THE GRIEF RECOVERY METHOD® INSTRUMENT: DEVELOPMENT AND VALIDATION FOR CONSTRUCT VALIDITY OF THE TREATMENT

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by

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DEDICATION

This dissertation is dedicated in-part to Nancy A. Griffith, one of the most fearless grievers I have ever known. Her strength and aptitude to care for those in their greatest hour of need far exceeds human expectation. It is also dedicated in-part to my step-mother Linda M. Nolan, and to my beloved mother, Mary S. Daus, whose earnest care and loving devotion to me and my two sons, Sebastian and Kaleb, made it possible to complete this work. It is also dedicated in loving memory to my father, Richard A. Nolan (1946-2013) and to the late Russell Friedman (1946-2016), co-founder of The Grief Recovery Method®.

To my beloved ∞^2…

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I would first like to acknowledge the hundreds of grievers who took part in this research so that the greater public health community might become more aware of The Grief Recovery Method®. I would also like to acknowledge Lois Hall, an outstanding committee member and expert griever, who first introduced me to the beauty of the program and later encouraged me to become a Certified Grief Recovery Specialist®. I would also like to acknowledge the unwavering support and mentorship of my committee chair, Dr. Jeffrey S. Hallam, a griever himself, who saw the value in this project from its inception. I would also like to acknowledge committee members Dr. Janice D. Yoder, Dr. Mary M. Step, and Dr. Clare Stacey, who offered continued support and guidance throughout my doctoral training. Finally, I would like to thank John W. James and the late Russell Friedman, co-founders of The Grief Recovery Method®; Cole James, Executive Director of The Grief Recovery Institute™; Amanda Lambros, personal friend, great hostess, and Executive Director of The Grief Recovery Institute™ (Australia); Brittany Johns, Communications Guru and Director of Specialist Relations and Events at The Grief Recovery Institute™; and all my fellow Certified Grief Recovery Specialists® who made this research possible. May we continue to dedicate each day to helping others cope with loss. Thank you.

LIST OF ABBREVIATIONS

A1-5	Attitudes (Variable items: A1, A2, A3, A4, and A5)
ACE	Adverse Childhood Experience
Beh1-11	Behaviors of Grief (Variable items: Beh1, Beh2, Beh3, Beh4, Beh5, Beh6, Beh7, Beh8, Beh9, Beh10, and Beh11)
Bel1-7	Beliefs (Variable items: Bel1, Bel2, Bel3, Bel4, Bel5, Bel6, and Bel7)
CBT	Cognitive Behavioral Theory
CDC	Centers for Disease Control and Prevention
CFI	Comparative Fit Index
CI	Clarity Index
CI-IRA	Inter-Rater Agreement for Clarity Index
CMIN	Chi-Square Goodness of Fit Index
CVI	Content Validity Index
CVI-IRA	Inter-Rater Agreement for Content Validity Index
DHHS	Department of Health and Human Services
DSM	Diagnostic and Statistical Manual of Mental Disorders
GCT	Group Cohesion Theory
GMRI	Grief and Meaning Reconstruction Inventory
GRMI	The Grief Recovery Method® Instrument

GRO1-5	Behaviors of Grief Recovery as an Outcome (Variable items: GRO1, GRO2, GRO3, GRO4, and GRO5)
IFI	Incremental Fit Index
IRB	Institutional Review Board
K1-K8	Knowledge (Variable items: K1, K2, K3, K4, K5, K6, K7, and K8)
KABB	Knowledge, Attitudes, Beliefs, and Behaviors of Grief Recovery as an Outcome
MDMQ	Multi-Dimensional Mood Questionnaire
MMT	Meaning Making after Death Theory
NFI	Normative Fit Index
PCFI; PNFI	Parsimony Goodness of Fit Indices
PE	Prolonged Exposure Therapy
PG1-PG7	Personal Growth (Variable items: PG1, PG2, PG3, PG4, PG5, PG6, and PG7)
P.S.	Postscript
RFI	Relative Fit Index
RMSEA	Root Mean Square Error of Approximation
STERBs	Short-Term Energy Releasing Behaviors
TI	Time Index
TLI	Tucker-Lewis Index
US	United States

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ABSTRACT

Most people have experienced a death-associated loss over the course of their lives, which has been shown to produce a wide range of emotions, most commonly characterized as grief. As of 2017, the annual number of United States (US) deaths almost reached three million. For each one of these deaths, the National Institutes of Health (2009) reported that four to five grievers remained to cope and mourn the loss. Due the essential provision of services required in order to recover from the grief experienced, grief has become a public health issue that has necessitated a population approach. Although several programs exist that aim to influence grief, many have not been theoretically evaluated for their effectiveness and have lacked valid and reliable instrumentation. Using The Grief Recovery Method®, a program that aimed to influence grief and promote grief recovery, this study described the development and validation of an instrument used to measure program variables. Using a construct validation of the treatment approach, a self-report instrument was developed to measure program variables believed to influence grief and promote grief recovery identified as a griever's 1) knowledge, 2) attitudes, 3) beliefs, 4) behaviors of grief (STERBs); and 5) behaviors of grief recovery as an outcome. The instrument was field tested using expert panel and peer-review. Pilot and validity tests were used to validate instrument. Confirmatory analysis (n=279) showed an overall adequate fit of the data to the hypothesized factorial structure (NFI=0.97; RFI=0.83; IFI=0.97; TLI=0.87; CFI=0.98; PNFI=0.19; PCFI=0.20; and RMSEA=0.09). The chi-square goodness of fit (CMIN=7.26) with two degrees of freedom (CMIN/df = 3.63) was large and significant (p=0.03), which suggested a

potential area of misfit within the model. Internal consistency for the full measure was acceptable with Cronbach's alpha=0.87. This study established a content valid and reliable measure. With impending use of the measure for future evaluation and testing of the implicit theoretical structure of the grief recovery program, research will be able to show how and to what extent programmatic aspects influenced variables of grief and grief recovery.

CHAPTER 1.

Introduction

Most people have experienced at least one life-changing or death-associated loss during the course of their lives, and over time, these individuals become increasingly met with the death of loved ones, family, friends, colleagues, and mentors (Ozer, Best, Lipsey, & Weiss, 2003). Responses to death-associated loss have varied greatly across populations and often included a wide range of grief-related emotions. As of last year, the Centers for Disease Control and Prevention [CDC] (2017) reported that the number of deaths in the United States (US) reached 2,626,418, with a combined death rate of 823.7 deaths per 100,000 people, which was a 2.2% increase from the year prior. The National Institutes of Health (2009) estimated that for each death, four to five grieving survivors remained. Annually, this estimate amounted to over 13 million Americans left to mourn and cope with the significant loss. Although death was unavoidable, the National Institutes of Health, a division of the US Department of Health and Human Services [DHHS] (2017), acknowledged that the provision of services both before and after death was a public health issue that required a population approach.

