CROSS-MODALITY GRIEF THERAPY: DESCRIPTION AND ASSESSMENT OF A NEW PROGRAM

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A recently developed program for extensive inpatient grief therapy in groups, administered on a time-limited basis, is outlined, an illustrative case study is described, and empirical assessment of the program's efficacy is provided. During a 3-month stay in a Dutch Health Care Centre, a combined treatment program was offered that integrated behavior and art therapy [so-called Cross-Modality Grief Therapy, (CMGT)]. Assessment (levels of symptomatology on the General Health Questionnaire) was made at pretest, post-test, and follow-up and was compared with levels at comparable time points among participants in a more traditional program. Systematic advantages were found for CMGT. Discussion focuses on the identification of elements within CMGT that were responsible for its effectiveness. © 1996 John Wiley & Sons, Inc.

How effective are intervention programs in alleviating the symptomatology of grief? In the last two decades a great variety of grief counselling and grief therapy programs have been developed (for a review, see Raphael, Middleton, Martinek & Misso, 1993). Yet very few methodologically rigorous assessment programs have been conducted to evaluate the efficacy of such interventions. None, to our knowledge, has focused on the effectiveness of therapy for bereaved persons in inpatient institutions. While inpatient care is indicated only for a relatively small portion of bereaved persons (most bereaved who need help are being treated on an outpatient basis), these patients are likely to be the most severely affected. Furthermore, it has been acknowledged for some considerable time that complicated bereavement occurs in large proportions of inpatients to psychiatric care (cf. Parkes, 1964). Thus, it seems timely to try to derive procedures to increase the efficacy of inpatient therapy, and it also seems essential to evaluate the effectiveness of new programs of intervention for such high-risk bereaved subgroups.

The opportunity to develop and assess an intervention program for the treatment of bereaved inpatients was offered to the authors by a Health Care Centre in The Netherlands a few years ago. Such Centres combine extensive inpatient treatment, frequently on a time-limited basis, with a non-stigmatizing environment, an advantage that they have over psychiatric hospitals. They are particularly suited to—and often attended by—people who are

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A previous version of this paper was presented at the Fourth International Conference on Grief and Bereavement in Contemporary Society, Stockholm, Sweden, June 12–16, 1994.

We are grateful to the staff of Health Care Centre 'Mens & Samenleving', in particular Louisette Baars, Maria Vos, Ineke Veldhuis and Wilma van Galen, for conducting the therapy. We are also indebted to Maria Vos for designing the art therapy. This project was supported by grants from the Dutch National Fund for Mental Health (NFGV) and HORA.

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Journal of Clinical Psychology, Vol. 52(3) 357–365 (1996)

CCC 0021-9762/96/030357-09

suffering from complicated bereavement, for whom time-limited therapy usually is indicated and for whom, in most cases, formal psychiatric hospitalization seems inappropriate.

The new therapy program was developed according to the requirements of this Centre and incorporated and integrated behavior and art therapy protocols. Thus, it has been designated Cross-Modality Grief Therapy (CMGT). The efficacy of this program in alleviating the symptomatology of bereaved patients was assessed by comparing outcomes with those that followed the customary therapeutic intervention that had been employed in the Health Care Centre.

In this paper, we first describe the intervention protocol that was devised for the treatment of bereaved inpatients, and then we describe its implementation and the evaluation of its impact on the patients. Next, we illustrate the new procedure and its effect on one patient with a case study. Finally we draw implications from the results of the study for the planning of inpatient intervention.

Description of the New Therapy Program

Requirements for the new program were that it should be technically simple, applicable in the particular context, and that it would fit into the organizational structure of the Health Care Centre. The aim was to develop a time-limited therapy protocol for small groups of bereaved who had suffered different types of loss (i.e., spouse, child, parent). This led to the integration of behavior and art therapy techniques in the designed treatment. Art therapy has been used fairly frequently in grief therapy (Irwin, 1991; Mango, 1992; Schimmel & Kornreich, 1993). Although its effects have not been studied systematically, its healing potential generally is thought to be high. Therefore, the current program offered further exploration of its potential.

