writing can be used as a way of bringing a person closure and saying goodbye to the deceased in their physical form, but also to help promote a continuing bond with the deceased in a psychological, symbolic, or spiritual way. Writing directly to the loved one is a way to bring them within reach, enabling ongoing communication, albeit a symbolic one. The bereaved person is often able to imagine how the deceased would have responded and may even write this as part of the letter. Thus, the bereaved person can be instructed to write about problems but also how the deceased person would have been able to help. If the client imagines that the deceased would have responded with advice or encouragement, it can be reassuring to the client to be reminded of this and ways of keep the deceased with them in their lives as they moved forward. The bereaved can also be encouraged to write about situations where the deceased will be missed, and describe how the deceased will be "present," for example, through rituals on special days (e.g., birthdays and holidays), in talking about the deceased (e.g., with grandchildren), sharing memories, creating a legacy and so on (Larsen, 2022).

HOPES FOR THE FUTURE

In addition to working on accepting the reality of the loss and establishing a continuing bond, another relevant focus of treatment can be working to re-engage in life and find hope for the future. Thinking of the DPM, this part of the grieving process belongs in the restoration-oriented process. Re-engaging with everyday life such as going to work, seeing friends and taking up old leisure activities can help in the readjustment to life, and subsequently to finding hope that a life and future without the deceased could be possible. What can complicate this reengagement, can vary from person to person. Examples could be low energy or mood, feeling guilty for still being alive, fearing other people's response. In therapy, it's important to explore what might help motivate the bereaved person to reengaging with their previous lives, but also what might be barriers to doing so.

CREATING HOPE FOR THE FUTURE THROUGH LETTER WRITING

In therapy, when using therapeutic letter writing to create a sense of hope for the future, the focus becomes helping the client find ways to engage in meaningful activities and overcome barriers to doing so. The therapist can ask the client to write a letter about the thoughts and feelings associated with starting a certain activity. The letters can be used to explore ways to address identify sources of apprehension and ways to address them. If life has changed in several ways following the pandemic, this may also be explored in letters. What thoughts and feelings are associated with reengaging with the world, what is perhaps encouraging them and what are holding them back. Having explored the feelings and thoughts, the client can then conduct small behavioral experiments. Perhaps meeting with a trusted co-worker outside of work could be a starting point, before returning to work. After the client has completed the activity, it can be helpful for the client to write about the actual experience. Did anything surprise them in the experience? Perhaps there was a second where they almost lost courage or did something happen, which made the experience easier? If the client perhaps failed to start work as planned or missed the training session in the football club, writing a letter

about that experience can be a helpful way of gaining a greater insight for both client and therapist of what was stopping them from engaging in the meaningful experience. The therapist can, on a temporary basis, provide the support and encouragement, which previously might have been provided by a partner or parent in response to facing challenging situations.

Other meaningful aspects to work with in letter writing when it comes to returning to life after the loss, can be letters about having to "invite" other people into the bereaved person's life, i.e. having to create new or change old relationships. For example, a letter to the mother in which the young person explains what he now needs from her after the father's death. It can also be letters about the bereaved person's identity now being different, about having to do new things without a dead partner, as well as letters about what it is like for the husband to have to clean out his deceased wife's treasured belongings and favorite clothes, etc. The aim here is to focus on the relational, identity and practical consequences of the loss.

This was a short introduction to some of the aspects of the eclectic approach to grief therapy used at the DNCG. This section has been strongly inspired by the DNCG's therapeutic manual on open groups, which is currently being used in DNCG. To learn more about the DNCG's bereavement intervention for young people and its effectiveness see Larsen, Guldberg and Kring, 2021; Harresen, Tølbøll and Larsen, 2022.

GROUP THERAPY

This manual has presented three theoretical approaches to working with bereaved in order to prevent complicated grief reactions following the COVID-19 pandemic. The three approaches have been presented with a view to conducting individual therapy. This follows on from the meta-analysis by Johannesen et al. (2019) which found, that the effect of the grief intervention was higher in individual therapy than in group. However, this could be due to the lack of RCT studies of group intervention as well and therefore more research is still needed in order to conclude on the effectiveness of individual therapy versus group therapy.

Historically grief groups have been used for decades as a way of working with bereaved, as it give unique opportunities for disclosure, empathic connection, shared goals, and psychological adjustments such as decrease of distress and sense of social isolation to life challenges (Davison et al., 2000). There is also a hypothesis, that for people bereaved under the pandemic, group therapy could be particularly beneficial, as they are more likely to have suffered in isolation and lacked social settings where their grief could be expressed and processed. Therefore, a short section will follow here on the specific aspects to bear in mind, when working with grief groups.

First and foremost, ensuring adequate professional training in working with bereavement and with groups is essential. The group therapies are expected to be conducted by an experienced trained clinician, due to the specificity of the competences required to perform the psychological functions and the complexity of the emotional process. Work of this kind requires the therapist to cope with intimacy and to represent and solicit the reflexive-analytic attitude in the group (Karterud & Bateman, 2012). Furthermore, the instructor has to be able to apply specific functions related to the management of group dynamics, which are rooted in group-analysis and psychodynamic group therapy (Anthony & Foulkes, 1965; Karterud & Bateman, 2012): e.g. the instructor sets the process norms, encourages turn taking and group interaction, and fosters the interpersonal group process as a vehicle for change

The group setting

The bereavement intervention tends to be conceived as homogeneous group. All members of the group grieving a significant loss, in order to increase fundamental therapeutic qualities such as opportunities for disclosure, empathic connection, shared goals, and psychological adjustments (i.e., decrease of distress and sense of social isolation) to life challenges (Davison et al., 2000). Research indicate that the group intervention may be more effective when it accounts for the level of grief reactions), bereavement characteristics, relationship to the deceased, and context of the death (Johannesen et al., 2019; Jordan & Neimeyer, 2003). The primary aim of group composition is to try and create the very opportunities that increase and maintain group cohesion. The therapist can support this with structure, interventions and the emotional climate in the group itself, as well as keeping the group as a whole in mind when creating the group and integrating new members into the group.