Given this public health burden of death-associated loss, between one and four million Americans could experience grief levels high enough to impact mental health and interfere with daily living (Schulz, Hebert, & Boerner, 2008). Confounding this issue was that within the next decade, the US population is expected to undergo a dramatic shift in the number of aging adults

with life-threatening illnesses. By 2030, the CDC (2009) reported that the number of aging adults (65 and older) would double to more than 71 million Americans, the majority (80%) of whom are expected to have at least one life-threatening chronic condition, with many having two or more. With the US death toll on the rise, research on the bereaved has shown that compared to non-bereaved persons, individuals who have experienced the death of a loved one have significantly worse health prior to and one-year following bereavement (Stephen et al., 2015). Moreover, these individuals were significantly less likely to maintain employment for up to two years following the loss of a loved one (Stephen et al., 2015). Therefore, Zaslow (2002) and The Grief Recovery Institute™ (2003) reported that the annual cost of grief and bereavement on US businesses had reached well over $75 billion, with approximately $37.6 billion attributed to the death of a loved one alone.

Determinants and intensity of grief responses have varied according to many factors such as the perceived significance of the loss, causes or circumstances surrounding the death, the nature of the relationship to the deceased, and the mode of death itself (Worden, 1991). Elsewhere, research by Dube et al. (2003) classified determinants of grief when a significant link was established between grief experienced in childhood to current leading causes of death and disability in US adults (Fig. 1-1). These leading causes of death and disability such as heart

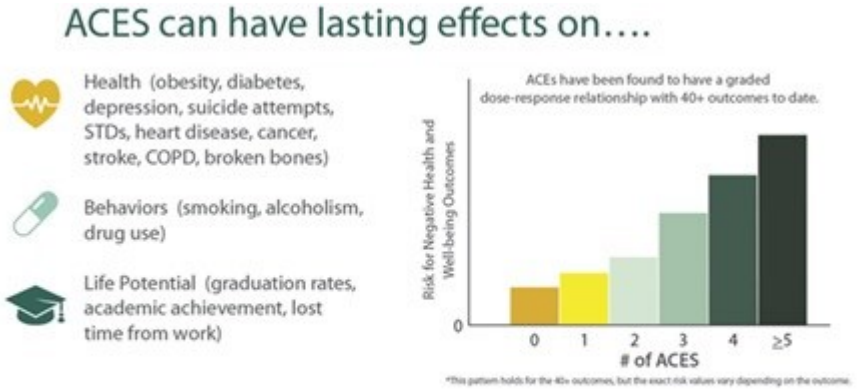

Fig. 1-1. Association between ACEs and Negative Outcomes

Dube et al. (2003)

disease, obesity, and cancer have been associated with several public health risk factors such as smoking and substance abuse experienced in early adulthood. The grief Dube et al. studied stemmed from an acute, adverse childhood events (ACE) such as the death of a loved one, incarceration of a household member, or parental separation and divorce, as well as sustained events overtime such as various forms of abuse and neglect. These adverse childhood experiences occurred in children aged 0-17 and were apparent across all socioeconomic statuses, races, and ethnicities. Although, a much higher prevalence of these adverse childhood experiences have been reported in those living in poverty. Other research on prenatal outcomes established an association between grief experienced during pregnancy and the mental health of the child as he or she matures into adulthood (Persson & Rossin-Slater, 2018). Felitti and Anda (2009) confirmed this finding through their research that showed grief experienced in early childhood (Fig. 1-2) led to increased healthcare costs, premature mortality, and a greater burden

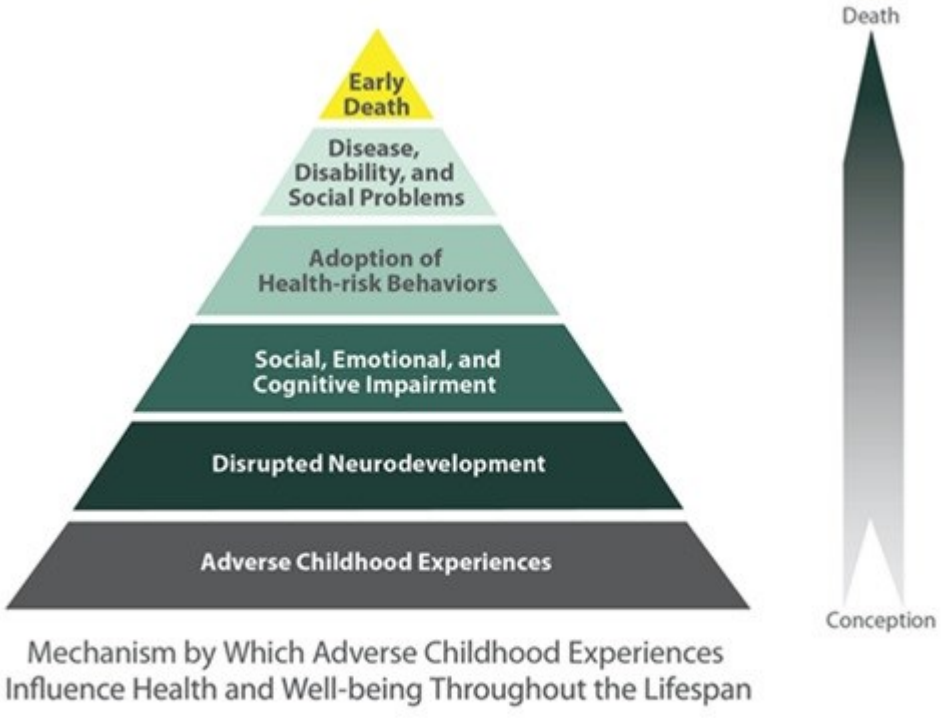

Fig. 1-2. The ACE Pyramid

Dube et al. (2003)

of disability in later adulthood. A substantial portion of these increased healthcare costs and greater disability are believed to stem from the increased use of antidepressants, opioids, and overall higher healthcare utilization (King, et al., 2013; Segal, De Biasi, Mueller, May, & Warren, 2017). Subsequently, a great number of children and adults, along with their family members, friends, and caregivers would require a diverse array of specific and personalized grief-related, bereavement, and end of life services in the immediate future.