The treatment was comprised of four phases: an introduction, an individual-oriented, a social-surrounding-oriented, and a completion phase. In general, the focus was on accepting the reality of the loss, the working through of emotions, and social adjustment to the new situation. Sequentially, treatment was designed in accordance with Worden's (1991) task model of grief, which identifies these elements as critical in coming to terms with loss.[1]

The Introduction Phase

During the introduction session the two central therapists (a psychologist and an art therapist) were both present to offer the group members information about each part of the treatment and to explain what would be asked of the group members. Subsequently, behavior therapy and art therapy sessions were held separately, although the therapists kept in close contact and gave each other (and the other staff members involved) feedback and the necessary information for close integration.

Central in the designed protocol was the creation of a hierarchy of problematic grief-related emotions. This is a seemingly simple technique, based on behavior therapy principles (cf. systematic desensitization) to assess, weight, and rank problems that people encounter in the grief process. What bereaved people often perceive as disordered, even chaotic, in their minds and their surroundings was structured through careful scrutiny of what they felt, when they felt that way, and under what circumstances they felt as they did. A subsequent ordering of these emotions was based on the self-reported level of distress associated with these particular feelings and situations.

To establish individual hierarchies, several exploratory techniques were used. In behavior therapy, this was done by means of group discussion of personal histories of the

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[1] Although there is good reason to doubt the general applicability of the grief work hypothesis in bereavement, there is reason to assume its applicability in the case of complicated bereavement. (See Stroebe, 1992 and Stroebe, van den Bout, & Schut, 1994.)

group members and by psycho-education, especially incorporating the use of reading materials, such as extracts from published diaries, interviews, ego-documents, and hand-outs written for this specific purpose. In art therapy, exploration was done by means of guided fantasy, making a patient concentrate on his or her emotions with the aid of different kinds of music, and painting these emotions. Another technique used was the mapping of emotions to depict all emotions that the person was experiencing. This led to the listing of personal hierarchies for all the group members.

The Individual Oriented Phase

Working through grief, the central focus in this phase of therapy, was approached and dealt with in a close integration of therapy modalities. In creative therapy as well as in behavior therapy (using cognitive techniques), barriers in the grief process were located. Such concerns as negative thoughts or fear of losing control often hinder this process. In art therapy, these obstructions were visualized. The group members provided support and helped each other to break through these blocks. Behavior therapy techniques, such as systematic desensitization and cognitive restructuring, facilitated working through. As is usual in systematic desensitization, a particular situation or emotion was selected first, which caused or was associated with difficulty for the client and which had a good probability of being treated with success. The underlying idea is that successful treatment of a part of the problem has generalizing effects. In other words, dealing with this specific concern lessens the distress in other areas and makes other problems more accessible for subsequent attention.

In art therapy, working through was approached by means of techniques such as the visualization of "disasters and jewels" in one's life, in which—as in other contrast techniques—the patient had to focus on positive and negative aspects of his or her life and situation. Other techniques that could be used were visualizations of the last day of the deceased and symbolizing the deceased in paint, clay, cloth, or other materials. An advantage of CMGT is that interventions could focus on the preferred modality to facilitate working through.

The Social-surrounding Oriented Phase

In behavior therapy, the focus gradually shifted from the intra-psychic to inter-psychic problems in the hierarchy. Social skills training was applied and was designed to tackle problems the patient had, for instance, with relatives and friends. In this stage, the group could function as a safe place to try out new behaviors, such as asking for and giving support. In addition, sharing personal experiences of non-supporting interactions with non-bereaved appeared to be very important. Cognitive interventions in this phase were designed to change the often-present passive victim perspective in the bereaved.

The Completion Phase

The completion phase concentrated on the transition from the Health Care Centre and the group to home. Comparisons were made with the bereavement process in general. Saying goodbye to the group members and therapists, and often also to a certain phase in the grief process, frequently was done in a symbolic way by means of ritualistic disposal of the things that were created in art therapy and by members' giving each other self-made symbolic presents.