In order to achieve recognition in a group and at the same time avoid a participant 'standing out' and feeling alone with their loss situation, some scholars suggest that it is advisable to compose the group so that there are at least two people with the same problem, for example loss of partner, loss after suicide, loss after illness, etc.

At the same time, the therapist should not only strive for the greatest possible homogeneity in the group, but also pay attention to the fact that diversity in, for example, personality, relationally and in the way of dealing with emotional situations, is given space in the group. The group is a mirror - a social microcosm - where people interact in an exemplary way and can learn from their challenges, resolve conflicts and deal

with their grief in a way that strengthens the cohesion of the group and where development takes place in the potential of being part of this particular group.

How Many People Should Be in a Group? As in other types of clinical groups, bereavement groups, usually, are conceived to be constituted with a minimum of 5 people and a maximum of 12 to facilitate effective engagement and communication between participants. Experience has shown that, although recognizing it is not optimal, it can be acceptable to run a group with 13-14 people.

Time. Regardless of the kind of group (e.g. supportive or therapeutic group; addressed to mourners not at risk of prolonged grief disorder or to mourners at risk or with complicated grief), fixed session times and lengths are an important aspect of the intervention frame and provide consistency, stability, and reassurance to participants about the boundaries, limits, and opportunities within the group setting.

Recruitment procedures. They should emphasize attracting participants who are motivated (Schut & Stroebe, 2005). Individual screening session are usually recommended for prospective group members to evaluate their appropriateness for group work. That being their ability to work adequately with others as well as their level of distress. Clients who appear very fragile or traumatized may not be best helped in a group but will initially require closer individual monitoring. Lastly, their goals and expectations for the group should be broadly compatible with the therapy offered (Neimeyer et al., 2022). Furthermore, it is useful to request a brief description of the interviewee's life circumstances and loss experience to acquire greater foreknowledge of the members' circumstances, struggles and strengths.

Group methods

It's beyond the scope of this manual to provide a manual for group interventions. Clinicians interested could look for further information in the following:

- Hedtke, L. (2012). Bereavement support groups: Breathing life into stories of the dead. Taos Institute Pub.
- MacNair-Semands, R. R. (2004). Theory, Practice, and Research of Grief Groups. In J. L. DeLucia-Waack, D. A. Gerrity, C. R. Kalodner, & M. T. Riva (Eds.), Handbook of group counseling and psychotherapy (pp. 518–531). Sage Publications Ltd.
- Piper, W. E., Ogrodniczuk, J. S., Joyce, A. S., & Weideman, R. (2011). Short-term group therapies for complicated grief: Two research-based models. American Psychological Association.
- Jordan, J. R., & Neimeyer, R. A. (2012). Techniques of grief therapy: Creative practices for counseling the bereaved.
- Darrow, L. S., & Childs, J. (2020). Experiential action methods and tools for healing grief and loss-related trauma: Life, death, and transformation. Routledge.
- Inspiration in appendix 5 on how to work with grief using psychodrama in a group setting.

ONLINE THERAPY

This section will briefly touch upon conducting online therapy for bereaved individuals. The section introduces some of the key aspects of online therapy to bear in mind as well as signpost for further reading.

One aspect to be considered when conducting therapy in a post COVID-19 setting, involves the increased use of telepsychology to provide professional assistance (Boelen et al., 2020; Barker & Barker, 2022). It is noteworthy to highlight that the online, internet-based or web-based format of delivery encompasses a multiplicity of forms of contact, from fully online, synchronous sessions between a client and a therapist, to blended treatments (i.e. combining face to face sessions with online, psychoeducational modules) or asynchronous forms of communication (such as e-mail exchange, messages, among other forms), all of which need to be carefully analyzed and compared in terms of effectiveness results (see Andersson et al., 2019).

Prior to the COVID-19 pandemic scenario, meta-analytic studies had highlighted that this format of delivering interventions was overall effective and positive, with a majority of clients benefiting from this format, especially when compared to a wait-list condition; see, for example, the meta-analysis by Andersson & Cuijpers (2009), concerning the treatment of depression). Yet, studies analyzing the client's perspectives or outcomes of internet interventions can also yield conflicting results: for example, Rozental, et al. (2015) showed that some clients experienced negative effects as outcomes of internet-delivered interventions (around 9% of the clients reported negative effects or deteriorated), while Treanor (2017) found that clients experienced important relational depth and deep connection with their therapists in online interventions. Some client's descriptions of these moments are for instance, "beyond words" and "liberating" moments. Therefore, it is best to be cautious concerning the current state of evidence and maintain awareness of possible less than ideal situations or clients with whom this may not be the preferred or beneficial modality for therapy.

Online and web-based interventions. A recent meta-analysis has shown that there is initial evidence regarding the efficacy of web-based interventions for bereaved clients (Wagner et al., 2020). All web-based intervention in the collected sample (N = 7) followed a cognitive-behavioral approach, with six of them being manualized. They made use of minimal therapeutic support, individualized feedback after treatment modules and included e-mailed homework assignments, exposure writing assignments, behavioral activation modules, and cognitive reappraisal. Five of them were derived by an adjustment of protocols for online treatment of post-traumatic stress disorder (PTSD). Results showed that all the web-based interventions considered showed moderate to large effects (in comparison to control groups) for symptoms of grief and PTSD but smaller for depression.