Findings from prior empirical research have shown that personal responses to death-associated loss varied greatly from prolonged, anticipatory grief and mild discomfort to unrecoverable, acute distress that resulted in psychopathology and poor health. These grief-related symptoms typically remained for a period of several weeks or months, and then gradually subsided to pre-death levels (Bonanno, 2004). For some, full abatement or recovery from grief-associated symptoms took as long as several years (Bonanno, 2004; Shear, et al., 2011). Although individual differences have been reported in the length of time one experienced grief, many clinicians have agreed that a typical course of bereavement lasted one to two years, but that some individuals experienced intermittent symptoms of grief for the rest of their lives (Friedman, 2012; Perper, 2013). Therefore, the importance of prevention of these grief-related symptoms both before and after a death-associated loss was critical to the well-being of populations (Balk & Meagher, 2013; Kristensen, Weisaeth, & Heir, 2002; Taylor, Kemeny, Reed, Bower, & Gruenewald, 2000). Key prevention efforts have been identified as human resilience, social support, and the distinct process of grief resolution and recovery.

The term recovery, as it related to grief, denoted a trajectory in which normal functioning temporarily gave way to psychopathology, producing symptoms of stress, depression, or sadness. Although previous research on grief and grief recovery has indicated that most bereaved

individuals demonstrated resilience and exhibited low levels of grief, approximately 10-15% of bereaved individuals reported significant distress (Bonanno, 2004). Later research established that between 10-20% of bereaved individuals developed a syndrome of complicated grief characterized by an intense and persistent longing for the deceased, a sense of anger and disbelief over the death, and a disturbing preoccupation with the deceased (Shear, Frank, Houck, & Reynolds, 2005). Yet, findings from Schulz, Hebert, and Boerner (2008) have suggested that as many as 30% of bereaved individuals reported experiencing abnormal emotional outcomes or excessive grief subsequent to a death-associated loss.

Common behavioral responses to grief and death have been described as normal, yet complex phenomena that Bowlby (1988) largely attributed to separation and loss. Later, Worden (1991) classified this vast repertoire of behavioral responses into four distinct categories defined as emotional response, physical sensations, altered cognitions, and behaviors. According to Worden, anger was the most frequently experienced emotion following a death-associated loss. The author stated that experienced anger quite often caused confusion among the bereaved and was most commonly directed at the deceased for leaving the bereaved behind, or from a sense of frustration that the death could not have been prevented (Worden, 1991). This anger, if not adequately managed, has been shown to lead to further complications in the grieving process by a griever turning it inward or directing it outward onto others (Worden, 1991). Other emotional and behavioral expressions of grief have included sadness, shock, relief, guilt, anxiety, fatigue, loneliness, isolation, and depression (Barbato & Irwin, 1992). Additionally, grief has been shown to produce physical symptoms such as tightness in the throat or chest, frequent crying, breathlessness, sensitivity to noise and light, muscular fatigue, malaise, immune susceptibility, and lethargy (Barbato & Irwin, 1992; Worden, 1991). Although these symptoms are considered

to be normal components of grief, if experienced overtime, could raise cause for concern and in some cases, warrant clinical intervention.

Tandem to behavioral responses, cognitive expressions of grief were thought to develop in the acute stages of mourning, immediately following death. Typically, these cognitions manifested upon learning of the death and dissipated with time. These cognitions have been shown to include sudden disbelief, denial, disorientation, and confusion; whereas, other cognitive responses were deemed more intrusive such as a preoccupation with how the deceased died and difficulty maintaining or composing thought (Worden, 1991). A further cognitive phenomenon reported by the bereaved was a sense of existential awareness that the deceased was somehow still alive. In some instances, Worden (1991) found that this perceived awareness led to auditory and visual hallucinations of the deceased to which grievers assigned a religious or metaphysical meaning. Worden reported that many grievers believed these experiences to be comforting and improved their ability to cope with the loss. Aside from cognitive disturbances, bereavement has been shown to produce sleep disturbances, altered appetites, vivid dreams of the deceased, and avoidance behaviors (Worden, 1991). Of the avoidance behaviors, Worden found that grievers most commonly evaded smells, objects, situations, places, and articles of clothing associated with the deceased.

Environmental factors shown to influence grief have been attributed, at least in part, to the fact that never before in society has death been more feared than it was today (Warraich, 2017). In a recent publication, author and palliative physician, H. J. Warraich (2017) has affirmed this notion by declaring, “The more medicalized death gets, the longer people are debilitated before the end, the more cloistered those who die become, the more terrifying death gets” (p. 9). Due to this changing landscape of grief and death, Warraich stated that a griever

must not only learn to cope with the complexities of extended grief but also learn how to live with loss and the imminent death of a loved one for a prolonged period. For this reason, Deffenbaugh (2008) noted that a significant, unmet need existed for grief and bereavement services.

Apart from the unmet needs of the bereaved, Kastenbaum (2015) uncovered the ever-changing relationship that early 21st-century society had with death from a death-denied perspective to one that has more recently become death-preoccupation and acceptance. Wittkowski, Doka, Neimeyer, and Vallerga (2015) echoed this notion when they reported that an extensive, yet artificial representation of death and dying existed on TV and in the social media. For example, the social media website Facebook has reported that over a million users have passed away. Yet, for these millions of deceased users' coined "Facebook ghosts," their pages have turned into memorial sites for the public expression of grief (Warraich, 2017, p. 272). Even people approaching death, such as those diagnosed with a terminal illness, have begun to use social media to blog, tweet, and post up until their final moments as a means to publicly record their death experiences (Warraich, 2017). Public forums on death known as death cafes and death salons have cropped up across the US where people openly conversed about death, grief, and bereavement. According to Wong and Tomer (2011), these combined movements have come to form what is now being referred to as the 'death positive' movement, which sought to promote the acceptance of death, dying, and grief within society.

Due to the death positive movement, caring for dying individuals and their families before and after bereavement has become a main priority for many health service providers (Waller et al., 2016). Yet, these same organizations have acknowledged that despite their significant concern, bereavement care must be met by a commensurate provision of investment

supported by a rigorous evidence-base. To date, research on grief and grief recovery has been largely qualitative, and mostly characterized by its associated strengths and weaknesses. Main critiques included that there have not been many research studies based on existing theoretical frameworks and that studies have not been implemented with experimental or quasi-experimental designs. Of the programs found, most were rooted in behavioral theory and group cohesiveness and failed to show how programmatic components led to changes in grief (Jordan & Neimeyer, 2003). More importantly, researchers Jordan and Neimeyer (2003) along with Stroebe, Stroebe, and Schut (2003) have shown that historically these programs have received limited evaluation for their effectiveness, demonstrated small to medium effect sizes, lacked valid and reliable instrumentation, and failed to incorporate control or comparison groups.