Supplementing the grief therapy-specific approach described above, treatment was comprised of general therapeutic modalities, such as individual guidance, gymnastics, relaxation training, and thematic group discussions. These were similar to those available in the previous therapy program. Furthermore, it should be noted that because therapy was conducted in a clinical setting, patients were continuously in a therapeutic environment, and, accordingly, they had certain tasks and responsibilities and were in continuous social interaction with other patients.

METHOD

Subjects

The CMGT sample. Fifty-two patients participated in the newly-designed program. Whether grief therapy was indicated in individual cases was decided by a psychologist doing the intakes. Naturally, patients had to agree with the treatment before final decisions were made to proceed with it.

The control group. The control condition was made up of patients undergoing the regular Health Care Centre therapy for complicated bereavement during 1991, which was the year before the newly designed treatment was instigated. Seventeen bereaved persons who participated in this type of therapy were assessed for comparison purposes. The groups who received the treatment were heterogeneous with regard to the diagnoses of their individual members. In addition to complicated bereavement, diagnoses of participants ranged from marital problems to anxiety disorders and from personality disorders to psychosomatic disorders. Only those suffering from bereavement were included in the control condition.

Procedure

In 1991, three psychotherapists and an art therapist were given a 3-day training course in the designed treatment method. These new and control programs were equivalent with regard to amount of therapy time allocated.

The CMGT condition. Twelve 2-hour behavior therapy sessions and eight art therapy sessions of 2 hours each were attended by the bereaved patients during their 3-month stay at the Centre (the legal maximum length). Patients were divided into groups for therapy sessions. Group size ranged from three to five members, and groups (which were closed) always were led by the same psychologist.

The control condition. As noted above, apart from the cross-modality extension, which was unique to the new program, this condition was comprised of similar elements to CMGT, although these were not integrated in the same way and were not focused specifically on grief. Individual psychotherapy was typically combined with group therapy for relaxation, social skills training, and thematic discussion.

Assessment of the Efficacy of the New Program

To analyze the efficacy of the new therapy compared with the control condition, data were collected four times: at intake, at entrance (baseline), directly after discharge (post-treatment), and three to four months after discharge (follow-up). Assessment was made in terms of patients' scores on the General Health Questionnaire (GHQ). This questionnaire was designed by Goldberg and Hillier (1979) for the detection of nonpsychotic psychological distress in a general population and has proven to be very well suited for assessing psychological problems after bereavement (Schut, 1992). The GHQ contains four scales which cover the most important areas of grief symptomatology, that is, depression, somatic complaints, anxiety and sleep disorders, and problems with daily functioning.

Socio-demographic characteristics of the participants are given in Table 1. The only difference with regard to socio-demographic characteristics between the 52 persons in the CMGT condition and the 17 in the control condition was that the level of education was slightly higher in the former of these, $t(64) = 2.31$, $p < .05$. However, because level of education was correlated only with GHQ-scores at T1 ($-.43$) and was not correlated at any of the other data collection points, this was not used as a covariate in the analyses. Because samples were small, checks of the association between GHQ and the variables relationship to the deceased, cause of death, and time since bereavement were made. These indicated no associations between distress and any of these variables.

A total of 14 patients (27%) dropped out of the newly designed therapy or did not complete all questionnaires. A comparison of all available variables suggested only one system-

Table 1
Demographic Characteristics by Condition

	Experimental (n = 52)	Control (n = 17)
Percentage of Women	88%	87%
Mean Age (*SD*)	51.6 (12.3)	54.9 (10.6)
Mean level of education (1 = low, 4 = high)	2.2 (.8)	1.7 (.8)
Relationship to the deceased		
Partner	54%	63%
Child	38%	19%
Parent	4%	19%
Sibling	2%	—
Other	2%	—
Cause of death		
Cancer	30%	38%
Heart Disease	30%	25%
Other Diseases	13%	6%
Suicide	9%	13%
Accident	13%	19%
Violence	4%	—
Cause Unknown	2%	—
Years Since Bereavement	3.9 (3.7)	2.2 (2.7)

atic difference between drop-outs and patients who continued therapy: drop-outs tended to have a lower level of education (M 2.4 [.8] vs. 1.3 [.8], t[49] = 3.65, $p < .01$). Because no posttreatment data were available from drop-outs, it is not possible to analyze their psychological functioning after discharge.