In Italy, a smartphone app-based group psychological intervention (*"Italia Ti Ascolto"* [ITA] – *"Italy I listen to you"*) was developed (Parolin et al., 2021). The aim was to provide psychological support to people experiencing psychological distress during the 2020 COVID-19 pandemic in Lombardy (Italy). In terms of promptly reducing emotional distress, reducing preoccupation about the pandemic, and linking affected individuals to local and national mental health services. The app provides several online rooms each with a specific thematic; a specific thematic room was included for those who experienced grief due to COVID-19. The online intervention group was delivered for three months by professional psychotherapists who underwent weekly supervision. Results from a preliminary investigation show an association between dysfunctional emotion regulation strategies (expressive suppression), depression and anxiety symptoms, levels of stress, and reduced perceived social support (Parolin et al., 2021). In Spain, similar initiatives have been carried out, such as the *Sperantia* app (Halty et al., 2020), which offers different psychology services when the results of the user's questionnaires reveal clinical scores or gives preventive recommendations in case of subclinical levels.

In Portugal, the SNS 24 Psychological Counseling Line was launched in 2020 through a partnership between the National Health Care, the Calouste Gulbenkian Foundation and the Portuguese Psychologists' Association. More than 148 thousand people, including 9,500 health professionals, received support mainly related to problems and symptoms associated with anxiety, the worsening of previous psychopathology, management and adaptation in a crisis situation. The psychologists in this service also identified the need for referral to the SNS 24 Triage, Counseling and Referral service, if they consider that the user's situation has not been resolved within this brief psychological counseling (https://www.inem.pt/2022/04/06/linha-de-apoio-psicologico-do-sns-24/).

One aspect to be considered is the management of the therapeutic relationship. In telepsychology, the therapeutic relationship is enacted in a setting that is for many unusual and different from more traditional settings, with the consequence of possible problematic issues in the development and management of the therapeutic relationship. The literature on this topic is still scarce (see Geller, 2021; Poletti et al., 2021; Sucala et al., 2012). However, it may be important to stress that we all should at least not take for granted that the usual ways we have learned to build and manage an adequate therapeutic relationship in more traditional vis-à-vis settings may be equally applicable in online settings. This requires the therapist to be aware and self-reflective regarding their relational stance in such settings. At a very general level, the long-term effects of such a change (from in-office to online setting) are still unknown. For sure, it appears that many professionals overestimate their competencies in being able to provide psychological assistance in online settings (Sammons et al., 2020).

Online presence

Therapeutic presence is a process that takes place between the therapist and the client and is related to their availability and openness to be both moment-by-moment. It is a way of being with the client that enhances the doing and the application of the techniques in therapy (Geller, 2017).
The polyvagal theory presents a biobehavioral explanation of how therapeutic presence can facilitate a sense of security in both therapist and client (Geller & Greenberg, 2015; Porges, 2017, 2021). This theory argues that neuronal mechanisms communicate the therapist's experience of safety by decreasing the client's involuntary defensive subsystems. Trust results from the synchronization of physiological rhythms, and body movements expressed by eye contact and the miming of client gestures and expressions, that facilitates clients' emotional regulation, ensuring a sense of tranquility and security that promotes the social interaction.

Figure 8 – Body cues to communicate presence

Presence
Prosodic tone of voice (accentuation, intensity of pronunciation)
Forward leaning
Harmonious gestures (in mirroring)
Open body posture
Harmonious and calm facial expression

The therapist uses their self and attention to their body awareness as a tool to understand the client as well as to understand how their responses are facilitating the therapeutic process. It is like an antenna/radar that allows psychologists to read the experience, moment by moment, and echo and tune their own experience. The therapist looks for clues in non-verbal expression, listening internally for a combination of a) resonating with clients; b) their understanding of the client's history and goals; c) clinical and theoretical wisdom. This is a very demanding process for therapists because their internal resources and active availability are always highly mobilized, hence their self-care, and a practice of cultivating presence in everyday life and

interpersonal relationships is fundamental to build the neural pathways for presence training and for the therapeutic presence (Geller, 2017).

During the pandemic crisis, psychologists, especially during the first wave of the COVID-19, as many other help professionals, were inhibited from pursuing their clinical practice in face-to-face interventions. Telepsychology or e-health was suddenly, the only way that they could use to continue to provide their services. Even though some were already familiarized to online services, some guidelines were made available in order to foster good practices, disseminated by professional organizations such as the American Psychological Association (https://www.apa.org/pubs/journals/features/amp-a0035001.pdf) or British Association for Counseling and Psychotherapy (https://www.bacp.co.uk/media/10850/bacp-online-and-phone-therapy-user-guide-feb21.pdf).

Nevertheless, there are some challenges in the online setting or format of delivery that may interfere with the relational ingredients such as therapeutic presence and relational depth. The main obstacle is the technical difficulties regarding the online connection including poor internet signal which may confuse the client. Another important aspect is the lack of non-verbal cues making it more difficult to attend to client's body cues (Cooper, 2020; Geller, 2020). Cooper (2020) adds the distraction that seeing themselves on the screen imposes and Geller complements with the therapists' countertransference (their own anxieties, fear of uncertainty and grief processes activated by the pandemic) and an increased fatigue, given that being on the computer for many hours facilitates disconnection and exhaustion from the therapist.

However, the personal and professional attributes from the therapist such as being authentic, "holding boundaries", and being competent may diminish these difficulties. Treanor (2017) states that the physical distance imposed by the online context enabled a more honest dialogue, and therefore a deeper level of communication between the client and their therapist, besides the convenience of the encounter and the facility of being at home in a safe place to embrace the emotional deepening of the experience at the end of the session. Please see appendix 4 for more information on cultivating online presence.

This section on online therapy has introduced new research shaped by the pandemic, as well as highlighted key aspects for therapist to bear in mind when working with clients in an online setting. Online therapy, which covers a multiplicity of forms of contact online, offers an opportunity to reach clients, who due to health issues or geographic or financial constraints may not be able to meet face to face with the therapist. For reasons of accessibility and principles of fairness, online therapy is an important aspect to bear in mind when planning future clinical services.