Despite these limitations, some of the research strengths that have been identified included that much of what has been studied thus far has been assessed in real-world, natural settings and that there has been increased interest in theoretical development relevant to grief. On the other hand, Balk and Meagher (2013) found that differences existed in the objectives of grievers and practitioners who used empirical evidence to develop grief-related programs when compared to researchers who evaluated and assessed the phenomenon of grief. Moreover, the lack of magnitude and reach of grief-related theoretic research has been associated with limited, and sometimes questionable validity and reliability of findings (Cohen & Deliens, 2012; Sallnow, Tishelman, Lindqvist, Richardson, & Cohen, 2016). Notwithstanding these associated strengths and weaknesses, one atheoretical practice-based program, known as The Grief Recovery Method® incorporated elements based on behavioral theory that have been supported by educational research.

Based on basic behavioral principles, the program closely aligned with elements of Prolonged Exposure Therapy (PE), a theoretically-based and highly efficacious treatment for chronic depression, anxiety, anger, and posttraumatic stress (Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010). Grounded in cognitive-behavioral origins, PE has been empirically validated and described as a flexible therapy that can be modified to fit the needs of individual grievers and those suffering from trauma (Foa, 2007). Moreover, PE has been specifically shown to assist individuals in the process of traumatic or grief-related events and has been widely used to reduce symptoms of psychological disturbance. Table 1-1 compared treatment modalities.

Table 1-1. *Comparison of Treatment Modalities**

The Grief Recovery Method®	**Prolonged Exposure Therapy (PE)**
Group or individual format	Individual format
Facilitated by a Certified Specialist	Facilitated by a Licensed Clinical Counselor
6, 8, 10, or 12-weeks	10-12 weeks
2 hour weekly sessions	1.5 hour weekly sessions
Manual	Manual
Education, written work, narrative	Education, written work, narrative
Loss history and relationship graph	In-vivo exposure
Viewing the entirety of the relationship	Cognitive reconstructing
Cognitive distortions lead to unresolved grief	Misinterpretation of events leads to an emotional response
A series of correct action choices leads to grief recovery	Awareness, thought modification, and habituating new behavior leads to change in emotional response and behavior
Having a sense of being able to cope better	Feel more able to cope
Reduction in psychophysiological symptoms of anger, guilt, and grief	Reduction in psychophysiological symptoms of grief, trauma, anger, anxiety, and depression
A realistic view of the relationship between death and loss	A realistic view of the event and world in which one inhabits
Personal responsibility	Personal role
Ability to feel more control over maladaptive thoughts, emotions, and behaviors	Ability to identify maladaptive patterns of thoughts, emotions, and behaviors
Ability to freely, and safely express thoughts and emotions that were previously withheld or self-restricted	Ability to express thoughts and emotions in new found ways that one was previously incapable of prior to treatment
Improvement in attitudinal, cognitive, emotional, relational, and personal functioning	Improvement in the internal state of well-being and various areas of life

*Adapted from Klimo, Henderson, Varley, Engel, & Pethtel (2013)

Addressing the call made by Felitti et al. (2010) for further research in population-based grief-related programming, theoretical testing and development must be conducted in order to evaluate and understand the mechanisms by which grief-related programs influenced variables of grief and grief recovery. Of these types of grief-related interventions, the current program's atheoretical model (Fig. 1-3) was believed to influence grief and promote grief recovery by influencing four specific variables that moved grievers beyond loss. The program defined these variables as a griever's 1) knowledge, 2) attitudes, 3) beliefs, 4) behaviors of grief (STERBs) and behaviors of grief recovery as an outcome (KABB). In the model, a griever came into the program with his or her individual level characteristics associated with grief and grief recovery (KABB) that received influence from one's own environment, community, and interpersonal support system. Upon program exposure, a griever's level on KABB received influence from intervention components towards the promotion of grief recovery. Because the program required grievers to perform a certain set of behaviors associated with the desired outcome of grief recovery, once these behaviors were performed, the griever was able to address his or her level of hopes, dreams, and expectations after a death-associated loss towards loss completion. These behaviors in tandem with a griever's level of resiliency moved him or her beyond grief towards the promotion of personal growth after loss. To this end, the primary aim of the current research was to use a construct validation of the treatment approach to develop and validate a self-report instrument, referred to herein as The Grief Recovery Method® Instrument (GRMI) to measure factors of the program believed to influence grief and promote grief recovery. The intention of this aim progressed beyond the question of internal validity of the treatment, which centered on the effectiveness of the program, and focused on the treatment's construct validity as a potential explanation for why beneficial effects have been reported with program implementation.