Results

Table 2 shows the comparative impact on mental health scores of the CMGT vs. the control condition at the four measurement time-points. Results are presented with regard to the total scores on the GHQ. MANOVAs over repeated measures show diminishing of distress over the time course of the study in both groups, $F(3,46) = 33.7$, $p < .001$. However, they evidence a significantly different course of symptomatology over time, $F(3,46) = 2.8$, $p < .05$. As can be seen, the patients in the new treatment condition reported more stable improvement than the regular patients. At follow-up, both groups reported some relapse, which typically is found after the cessation of therapy, but it is noteworthy that this is more extreme in the control condition.

Cohen's d coefficients were calculated to assess the magnitude of change (see Cohen, 1988). Table 3 presents Cohen's d at the follow-up measurement point for the total GHQ-score and the four subscales. This analysis was restricted to the last measurement point because it provides a more accurate indicator of longer-term benefits of the therapy than would

Table 2
GHQ-total Scores by Condition

		Intake		Entrance		Post-treatment		Follow-up	
	N	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Cross-modality Therapy	38	18.5	6.5	20.1	6.0	6.5	6.8	10.5	7.9
Control Condition	12	21.1	4.2	18.5	8.5	7.3	7.3	15.3	6.5

Note. Only people with complete data set over the four time points are included.

Table 3
Cohen's d Coefficients for Baseline vs. Follow-up Change on GHQ-scales by Condition

	$d^{\text{baseline-follow-up}}$	
	CMGT	Control Condition
Problems with Daily Functioning	1.52	.39
Anxiety and Insomnia	1.38	.22
Severe Depression	.60	.33
Somatic Complaints	.94	.45
Total GHQ	1.43	.42

Note.—d = .2 = small; d = .5 = medium; d = .8 = large (Cohen, 1988).

the immediate post-therapy assessment. A consistent pattern of results can be seen across all four subscales of the GHQ: the control treatment leads to no more than small to medium improvement, while in the CMGT condition changes range from medium to very large. The largest differences were found in daily functioning and anxiety. Depressive symptomatology appeared to be least influenced by the newly designed treatment, and differences between conditions appeared to be least visible for this subscale.

Case Report

To illustrate the design and content of CMGT, in this section we follow one particular patient, Anna, through the course of her participation in the program.

Anna was a 43-year-old married woman. The marriage had been good until five years previously, when the couple had lost one of their three children: their 18-year-old daughter Marieke died of meningitis. The family almost fell apart afterwards, not being able to support or even understand each other in their grief. Anna's husband tried to pick up normal life as soon as possible, while Anna could not get over the loss, finally becoming depressed (DSM-IIIR diagnosis: 300.40—dysthymia—and V62.80—relational problems). Her worries over the family disintegrating finally made her decide to ask for professional help at the Centre.

Initially Anna was rather withdrawn. During behavior therapy sessions she felt very tense and was hardly able to talk. Art therapy, by contrast, seemed easier for her to relate to, and it also worked very well for her in a therapeutic sense. After participation in the art sessions, it became easier for her to talk about her problems in the therapy group.

Her art works not only reflected where she was in terms of her grieving process (e.g., her preoccupations, anxieties, and so on), but they also revealed her ongoing, active, effort to cope with grief during—even by means of—their actual creation. Thus it became evident how she was grappling with herself to portray these feelings on paper, and trying to come to terms with certain harrowing aspects of her grief while doing so. Description of a few of these art works across the course of treatment elucidates both these aspects.