Finishing remarks

This manual has been co-produced in order to further strengthening therapeutic interventions for complicated grief reactions for adults as a response to the COVID-19 pandemic. The manual combines new knowledge from research on the COVID-19 pandemic and how it has impacted bereavement in Southern Europe with three theoretical approaches to grief interventions. The goal of the manual is to assist psychologist and psychotherapist across southern Europe in their work with bereaved individuals. As this manual has elaborated on, losing a loved one during COVID-19 poses a specific risk to developing complicated grief reactions. This manual is a contribution and a starting point for further understanding these specific aspects of grief and providing adequate clinical treatment for a bereaved population at risk.

Appendix 1 - Further resources and reading

Cognitive behavioral therapy, read more from Paul Boelen and colleagues on Cognitive Behavioural Therapy for transdiagnostic complicated grief.

- Boelen, P.A., de Keijser, J., van den Hout, M. A., & van den Bout, J. (2007). Treatment of complicated grief: A comparison between cognitive-behavioral therapy and supportive counseling. *Journal of Consulting and Clinical Psychology, 75*(2):277-84. doi: 10.1037/0022-006X.75.2.277.

- Boelen, P. A., van Den Hout, M..A. & van Den Bout, J. (2006), A Cognitive-Behavioral Conceptualization of Complicated Grief. *Clinical Psychology: Science and Practice, 13*: 109-128.

- Boelen, P. A., Eisma, M. C., Smid, G. E., Keijser, J., & Lenferink, l. (2021). Remotely deliverd cognitive behavior therapy for disturbed grief during COVID-19 crisis: challenges and opportunities. Journal of Loss and Trauma, 26, 3, 211-219. https://doi.org/10.1080/15325024.2020.1793547

Emotion focused Therapy

- Elliott, R., & Greenberg, L. (2021). *Emotion-Focused counseling in action*. SAGE.

- Greenberg, L. (2022). *Emotion-Focused Therapy. Coaching clients to work through their feelings*. APA.

- Timulak, L., & Keogh, D. (2021). Transdiagnostic Emotion-Focused Therapy. A clinical guide for transforming emotional pain. APA.

The eclectic approach and letter writing and in grief therapy

- Larsen, L. H. (2022). Letter Writing as a Clinical Tool in Grief Psychotherapy. *OMEGA - Journal of Death and Dying*, doi: 10.1177/00302228211070155

- Franza, F., Basta, R., Pellegrino, F., Solomita, B., & Fasano, V. (2020). The role of fatigue of compassion, burnout and hopelessness in healthcare: Experience in the time of COVID-19 outbreak. *Psychiatria Danubina*, *32*(suppl. 1), 10-14.

- Neimeyer, R. & Sands, D. (2022). Meaning Reconstruction in Bereavement. From principles to pactice. In R. Neimeyer, D. Harris, H. Winokuer, & G. Thornton. Grief and Bereavemnet in Contemporary Society. Routeledge.

- Payàs, A. P., & Chauraud, A. M. (2019). Unfolding Meaning From Memories: An integrative Meaning Reconstruction Method for Counseling the bereaved. *Ilness, Crisis and Los, 27* ,3, 209-225. DOI: 10.1177/1054137316687954

Other resources:

Larson, D. (2020). *The helper's journey. Empathy, compassion and the challenge of caring*. Research Press.

Appendix 2 - Prolonged Grief Disorder

ICD 11 PGD Narrative Definition

Criterion	Details
A. Event	Death of someone close at least six months ago
B. Core items	At least one of persistent and pervasive longing for the deceased, or persistent and pervasive preoccupation with the deceased
C. Accessory items	Accompanied by at least one example of intense emotional pain, e.g. Sadness Guilt Anger Denial Blame Difficulty accepting the death Feeling one has lost a part of one's self An inability to experience positive mood Emotional numbness
D. Impairment criteria	Substantial impairment in personal, family, social, educational, occupational, or other important areas of functioning as a result of the symptoms
E. Cultural features	The grief response has persisted for an atypically long period (≥6 months) and clearly exceeds norms for the individual's social, cultural, or religious context

PGD, prolonged grief disorder.
Source: Killikelly et al., 2021, available in https://doi.org/10.1016/j.puhe.2020.10.034

Table 3 Essential (required) features for prolonged grief disorder in the ICD-11 Clinical Descriptions and Diagnostic Requirements (CDDR)

- History of bereavement following the death of a partner, parent, child, or other person close to the bereaved.
- A persistent and pervasive grief response characterized by longing for the deceased or persistent preoccupation with the deceased accompanied by intense emotional pain. This may be manifested by experiences such as sadness, guilt, anger, denial, blame, difficulty accepting the death, feeling one has lost a part of one's self, an inability to experience positive mood, emotional numbness, and difficulty in engaging with social or other activities.
- The pervasive grief response has persisted for an atypically long period of time following the loss, markedly exceeding expected social, cultural or religious norms for the individual's culture and context. Grief responses lasting for less than 6 months, and for longer periods in some cultural contexts, should not be regarded as meeting this requirement.
- The disturbance results in significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Source: Read et al., 2022

Criteria for Prolonged Grief Disorder in DSM-5-TR (2022)

A. The death, at least 12 months ago, of a person who was close to the bereaved (for children and adolescents, at least 6 months ago).