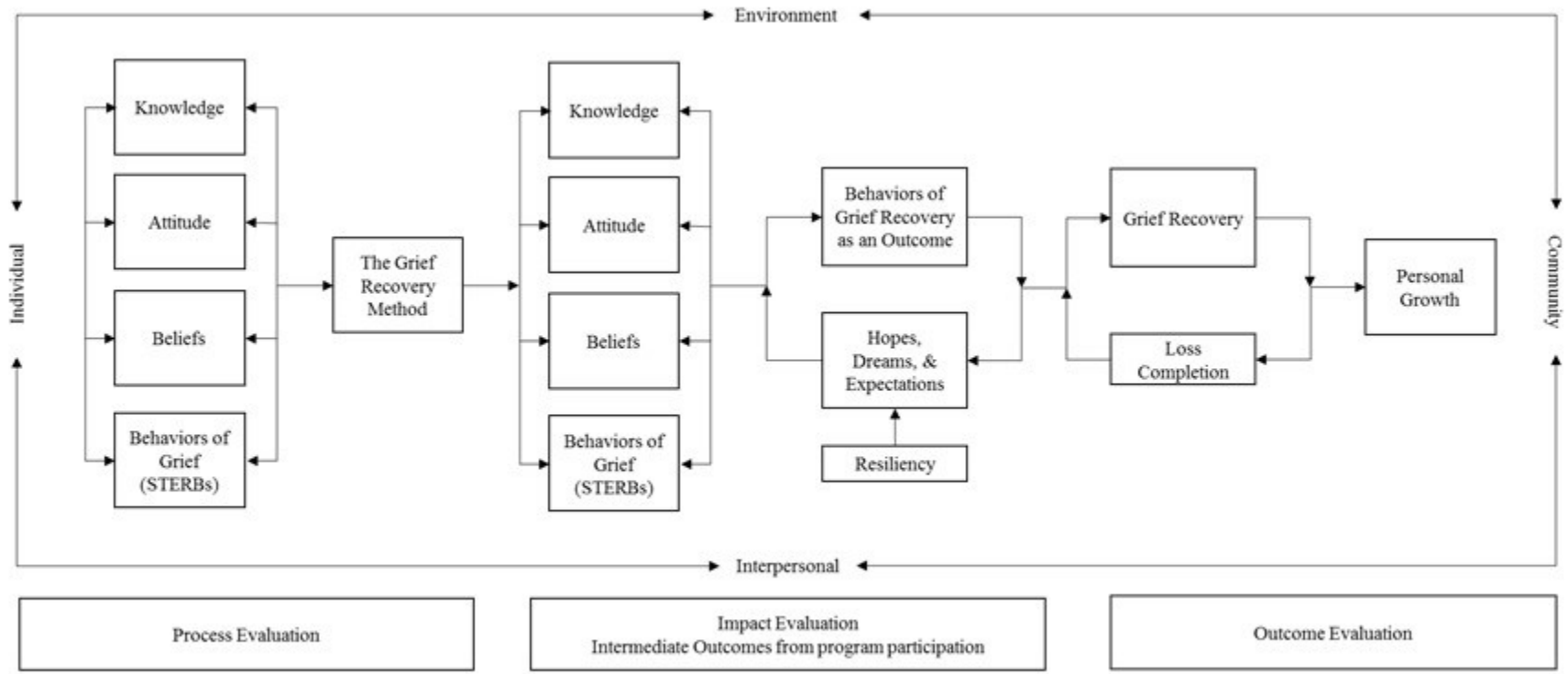

Fig. 1-3 Conceptual Model of The Grief Recovery Method® Program

According to Cook and Campbell (1979), McDaul and Glasgow (1985), as well as Hallam and Petosa (2004), the concept of construct validity of the treatment has received minimal attention within the context of social science and behavioral research. For example, these researchers have described a historic, methodologic hierarchy that has placed emphasis on internal validity, whereby a causal association between the intervention and some health outcome or statistically significant effect was established, followed by external validity, construct validity of the effect, statistical conclusion validity, and construct validity of the treatment. Yet, Judd and Kenny (1981) showed that construct validity of the treatment was a critical element of program theory testing and development because most interventions received basis, at least implicitly, on theoretic models. Characteristically, these implicit models posited that cognitive and behavioral variables influenced the initiation and maintenance of health outcomes. Therefore, validity of these models was best assessed by evaluating whether programmatic exposure influenced theoretically relevant program variables, and whether these variables were associated with the desired health outcome. Along these lines, Newman (1981) argued that construct validity of the treatment was important for generalization purposes since the question often remained as to whether or not program users entirely adopted all aspects of an intervention after exposure. To address this concern, Newman, McCaul and Glasgow explained that in the event an empirical rationale was able to demonstrate how and why a program produced desired results (i.e. construct validity of the treatment), exact replication of the program and all its components became unnecessary; as an emphasis on crucial programmatic elements was all that was required in order to produce the intended effects across varied treatments, settings and populations. Lastly, McCaul and Glasgow determined that understanding the construct validity of any given treatment could lead to a more efficient and less costly program

because extra attention could be placed on increasing the effectiveness of programmatic features found to be relevant and not those less influential. Given the importance of construct validity in theoretical development, a secondary aim of this research was to confirm the implicit program theory by testing the logical fit of the hypothesized factorial structure (KABB) to the data collected from the GRMI through confirmatory factor analysis in a sample of adult grievers who have completed the grief recovery program.

Specific Aims

Specific Aim #1: To use a construct validation of the treatment approach to develop a self-report instrument (GRMI) based on the grief recovery program that measured participants' self-reported knowledge, attitudes, beliefs, behaviors of grief (STERBs), as well as the behaviors of grief recovery as an outcome (KABB).

Specific Aim #2: To field test the instrument (GRMI) using the expert panel and peer-review comprised of individuals both certified and not certified in the grief recovery program to ensure content and face validity.

Specific Aim #3: To conduct pilot and validity tests on the instrument (GRMI) in an independent sample of adult grievers who self-selected to receive the grief recovery program offered by a local office of a national hospice organization.

Specific Aim #4: To test for the logical fit of the hypothesized factorial structure (KABB) to the data using confirmatory factor analysis in an independent sample of adult grievers who have completed the grief recovery program.

Public Health Significance of the Study

With increased relevance and acceptance of end-of-life care, death, dying, and grief in the public health spectrum, the proposed research sought to use a construct validation of the

treatment approach to develop and validate an instrument based to measure program variables that are believed to influence grief and promote grief recovery (Neimeyer, Harris, Winokuer, & Thorton, 2011; Sallnow, Tishelman, Lindqvist, Richardson, & Cohen, 2016). In doing so, the intent was to further the field of prevention science research by confirming the implicit theoretical foundation of grief recovery envisioned by the founders of The Grief Recovery Institute™, John W. James and the deceased, Russell Friedman. With empirical instrumentation established and validated on the program theory of grief recovery, future evaluation and research can be conducted based on construct validation of the treatment to demonstrate how and to what extent programmatic aspects influence variables of grief and grief recovery, building a body of empirical evidence on the program's efficaciousness. Empirical evidence validating the theory of the grief recovery program and the level of influence programmatic exposure has on variables of grief and grief recovery, in turn, can lead to increased exposure and implementation of the program, thereby potentially reducing the burden of grief experienced by millions of grievers worldwide.

Research Benefits

The present study had several significant and unique features. The research reflected a community-based research partnership between The Grief Recovery Institute™ and the Kent State University, College of Public Health. The study examined and confirmed the implicit program theory of a community-based, grief recovery intervention that has been reviewed by experts using criteria for effective grief recovery programming. This criterion was based on existing meta-analyses and peer-reviewed descriptive and experimental literature.

Assumptions

Programmatic assumptions made for the purpose of conducting this study included that the practice-based educational curriculum of the grief recovery program had an implicit theoretical foundation based on scientific realism that can be represented by numerical data (Lodico, Spaulding, & Voegtle, 2010). According to behavioral theory, grievers constructed their reality based on values and meanings they attached to the loss, which influenced cognition and awareness related to the loss, and resulted in emotional affect and behavior (Clark & Steer, 1996). Moreover, finding or making meaning from the loss enabled grievers to reconstruct cognitive frameworks that allowed them to process and interpret their individual grief experiences (Currier, Holland, & Neimeyer, 2006; 2008, 2010; Gillies & Neimeyer, 2006; Park, 2008; 2010). Presented this way, grief was not a state but rather a process that could not be limited to a specific timeframe or period of adjustment (Worden, 2001; 2009). In order to move beyond the loss, acceptance and adjustment to life without the deceased were required, as was the resolution of grief or sense of incompleteness related to the loss (Green et al., 2001; James & Friedman, 2009; Zisook & Schuchter, 2001). If left unresolved, as stated by Neimeyer, Harris, Winokuer, and Thorton (2011) along with Rando, Nezu, Nezu, and Weiss (1993), grief could inhibit normal functioning and lead to premature psychophysiological morbidity.