During the third week of her stay, Anna visualized her moods in different sections within one of her paintings: loneliness in one corner, where she drew herself being lonely, even in a crowed of people; sadness in another, in which she depicted her own crying heart, missing Marieke; her fear she also portrayed, the feeling that something could happen to her at any time; but she was also able to draw happiness, depicting happy memories of a holiday with Marieke in one part of this work. In a different depiction created during that time she was able to express her anger and also her guilt at not having done enough to prevent her daughter from dying.

Simultaneously with, and subsequently to, these art therapy sessions, during behavior therapy, a hierarchy of problematic emotions was constructed. Loneliness, sadness, and an-

ger appeared to be the most difficult for Anna to deal with. The hierarchy appeared to make her emotions less diffuse for her. Attention was primarily focused on her anger, which she felt helpless to deal with. The sequence of visualizing and then discussing this made it easier for her to work it through. Especially the sympathy and encouragement she got from the other group members made it easier for her to confront her problems.

One of her most visually powerful—and perhaps for her the most significant—art works was accomplished around this stage of the therapy: during a music-guided visualization of fantasy she created a monster symbolizing the virus that had caused her daughter's death. Doing so gave her a sense of control over her feelings. She symbolized how this "beast" grabbed Marieke. It was a very emotional experience for her to draw this monster, and it triggered more anger, which she first expressed explicitly during the next behavior therapy session. The support and understanding she got for her feelings during this session made her feel stronger and gave her the strength to focus again, this time solely, on the virus during the next art therapy session. Along the edge of this art work she wrote the word "KILLER" in bold black letters. It was indicative of the intensity and concentration that this creation demanded of her that she did not speak a word during the entire session when she produced it. She only spoke about it during the subsequent behavior therapy session, when she discussed her anger and her powerlessness in detail with the group members.

To her relief she slowly but surely discovered that, although the other group members had suffered completely different losses, they all recognized her feelings and were able to verbalize these for her at a point where she herself was still unable to do so. This facilitated her own confrontation with her emotions. After a while she felt she had dealt with the matter sufficiently for the moment—she was in fact exhausted—and she went on to focus on other things. It is perhaps significant that she turned to the reading of a religious book (she was herself religious) in which the question 'why' was addressed. At that time she also addressed her guilt feelings regarding the fact that she had been sent home by the doctors the last evening Marieke had been in a coma in the hospital and so had not been present when her daughter died. Through discussing this with the other group members she finally came to distinguish her personal wishes from the actual options she had at that time, diminishing her guilt feelings.

After these confrontations, Anna also felt more able to confront the death of her daughter. She started listening to Marieke's favorite music and reading her diaries. She felt relief about this, and slowly but surely she felt more in control of herself and her situation. She did still feel depressed, but this was understandable because she had come to realize the full impact of the death of her daughter.

During the final stage of therapy Anna was given the assignment to talk about her feelings with her husband. Initially this was done under supervision of the therapist, but after two meetings it was decided to let them continue on their own. She appeared not only to be able to communicate her feelings towards her husband, but it also became clear to her that his way of coping with the loss was the result of his incapability to confront the loss. Since Anna had always attributed his avoidance of the topic to reflect his lack of love for their daughter, this made her understand and even appreciate his way of dealing with it. And although Anna's husband still found it very difficult to be confronted with his daughter's death, he became more understanding and supportive of Anna.

In behavior therapy Anna was given the assignment to write a final "goodbye" letter to Marieke, which occupied almost all of her time during the rest of her stay. This forced her to focus on her daughter, as was reflected in a later drawing, in which she depicted the graveyard. Marieke was pictured as dead and buried and she herself was portrayed as feeling as though she too were dead. The other family members (her husband and two other children) were painted in yellow. It appeared that she had to deal with death in this "factual" way first, before she could confront the realization of death on a spiritual level in general and the loss of her daughter specifically. This was achieved by talking about the past–present contrast in behavior therapy, after which she drew a painting wherein, for the first time, she was able to

divide her life into two periods: when Marieke was alive and the time subsequently. In the very last behavior therapy session the future was talked about, as was the imminent ending of her stay at the Centre and what the group members were to do with the art works that they had created.