B. Since the death, there has been a grief response characterized by one or both of the following, to a clinically significant degree, nearly every day or more often for at least the last month:
1. Intense yearning/longing for the deceased person
2. Preoccupation with thoughts or memories of the deceased person (in children and adolescents, preoccupation may focus on the circumstances of the death)

C. As a result of the death, at least 3 of the following 8 symptoms have been experienced to a clinically significant degree since the death, including nearly every day or more often for at least the last month:
1. Identity disruption (e.g., feeling as though part of oneself has died)
2. Marked sense of disbelief about the death
3. Avoidance of reminders that the person is dead (in children and adolescents, may be characterized by efforts to avoid reminders)
4. Intense emotional pain (e.g., anger, bitterness, sorrow) related to the death
5. Difficulty with reintegration into life after the death (e.g., problems engaging with friends, pursuing interests, planning for the future)
6. Emotional numbness (i.e., absence or marked reduction in the intensity of emotion, feeling stunned) as a result of the death
7. Feeling that life is meaningless as a result of the death
8. Intense loneliness (i.e., feeling alone or detached from others) as a result of the death

D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

E. The duration and severity of the bereavement reaction clearly exceeds expected social, cultural, or religious norms for the individual's culture and context.

F. The symptoms are not better explained by major depressive disorder, posttraumatic stress disorder, or another mental disorder, or attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Appendix 3 - Assessment interview

Below are suggested headings that could help structure the assessment interview and together form the basis for an assessment of whether a bereaved should be considered for therapy. Under each heading you will find a series of help questions. It is not intended that all information should always be obtained.

Considerations related to the enquiry:

(background to the enquiry, wishes for help, motivation)

The illness:

(What illness, duration, changes in physically and mentally abilities over time, particularly violent episodes, involvement, responsibility, impact on everyday life e.g. things they could not do, how illness was talked about in family, prepared for severity including possible death. Focus: impact of the illness on the person including any traumatic experiences and regrets).

Death of loved one:

(when, circumstances of death including whether the person was present and/or saw the dead person, whether they were prepared for death and could say goodbye. Focus: any traumatic circumstances of the death e.g. found dead, self-involved, violent death and perceptions etc.)

***Reactions of the bereaved*:**

(emotional, cognitive, behavioral, physical, existential, changes, level of functioning, after-images, suicidal thoughts, self-harm)

***Family situation*:**

(the family members, living together, communication in the family about the deceased and the feelings of grief, family functioning before and now, including other close family members grief process, key consequences of the course of the illness e.g. moving house, family networks.

Other social factors:

(housing situation, level of functioning at work before and now, level of social functioning before and now, network outside the family, addiction, level of support at college/work, major changes in everyday life)

Background:

(upbringing, relationship with parents, other difficult circumstances including possible past losses and coping, possible own psychological difficulties)

***Previous treatment**:*

(special interventions around the client and their impact)

Clinical impression:

(e.g. appearance, contact, level of mentalization, emotional tone, sense of client's grief process with avoidance/overwhelm, motivation)

Overall assessment:

(brief summary of main findings including grief state, level of functioning, risk and protective factors, plan (including group/family/individual and focus if appropriate) for the child/young person in BU&S and any other interventions, information given to client)

Other resources available online in different languages

Prolonged Grief Disorder (PG13 Scale)

https://endoflife.weill.cornell.edu/sites/default/files/pg-13.pdf

Prolonged Grief Disorder Revised (PG13-R)

https://endoflife.weill.cornell.edu/sites/default/files/pg-13.pdf

Appendix 4 – Online therapy

Tips for cultivating an online presence (Adapted by Geller, 2020)			
	Before Session	**During Session**	**After Session**
Therapists	*Creating online safety*: basic cyber security, privacy, and data protection skills, using secure platforms with data encryption that ensures everyone's confidentiality and safety; *Consistency and configuration*: - Finding a suitable space in the home/office that is always the same to ensure a sense of predictability - Encourage clients' privacy by trying to ask them to be in a private place, wear headphones, and not be disturbed by family members. *Optimal distance* - Approximately one meter away from the screen, but we can ask clients to find the distance that is comfortable for them. - Keep the camera at eye level to favor eye contact. *Lighting* - Adequate, without windows in the background *Clothing* - Maintain the same style of dress as if you were in the face-to-face setting Provide these writing recommendations before the sessions to help them create a safe environment. Self-care: - Take a walk or do something physical, leaving the consultation room, go to the bathroom. - Take 5-10 minutes to focus on the here and now, such as a meditation exercise, deep breathing, yoga posture (tree), and only then let the client enter the session.	*Communicating presence, empathy, and resonance* - Facial expression, vocal prosody (rhythm, timbre, volume, and metrics), eye contact, non-verbal cues, gestures, are many ways to communicate our presence and attunement with clients). Being simultaneously attuned to our internal experience: attention to our tolerance for affect and presence cues - Maintaining eye contact Invite synchronization - Allow yourself to co-regulate with clients by mirroring their expression, eye contact, rhythm and tone of voice, and training diaphragmatic breathing together. Receptivity: openness to the experience, pushing away distractions Tuning in to the internal experience - Being in touch with internal experience and emotional states in a compassionate way to be able to recognize important emotional states in clients (how the clients' experience is manifesting in our body) and to countertransference responses (switching off, triggers, etc.) Track client's response - Attend to the nuances of clients' micro-expressions, attend when they are open in their window of tolerance or overwhelmed and disengaged. To facilitate a sense of co-regulation, adjust posture or tone of voice - Access the facial micro-expressions Contact: Confirm that the image stays aligned Pay attention to your responses so that they reflect the client's experience and needs Check in with client Deal with countertransference and presence challenges: if we are invaded by the client's anxiety, we can become anxious ourselves. In this sense it is important to practice PNR (Pause, Notice and Return), or a short practice of self-compassion, or three long deep breaths, with Grounding (feeling our feet on the ground) to help us re-center. This also gives the client a sense of humanity and modeling opportunity for the client. If the technology freezes/bad connection: have compassion with us, acknowledge the problem and try again.	Self-care after the sessions - move the body and/or do some stretches. Closing Sessions - Determine if you need more time between sessions, for notetaking, breaks, stretching, etc. Ending with intentionality: - Closing the day, closing the computer, tidying up the office - Before "going home" also take a few minutes to pause
Clients	*Optimize clients presence* - Ensure that clients have a private environment - Invite clients to intentionally minimize distractions, such as turning off their phones, turning off computer applications like email notifications, etc. - Asking to keep the camera on - Reminding them to have tissues nearby - If there is a need to use specific material: e.g. in EFT have chairs nearby; in CBT: notebooks nearby; DBT: journal cards and emotion regulation tools.		Helping clients understand what they need to transition after the session (in face-to-face format some clients go to the bathroom or have the car ride home). In online format, they may need some time at the end of the consultation to absorb or process it before they open the door and re-enter their home environment.