Methodological assumptions made for the purpose of conducting this study were that phenomenon in nature can be observed and measured, thereby, reflecting a post-positivist paradigm that the applied method was selected based on the nature of the research and the inquiry being addressed (Leedy & Ormrod, 2012). It was further assumed that knowledge was quantifiable, therefore measurable, and that knowledge could be used to understand processes or experiences, and that the role of the researcher was to be objective and value-free (Babbie, 2010;

Frankfort-Nachmias & Nachmias, 2008; Kerlinger & Lee, 1999). Given that the ultimate goal in social behavioral and prevention science was to produce a cumulative body of verifiable knowledge, the researcher assumed the implicit theoretical foundation of the program held and could be confirmed by the proposed methods of this study.

General assumptions made for the purpose of conducting this study were that fidelity of the program was maintained by certified program experts who delivered the program in its entirety as outlined in the program manual and per the license, service, and support agreement. Individuals who agreed to participate in the study completed the developed self-report instrument (GRMI) as instructed and that the answers selected best-reflected respondents' truth. Lastly, participants included within the study have met all specified inclusion criteria and completed the grief recovery program.

Limitations

For this study, several limitations are noted. Since participants voluntarily agreed and consented to take part in the study, there was likely to be some degree of self-selection bias. This inherent limitation led to the sample not being fully representative of the population of adult grievers who have experienced a death-associated loss. Furthermore, response rates in social science research have historically decreased with rates that have ranged from 16% to 91% (Carley-Baxter, et al., 2009). However, the response rate from the main study's sample did not impact measurement of hypothesized program variables (KABB). Randomization was not ethically possible as participants self-selected to receive the program. Therefore, convenience sampling methods were used to recruit participants from a population specific to the research subject. One valid instrument (GRMI) was used to collect data on program variables. The internal consistency of the instrument was assessed using Cronbach's alpha.

Delimitations

The program for which this study is based upon has not yet been theoretically tested nor evaluated for its effectiveness. However, modern theories on grief and grief recovery have suggested that in order for grievers to recover from a loss, a psychological intervention might be required (Green et al., 2001; Zisook & Shuchter, 2001). The program was designed with specific theoretical, psycho-educational components that were amenable to change and have been empirically shown to have a relationship with grief (Boelen et al., 2003a; 2003b; Fleming & Robinson, 2001; Gluhoski, 1995; Janoff-Bulman, 1989; Parkes, 1988; Rando, 1993; Robinson & Fleming, 1992; Schwartzberg & Janoff-Bulman, 1991). Grief recovery has been defined as the process of "completion-recovery," where one's grief and pain from a loss became emotionally complete (James & Friedman, 2009). The result of this completion process was personal growth after loss, defined as the adaption to loss in combination with a renewed sense of hope and self-efficacy in a bereaved person's life (Neimeyer, Hogan & Laurie, 2008). On the basis of this definition, grief recovery would require a griever to thoroughly examine both positive and negative aspects of the relationship with the deceased, as well as both positive and negatively held knowledge, attitudes beliefs, and behaviors associated with grief, dying, and death.

Chapter Summary

Grievers were individuals who have experienced a loss of any kind, but more importantly the loss of a loved one. The complex and subjective nature of grief particularly that which is experienced after the death of a loved one represented an important area of study. Grievers were far more at risk for developing poorer psychological, physical, emotional, and social health outcomes, as well as the reduction of individual and family resources, whether personal, material, or symbolic as the result of bereavement (Stroebe, Schut, & Stroebe, 2007). When

comparing the effects of grief, the nature and perceived quality of the relationship with the deceased was more likely to influence the intensity of the grief reaction; as were the historical experiences of loss over the course of one's life (Parkes & Prigerson, 2010; Worden, 2008). For each year in the US, an estimated 12 to 15 million grievers were left to cope and mourn significant loss, of whom 35-65% experienced mild or clinical depressive symptoms, and an estimated 3-5% experienced posttraumatic stress disorder (Stroebe, Schut, & Stroebe, 2007). Moreover, the impact of concurrent or preexisting stressors such as holidays, anniversaries, and shared places has been shown to fluctuate with time and further confound the grief experience.

There has been a limited understanding of how grief and associated health outcomes received influence through participation in grief recovery programming, and a dire lack of theoretic and program evaluation on both practice and evidence informed interventions that claim to promote grief recovery. In response to the decade long debate over whether credible evidence on the efficacy of grief recovery programs existed (Bonanno & Lilienfeld, 2008; Hoyt & Larson, 2008; Jordan & Neimeyer, 2003; Larson & Hoyt, 2007), the present study described a construct validity approach to develop and validate a self-report instrument that can be used in future theoretic evaluation and testing of the grief recovery program to assess how and to what extent programmatic mechanisms influenced variables of grief and grief recovery. Furthermore, since no empirical instrumentation has been established within the literature to specifically measure the implicit theoretical constructs of The Grief Recovery Method® program, the validated instrument allowed for future research to be conducted on the intervention to address the following questions of construct validity: Did the implicit program model (theory) hold? How and to what extent did program variables influence grief? What was the estimated effect of the program on variables of grief and grief recovery? Finally, this study attempted to build

support for the use of valid instrumentation in the evaluation of the implicit theoretical structure of a program that aimed to influence grief and promote grief recovery in those who have experienced a death-associated loss.

Borrowing from Kane (1992, 2001, 2006a, 2006b) and Kane, Crooks, and Cohen (1999), this study approached the establishment of empirical instrumentation as an iterative process between scale development and validation using a formative and summative stage. In the formative stage, a review of the literature was used to assess and evaluate existing instrumentation and programming on grief and grief recovery. Based on the selection of The Grief Recovery Method®, the corresponding program model was used to structure and develop a pilot version of the instrument. Expert panel and peer-review were used to field test the instrument. Pilot and validity tests were conducted to assess the instrument's clarity, content, and adherence to language specific to the grief recovery program. At the summative stage, the finalized instrument was subjected to confirmatory factor analysis to establish the tool's psychometric properties.

The significance of this research was that it presented an opportunity to understand how the targeted program influenced variables of grief and grief recovery by means of producing valid instrumentation for future use in the theoretic evaluation of The Grief Recovery Method®. Through the conceptualization and future evaluation of the program theory, explicit information will be gained on how targeted variables of grief and grief recovery influenced what grievers know about death and loss, what they can do to reduce their level of death-associated grief, and what they must to do in order to engage in grief recovery. From Green's (2006) perspective and focus of bringing more practice-based evidence to evidence-based practice, if variables of grief and grief recovery are determined to be influenced by the intervention, knowing the mechanism

by which the program produced the change has the potential to lead to a substantial reduction in the burden of grief experienced by millions of grievers each year.

CHAPTER 2.