Anna's last drawing was called "my thoughts are getting lighter," which was her personal goodbye and way of saying thank you to the therapists and the members of the group. At discharge she had not finished her letter to her daughter and she wanted to postpone the decision on what to do with her art works until she had completed it. It transpired three months later that she had buried the letter and a selection of her paintings near Marieke, after consulting her husband and surviving children about this closing gesture.

Conclusions

Two types of therapy treatment for complicated grief reactions were given in bereaved inpatients, the one a regular type of intervention administered at a Health Care Centre, the other a newly designed program integrating various modalities and implemented at the Centre. The impact of these two programs on symptomatology was assessed. Patients in both groups showed improvement when pre-test was compared with post-test levels of symptomatology. We cannot say to what extent improvement in the two groups reflected a 'natural' process of recovery from bereavement over the course of time (although, since bereavement was of long duration and complicated, this would seem unlikely in the time)—for ethical reasons it is not possible in such a study to assign patients to a non-intervention comparison group. This becomes relatively unimportant when the results of the two interventions are compared, for then we find that there were significant differences in efficacy between the two programs: more successful results of the new approach were found, compared with the regular treatment at the Health Care Centre. Participants in the CMGT condition showed relatively greater improvement on GHQ scores in general, and this was also reflected in their scores on the GHQ subscales measuring problems with daily functioning, symptoms of anxiety and somatic complaints. The former group also showed slightly more favorable results with regard to depressive symptomatology.

Why was the CMGT program comparatively more successful? In our opinion, basically four things led to this.

1. *The combination of treatment modalities.* Clearly it is not possible to distinguish precisely what aspect or aspects were critical in making the program successful. Nor was this crucial, because, in our view, it was the very combination of treatment modalities that was of value. In our opinion, one of the most beneficial aspects of the treatment was the close integration of both main therapeutic approaches. Some people found it difficult to verbalize their feelings—like the woman in the case report—and art therapy seemed a powerful method of removing those barriers. On the other hand, others were able to verbalize their emotions quite well, but in fact blocked their feelings. The combination of treatment techniques therefore seemed to be quite capable of tackling most basic barriers found in the dynamics of bereavement.
2. *The structured approach.* A second contributing factor to the program's success we think was the structure offered to the patients. The general structure of the protocol reduced disorganized thoughts and feelings and anxiety, and offered the patient the explicit information that the—often painful—interventions are limited. Structure was also provided in the program through the introduction of the system of a hierarchy of emotions. This actually served three functions. Like a comb, it structured chaotic feelings; like a compass, it presented goals and directions; and like a thermometer, it was an instrument for feedback about effects of interventions.
3. *The homogeneous group.* The fact that therapy was conducted in homogeneous groups we consider to be a third important healing factor. At difficult moments

during their stay, patients often felt supported and understood by the other group members and even difficulties between members eventually seemed to further insight in their individual and social functioning.

4. *Cross-modality therapy in a group context.* It is also important to remember the interactive nature of participating in the variety of therapy tasks required in the new program. While some group members may relate more easily to the art, others to the more verbal tasks required of them, in interacting with each other about the work they produced in the art therapy sessions, in addition to that in the general discussion sessions, it seems likely that there will be further, mutual processing and restructuring of experiences. Participants are likely to learn from and help each other by being exposed to a greater variety of portrayals of each others' grief.

In conclusion, the results of this study support the implementation of a structured and combined verbal and non-verbal approach in groups in the treatment of complicated bereavement. Substantial results over and above those of regular therapeutic procedures were evidenced in this study. Furthermore, in their subjective reports, participants also acknowledged it to be a very meaningful experience for them. For these reasons, the Centre where CMGT was implemented continues to incorporate it in the treatment of bereaved patients to this day.

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