Appendix 5 – Express and share emotions through the psychodramatic techniques in group

Most bereaved people need to be helped to express their emotions about grief, to know that their grief is legitimate, that the intense emotions they are experiencing are felt by others, and that other people could listen to them, understand them and accept how they are feeling. Dickson (2002), introducing the value of the dramatic techniques in a group setting addressed to bereaved people, noted how soon after the death, the close network of bereaved appears to be not able to support them: when the dead is that of a familiar, often each member fear of overwhelming the other members further by adding their own grief onto what the other were already experiencing; some friends deliberately avoided mentioning the dead; others actively avoided the bereaved or wanted the bereaved to be as happy as they used to be, and criticised them for still grieving after several months. In many workplaces and schools, the bereaved were expected to perform as normal, despite the known effects of grief such as lack of concentration, low energy and intense changeable emotions, which lead to lower school marks and to work performance dropping below previous standard.

In the pandemic scenario, to the social and cultural difficulty of making contact with the suffering of death, was added the isolation related to anti-covid measures. Most people lived their grief in a private way, leaving them with intense, overwhelming and confusing emotions, also related to the traumatic character of the loss experience (see Chapter 2): the impossibility to be with their relatives in their final moments, the rapid and unexpected character of the dead, a lack of clear understanding of how the loved ones died, the lack of farewell and of possibility seeing the body.
Psycodrama techniques (or games) can represent elective strategies to manage overwhelming affect, favouring the contact with deeply emotional elements and facilitating emotional expression and sharing related to painful emotional experiences (Margherita, 2009; McVea & Gow, 2006).

Psychodrama is largely associated with effective treatment for trauma survivors, for instance, to increase self-disclosure and depth of experience in persons with PTSD (McVea, Gow & Lowe, 2011). Few experiences using psychodrama to deal with grief are also recounted in literature (e.g. Dayton, 2005; Dickson, 2002; Figush, 2009; Istvan, 2014; Testoni et al., 2019).

In this section, we firstly will introduce the key principle of psychodrama as action method and its classical structure; then, we will present the main techniques, with the idea that they can constitute a tool of the clinical practice, which may be integrated with different psychotherapeutic methods and which also may include conversation, using drawing, letters and other creative expressive techniques.
In all the cases, given that an intense emotional experience can be triggered by psychodrama, practitioners require high methodic and counseling/therapeutic competence, to manage the process, to select appropriate techniques or also develop new techniques according to the situation, the clients, the topic and the goal of the meeting. In a process-oriented approach, the director must also be consciously aware of the level of group dynamics, paying attention to the integration of the group, demanding adherence to elementary norms and boundaries, and helping clarify conflicts (von Ameln & Becker, 2020).

X1. Psychodrama as action method

Psychodrama is an action method pioneered by Moreno (1946-1993), one of the founders of group psychotherapy, in which "people enact scenes from their lives, dreams or fantasies in an effort to express unexpressed feelings, gain new insights and understandings, and practice new and more satisfying behaviors" (Garcia & Buchanan, 2000, p. 162).
The re-enactment of a painful experience in a group, the possibility to identify, through the help of the other members, more adaptive ways to think, feel and act about the experience, the role reversal

allowing a different perspective or the feedback of others sharing the same problem, critical event, or life challenges, are basic concepts of psychodrama.
While Freud considered "acting out" as resistance to psychotherapy, Moreno (1969) considers the action which takes place in the relationship (e.g. the safe and supportive environment of a group session) a key factor of the healing process (Nolte, 2020). Today, psychodrama is recommended by several European governments as a good health practice (Cruz et al., 2018).

Although psychodrama has historically relied on psychoanalytic and interpersonal frame, from the end of the twentieth century, several authors integrated the original psychodramatic theory with other theories or suggested new theoretical bases for the method (Cruz et al., 2018). For instance, psychodrama practice was used in the frame of cognitive-behavioral therapy (e.g. Somov, 2008) and family therapy to increase empathy, give opportunity for amendment of misunderstandings, and establishment of connection (Farmer et al., 2018; Homes & Kirk, 2014).
So, actually, specific psychodramatic techniques are applicated as independent interventions within the more traditional, verbal psychotherapy (Kipper, 1997). They have an extensive use in health settings, including hospitals and mental health services, and also in educational and work environment (von Ameln, F., & Becker, 2020; Bendel, 2017; Lipman, 2003).

Structure

Primarily used as a group method, psychodrama usually involves at least one psychodrama therapist, referred to as the director, and approximately five to fifteen clients or participants, meant to accommodate exploration of individual or group problems through the use of enactment and feedback (Holmes & Kirk, 2014).
In the protagonist-centered psychodrama, one of the group members – the protagonist – is the focus of the play and the participants represent "auxiliary egos", called to embody the protagonists' relationships or to represent abstract entities and things (von Ameln, & Becker, 2020). There is no protagonist in sociodrama, where the play focuses on the whole group and each member is an auxiliary ego.
The session begins similarly at each meeting, with procedures designed to provide a sense of predictability and safety to group members while also allowing members a measure of control. Members sit in a circle, which reinforces the literal and symbolic sense of safety and care. Participants are introduced to the purpose of the session and the procedures and the group expectations are shared. Importantly, confidentiality is reviewed.

In the work with bereaved people, the group can be presented as a time-space where people can talk with each other about the way the death of their loved one was affecting their life and related emotions can be expressed and shared. People are allowed to cry freely, express anger and talk openly about the loved one who had died (Dickson, 2002).