Literature Review

Grief, Loss, and Associated Outcomes

Described as a universal phenomenon, grief was a normal and natural reaction to a loss of any kind (James & Friedman, 2009). Accordingly, grief and the need for effective grief recovery programming have received considerable attention in recent years (Doka, 2016; Seib & Hughes, 2016; Segal, De Biasi, Mueller, May, & Warren, 2017). Grief has been shown to be subjective, complicated, disturbing, and like many life circumstances has been described as a deeply personal, highly complex, irregular, and emotional process (National Cancer Institute, 2014; Rando, Nezu, Nezu, & Weiss, 1993; Worden, 2001; 2009). Additionally, research has suggested that grief post bereavement could be likened to a form of trauma (American Psychiatric Association, 2013). Table 2-1 provided a detailed comparison between grief experienced by someone who has experienced a death and someone who has, by definition (DSM-5), experienced a trauma.

Research on bereavement has primarily focused on the loss of a partner, whereby a person's grief was attributed to the death of a loved one, the death of a significant relationship, and the loss of future hopes, dreams, and expectations with the deceased. However, the dynamic and multi-faceted nature in which grief manifested has been attributed to a number of factors including acceptance of loss, thoughts concerning loss, and emotional responses to loss

(Baier & Buechsel, 2012; Futterman, Holland, Brown, Thompson, & Gallagher-Thompson, 2010). Furthermore, the accumulation of loss over time and the fluctuation of social, cultural,

Table 2-1. *Comparison between Grief from a Death-associated Loss and Grief from a Trauma**

Detail	Death-Associated Loss	Trauma (DSM-5)
Definition	Bereavement, or loss or a change in a familiar pattern of behavior	Exposure to an actual or witnessed death, serious injury, or sexual assault
Response	Pain, sadness, anger, guilt, distorted blame of self or others, irritability, lack of concentration, isolation, disbelief, confusion, loss of appetite, fatigue, social withdrawal, self-destructive	Pain, guilt, anger, blame of self, irritability, lack of concentration, negative alterations in mood, persistent distorted blame of self or others, self-destructive
Re-experience	Recurring dreams, nightmares, excessive thoughts or psychophysiological response to cues or memories	Recurrent distressing dreams, flashbacks, involuntary and intrusive recollections, psychophysiological distress to cues, nightmares
Avoidance	Persistent avoidance of thoughts, memories, and reminders associated with the loss	Persistent avoidance of thoughts, memories, and reminders associated with the trauma
Numbness	Diminished interest in life, alienation or isolation of self, detachment or estrangement, inability to experience positive emotions, negative affect	Markedly diminished interest in significant activities, feeling alienated from others, detachment or estrangement, constricted affect or persistent inability to experience positive emotions
Hyper-arousal and hyper-vigilance	Exaggerated startle response, sleep disturbance, decreased concentration	Exaggerated startle response, sleep disturbance, decreased concentration

*Adapted from: Klimo, Henderson, Varley, Engel, & Pethtel (2013) and the American Psychiatric Association (2013)

and behavioral methods to manage grief and bereavement have been attributed to a number of poor health outcomes, particularly among older adults (Muller & Thompson, 2003; Parkes & Prigerson, 2010; Richardson & Balaswamy, 2001; Worden, 2008). These poor health outcomes along with deficits in social-functioning have led to an increased risk of premature mortality, placing grief and bereavement as a major public health concern.

Theories of Grief within the Public Health Framework

Grief within the theoretical framework of public health was first established by Freud (1957), who was credited as publishing the first proposed theory on grief known as the 'grief work theory.' The main tenant of this theory was that grievers broke ties with the deceased and readjusted to new life circumstances post bereavement. In doing so, Freud argued that grief was primarily about personal attachment, and not the loss itself; whereby grievers searched for an attachment that was lost as the result of a death. The loss of attachment, better stated as detachment from the deceased, produced mourning defined as a state of melancholia. Freud argued that melancholia, which originated from a sense of complete loss of pleasure, could significantly escalate to pathological levels if not treated. Yet, in the non-pathological presentation of grief, Freud viewed the process of mourning as a task to rebuild one's inner self by experiencing intense pain that mimicked the depth of love felt by the griever. A major flaw of this theory, however, was that it stressed the importance of 'moving on' as quickly as possible; which according to Shapiro (2001), Freud later revised due to the long-term grief he experienced from the tragic death of his beloved daughter.

Freud's idea of mourning as a result of detachment was later built upon by Bowlby (1961) who developed attachment theory. This theory argued that grief stemmed from an individual's attachment developed early in life to an individual who offered security. However, once this attachment became severed, individuals experienced a wide range of distress and emotional disturbance defined as mourning. According to Bowlby, and later Bowlby and Parkes (1970), mourning consisted of general phases or stages of grief. The first among these phases was numbness. Characterized by feelings of disbelief, numbness occurred for a brief period following the loss and provided grievers with a temporary respite from experiencing the extreme

pain of detachment. After the numbness subsided, the phase of yearning occurred; whereby, grievers came to realize the gravity of the detachment and became angry or frustrated as they searched for someone or something to blame for the loss. This quest for culpability unfolded into a phase beset by disorganization and turmoil that involved a griever's acceptance of the loss and an evaluation of life without the deceased. The last and final phase, known as reorganization and recovery, took effect once the bereaved processed the loss and made gradual changes to move beyond it and find new meaning for life. This theory was not without fault, however, as a major cultural shift took place in the 1960s and 70s that brought about new insight on how other nations of grievers viewed the relationship between life and death. For example, Yamamoto, Okonji, Iwasaki, and Yoshimura (1969) found that in some Asian cultures, the bereaved maintained strong emotional bonds with the deceased, which was counter to the emotional detachment described by Freud (1957), Bowbly (1961), and Bowlby and Parkes (1970). In other Asian cultures, Fiske (1969) described that yearning or blame finding for a loss that occurred could be met with disapproval from elders as it was believed that such emotions would infringe upon the deceased's journey into the afterlife.

Despite diverse cultural perspectives, Bowbly's (1961) grief as a series of phases was further expounded by Kübler-Ross (1969) who proposed a 'stage theory,' otherwise referred to as the grief cycle. Amidst this cycle, grief experienced by an individual evolved into a series of five predictable stages. The first stage, described as a state of shock and denial, was characterized by the conscious or unconscious refusal to accept the death. In this stage, grievers made use of defense mechanisms in order to cope with the loss. However, the depth to which grievers deployed these defense mechanisms and processed the loss determined whether or not they could move forward in the cycle. Following denial, came the second stage mostly

distinguished by extreme anger or rage. In this phase, grievers experienced a variety of unpleasant emotions that ranged from inner and external turmoil, to lashing out, and expressed resentment towards the deceased and to those still living. After the second stage, came bargaining whereby a griever negotiated the intense anger or resentment felt towards the loss experienced against what could be attributed to a more hopeful circumstance. More hopeful circumstances have been described as an extended life of the deceased, a reformed lifestyle of the living, or a newfound freedom from pain, illness, or cause of death. According to Kübler-Ross, this stage was exemplified by statements such as, "I'd give anything to have [the deceased] back," or "If [the deceased] came back, I promise to…" Depression was the fourth stage of the grief cycle, and was commonly accompanied by feelings of sadness, regret, fear, and uncertainty. At this stage, a griever most likely had begun to accept the reality of the loss, but not necessarily the death. The acceptance of death did not come until the last and final stage of the grief cycle, and was symbolized by an individual's emotional detachment and objectivity from the loss. This stage, as Kübler-Ross described it, became the pivotal moment in griever's life when he or she processed the death and sought to move beyond the loss towards a new life without the deceased. Yet, from this model's perspective, grief was assumed to be a linear process, and not one that was more fluid in nature. Therefore, a major critique of this theory was that most people did not progress through prescriptive stages of grief in an orderly manner; rather, grievers moved freely about stages in a noncyclical fashion of their own volition.