After creating the holding environment, a standard psychodrama group includes three essential stages: warm-up, action, and sharing (Kellermann, 1987).

The warm-up stage.
It serves to both warm-up participants to physical action and internally to warm up to a psychodrama (Giacomucci, 2021). This phase is designed to bring critical events or distressing experiences into the present ("here and now") of the session. Warm-up activities are intended to help group members i) identify what they need to work on, (ii) allow a group theme to emerge, and (iii) facilitate group members' self-expression and self-exploration. The director may use physical exercises (e.g participants are invited to walk around the room), mental starters (e.g. participants are invited to think about how they feel in that moment) and check-ins (each group member recounting important events experienced) (Nolte, 2019). In the warm-up stage, a group member is selected as the protagonist of the following

action stage. Group members indicated which of the proposed topics would most help them; the topic and protagonist are chosen democratically to ensure that the group topic collectively represents the group as a whole and that each group member's story is related to the topic.

An example of technique which can be used at the beginning of a session with bereaved people is the "Introduction from Another Role" (von Ameln & Becker, 2020), where the participants, in turn, take on the role of an attachment figure of their choice (e.g. the deceased parent, brother, friend, etc) and introduce themselves from the chosen role. An example:

> Mr. Smith gets up and introduces himself from the role of his deceased wife:
> "This is my husband, John Smith. John is 45 years old and he is an airplane pilot, so he is often away from home—. For this reason, I cared especially for our two children, Helen, 4 years, and Stewart, 8 years. I know that John likes his children very much but I wonder if he will be more present at home, now that I am no longer there (etc.)."

This technique is not only a way to allow the participants to present themselves in the introductory round, but it also allows participants to express the thoughts, concerns or role changes they feel they have inherited and/or feel they have to deal with after the death of their loved one.

<u>The actions stage</u>

It aims to bring the intrapsychic or interpersonal life of participants onto the stage through role-playing and other psychodramatic techniques. Depending on the themes that emerge during warm-up stage, a number of scenes can be enacted that approximate real-life situations (for example, memories of specific situations shared in the past with the deceased person or lived in hospital, in the relationship with the healthcare staff who cared for their loved one, or situations that may arise after his/her death, like having to deal alone with decisions related to the education of children), or are externalizations of inner mental processes (inner dramas, fantasies, dreams, or unrehearsed expressions of mental states in the here and now). Usually, the activity focuses on a specific participant (protagonist-centered psychodrama) who takes the role of the protagonist and stages a specific crucial experience, with the support of at least one auxiliary who takes the part of the significant other for the protagonist (e.g. the deceased person, a doctor with whom you have come into conflict, a son who shares with the protagonist the loss of the loved one) or of an abstract idea (e.g. the strength, the patience, the support that the protagonist feels he needs to face the loss) (Holmes & Kirk, 2014).

An example is offered by von Ameln and Becker (2020, p. 90) through the case of Mrs. Madison, a patient who had lost her daughter and her husband a few years ago. Mrs. Madison had no close friendships and she has no idea of how to make her existing relationships more active. Her therapist, Mr. Smith, places a chair for Mrs. Madison in the middle of the therapy room, while more chairs are grouped around it for her attachment figures. Mrs. Madison is requested to change various roles by sitting on the respective chairs.

> "Mrs. Madison, please sit here and change into the role of your brother James. You are now James Madison. Please introduce yourself."
> (The protagonist introduces the brother.)
> Mr Smith asks "Mr. Madison, how is the relationship between you and your sister?"
> "Well, since my sister lost her husband, she has been very withdrawn. I seldom hear from her anymore" replies Mrs. Madison from the role of her brother.
> "Would you like to be in more contact with her?" asks Mr. Smith.
> "We've grown apart now. We used to meet more often in the past, sometimes for a weekend" comes the reply.
> Mr. Smith asks: "Would you like to revive that time, Mr. Madison?"
> "Yes, of course, I have plenty of time now since I am retired" comes the reply.

The sharing phase

Moreno describes sharing as the "group therapeutic part of the session". This phase (also named 'the return to the group', Schützenberger, 1979) aims to allow each of the members of the group to share their emotions about their own experience of playing a role or observing the psychodrama of another participant carried out during the session. This process helps the protagonist to come back into the group, whereby the group members can identify with to the protagonist, expressing, in a non-analytical and non-judgmental way, where they have identified themselves and/or why their own experiences are similar to what the protagonist has portrayed. Homes and Kirk (2014) refer to the sharing stage as a "love-back", to underline that sharing should serve to express empathy and support for the protagonist. Leutz (1974) points out that the communication takes the protagonist and the audience away from the idea that the suffering depicted is something unique. Sharing can be expressed through verbal statements and non-verbal communications (e.g. embracing the protagonist). An example:

> Mrs. Katy Holmes staged her difficulty in thinking herself alone in the management of daily life and in the care of her two young children after her husband's death. The latter was very present at home; he helped her with household chores, but he also played a lot with his children. In one scene Mrs Holmes represented the fear of not being up to the task, asking an "I auxiliary" to play the part of one of her children who while playing tells her 'I miss dad'. Another participant took the place of Mrs Holmes; she approached his son, told him 'I miss him very much too', and she hugged him; then they cried together. During the sharing phase, interventions of this type follow one another among the other participants:
> Joana (who, like Mrs. Holmes, recently lost her husband): 'I identified myself so much with Katy's fears. I always wonder what I can say to my children; now I feel that the important thing is not what to say, but to allow them to express their pain, together with me'
> Steven (who lost her mother): I identified with the son of Katy and I felt that one of my greatest difficulties when I lost my mother was to fear weighing my father further with my pain; maybe it was enough to hug and tell each other how much we missed her
> Mary (who lost her boyfriend): I really want to hug you, Katy, can I?
> Mrs Katy Holmes: Of course, I need it too

When the encounter is about to end, participants can be invited to reflect on what they had gained from being in the group. This stimulus can be proposed through a free discussion in a circle or even using a psychodramatic game, like "Take your place why …" and "Goodbye to the group" (Montesarchio & Marzella, OBJOBJ2004).

> *Take your place why….* The conductor invites the participants to form a circle together with the others. In turn, who wants can cross the circle and stand in front of another participant verbalizing with a few words because 'takes its place' (e.g. I take your place because I like the way you are managing to face this experience'). After the verbalization, the two participants exchange places in the circle. Afterward, other participants may ask to take someone else's place. It can be used after a real game involving the whole group, to urge participants to share impressions about the resources that other members have demonstrated
>
> *Goodbye to the group*. The conductor suggests participants to distribute themselves in the available area, sit and imagine their own greeting. Then, invite each one to form a circle together with the others, first holding for hand, then side by side, finally with the arms intertwined, forming a group very compact, as close as possible to each other. After a few moments in this position, each in turn pronounces his/her own greeting towards the group and, always keeping the circle, it turns outwards. When everyone has spoken their greeting, the conductor invites them to imagine their own return home and finally to melt the circle.

Being an exercise to close the session or even a cycle of meetings, this game does not provide the moment of verbalization, having in itself the function of providing the group with a sort of "restitution" of the experience made together.

The main specific psychodrama techniques

- Role training. The protagonist identifies familiar and unfamiliar roles (e.g. a familiar from whom he feels left alone, a doctor who makes the protagonist feel impotent), and then practices adjusting the unhealthy roles into healthy functioning roles (Holmes & Kirk, 2014). A group member (the auxiliary ego) serves as a significant other for the protagonists, taking the part of an individual, or an abstract idea, like strength or hope (Holmes & Kirk, 2014). An example:
  Mrs John, who lost her mother, recounted the difficulty of handling the calls of relatives and friends; often she finds herself passively listening to advice, suggestions, invitations to be distracted. An auxiliary ego takes the place of a friend who, on the phone, invites her to go ahead and get distracted. Mr. John takes a long breath and then explains what she needs: 'I feel it is too early for me to imagine myself distracted, I feel the need to be a bit alone with myself, to browse the albums and collect thoughts, but I have something to ask you: Marie and John told me that they would love to play with their friends. Could you take them with you when you take your kids to the park? I would feel relieved'
- Role reversal. The protagonist steps out of his/her role and takes on the role of a significant person in their life (e.g. the dead person) or part of his/her self (e.g. the courage, the idealism, the values that he/she thinks to have inherited from his/her loved one who is died), or an object (e.g. a letter, a necklace inherited by the death person) (Holmes & Kirk, 2014).
- Double. While the protagonist represents his/her own role, the auxiliary ego stands beside or behind him/her, adopts his/her body and emotional expression but also encourage self-exploration (von Ameln & Becker, 2020), slowly adding the emotions, fears, motives, or hidden intentions that the protagonist is not explicit about. The double, thus, voices aloud in the first person what he believes the protagonist is suffering/feeling but, for some reason, s/he does not perceive or avoids expressing. Returning to the example of Mrs John, if she had difficulty to express their feeling and needs in the scene with her friend, the director might instruct a member to increase her expression of distress and to make explicit the tacit thoughts (e.g. 'that's not the help I need').
- Mirroring The protagonist steps out of the "stage" and a group member or the therapist adopts the role of the protagonist, fulfilling a function similar to that of a video feedback but a video that goes deeper and can emphasize some aspects (von Ameln & Becker, 2020). In this way, the protagonists can see themselves from a critical distance (Holmes & Kirk, 2014).
- Soliloquy. The protagonist verbally expresses his/her thoughts and emotions about something (e.g. the things that he/she fear to have loss with the death of loved one, the challenges he/she will face, the unresolved conflicts, the unfulfilled dreams).
- Empty chair. The exercise begins with the group sitting in a semicircle in front of the space with an empty chair placed in the center. The chair is occupied by those who feel ready to start the exercise with the delivery of talking to themselves, articulating the dialogue in questions and answers, remaining seated when answering, and standing, with the empty chair, when making the question, or vice versa, but with the idea that in the two phases the protagonist really has as an interlocutor, a part of himself.
- Chair with significant person. In this case, the protagonist is invited to imagine that in the chair there is a significant person (parent, best friend, boyfriend/girlfriend, etc.) and to choose, among the members of the group, a person that will play the chosen character. In the work with the bereaved, the decesead person can be called to sit in the empty chair and, in so doing, to work on everything that had been suspended in the dialogue with the dead person (e.g. contradictions, ambiguities and ambivalences and all the "not said").

Applications and clinical beneficial of psychodrama techniques

The role players acting "as-if" has multiple clinical implications including providing role training for future situations, offering moments of developmental repair or corrective emotional experiences and providing the body with the chance to complete survival responses to traumatic events that were interrupted leaving one frozen (Giacomucci, 2021). The action in a group relationship allows to overcome the isolation, through the communication with others suffering from similar problems and to benefit from the group's experiences and views on the problem being worked on. Each event is processed through multiple and diversified vertices of observation, and this makes possible a reflection to several voices on materials experienced in common.

Tele-psychodrama

Recently, psychodrama techniques were adapted to the online modality (Biancalani et al, 2021). For instance, significant events of the participants can be represented through significant objects or photographs that group members had at home; specific feelings related to the circumstances of physical distancing can be represented, through drawings made by the participants which can be displayed on the screen and shared and commented on by the whole group. Biancalani and colleagues (2021) qualitatively investigated the impact of a group tele-psychodrama implemented during the lockdown measures. The 15 members, belonging to a pre-existing in-person psychodrama group, refer increased personal well-being due to tele-psychodrama and mitigation of the sense of social isolation.

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