Based on the stage-based work of Bowbly (1961) and Kübler-Ross (1969), Worden (1983) proposed an alternate model that described grief as an active process that included the completion of overlapping moral, psychological, intellectual, and spiritual tasks associated with bereavement. Referred to as the 'four tasks of mourning,' Worden posited that a griever must

work through these tasks in order to overcome the emotional pain of the loss, all the while adjusting to new circumstances, roles, status, or identity without the deceased. Worden believed that a griever's tasks were not complete until the loss was fully integrated into one's life and emotional attachments to the deceased were let go of; allowing the griever to invest in the present and the future. However, a major objective of this theory was to achieve total detachment from the deceased, which can be perceived as a theoretical flaw. For example, in their unpublished manuscript, Stroebe, Gergen, Gergen, and Stroebe (n.d.) argued that retention of strong emotional ties to the deceased was in many ways non-pathological, and a part of normal healthy functioning. This finding was further corroborated by Raphael and Nunn (1988) who acknowledged that ties to the deceased were as profound and intricate in death as they were in life. Moreover, Valiant (1986) stated that the value a griever placed on these ties added to the complexity and richness of one's life as bonds with the deceased were maintained through dreams, rituals, memorials, and photographs.

Given the notion that bonds with the deceased were thought to be maintained throughout the course of a griever's life, Klass, Silverman and Nickman (1996) proposed the continuing bonds theory. This theory posited that maintaining a bond with a deceased loved one was a healthy practice and that death caused an end to a life, but not an end to a relationship. Rather than a severance of ties or complete abolishment of a relationship, the authors recognized that a connection with the deceased was both active and to some extent removed. Therefore, the development of this bond was described as a conscious, dynamic, and ever-changing relationship that could be expressed in a variety of forms (Hall, 2011). For example, Hall (2011) stated that the deceased might serve as a role model who the bereaved could turn for guidance or clarification of values. Hall also offered that this bond could be co-created with others when

grievers came together to talk about the deceased, visited the gravesite, or felt the presence of the deceased through participation in rituals or sharing objects of remembrance. Along these lines, some qualitative studies on continuing bonds with the deceased have indicated positive outcomes for the bereaved (Normand, Nickman, & Silverman, 1996; Nowatzi & Kalischuck, 2009). On the other hand, some quantitative studies have shown that continuing bonds has been linked to increased distress for several years post bereavement (Field & Friedrichs, 2004; Field, Gal-Oz, & Bonnano, 2003). Irrespective of both positive and negative associations, Root and Exline (2014) have suggested that the experience of continuing a bond with the deceased might better reflect an inherent part of the loss experience as a typical feature of bereavement.

With regard to typical aspects of bereavement, Stroebe, Schut, and van den Bout (1994) recognized the importance of both positive and negative influences that continuing a bond with the deceased could have upon a griever. In doing so, the researchers argued for the existence of a dual process model where a griever oscillated between adaptive and maladaptive coping as a means to process the loss. The significance of this model was that it acknowledged that grief arose when the bereaved experienced difficulty accepting the loss, and in order to cope, developed maladaptive behaviors. Additionally, the model recognized that grievers typically experienced oscillation between focusing on the loss (loss orientation) and avoiding the loss (restoration orientation); whereby a griever might at times confront associated tasks of grieving, and at other times, avoid them (O'Day & Goetter, 2018). However, in the event a griever failed to alternate or find balance between these two grieving orientations, pathology arose such that the bereaved might focus solely on the loss and not the reengagement in life without the deceased. Recognizing the significance of both the loss and restoration-focused orientations of grieving as necessary for future adjustment, Stroebe and Schut (2010) stated that the degree to

which a griever emphasized each approach was dependent upon the circumstances of the loss, the personality of the griever, as well as his or her gender and cultural background. According to McTighe (2018), an inherent shortcoming of the dual process model was the stark ambivalence at which the bereaved moved back and forth between the two grieving orientations. In an attempt to address this pitfall, Rubin (1999) suggested that instead of the bereaved oscillating between two grieving orientations, grief unfolded on two parallel, simultaneous tracks. The first, the biopsychosocial track, focused on the physical and emotional manifestations of grief and loss. The second, the relational track, related to the internal transformation of the relationship with the deceased.

In stark contrast to earlier views that focused on attachment and continuing bonds with the deceased, Neimeyer (1998; 2000a; 2000b; 2000c) saw bereavement as a process of reconstructing a world of meaning that was challenged by loss. From the meaning reconstruction perspective, the early emphasis on finding an answer as to why a death occurred (meaning-making) shifted overtime to focus on the positive benefits of the loss (benefit-finding). It became important to acknowledge, however, that the experience of a loss post bereavement did not necessarily reconstruct a griever's self-narratives in a way that gave rise to a new quest for meaning. Rather, a griever self-reorganized his or her personal meaning system to accommodate the loss within a coherent and flexible self-narrative as an adaptive response despite grief (Neimeyer, Burke, Mackay, & van Dyke-Stringer, 2010). This notion seemed to underscore the resilience or grief recovery process experienced by most grievers, who after several months following a loss, returned to baseline functioning without extensive or prolonged psychological treatment (Currier, Neimeyer, & Berman, 2008). Thus, meaning reconstruction could be defined as an iterative and interactive process that a griever used to affirm or disconfirm one's life

experience as a potentially important outcome of bereavement. The difficulty with this definition, however, remained in the increased theoretical interest and conceptualization of the term as multiple, sophisticated, and useful constructs of meaning reconstruction have emerged (Hibberd, 2013). For example, numerous historical definitions have been found in the literature ranging from rebuilding shattered assumptive worldviews (Janoff-Bulman, 1992), to sense-making and benefit finding (Davis, Noelen-Hoeksema, & Larson, 1998), to positive reappraisal (Folkman, 2001), to searching for meaning (Bonanno, Wortman, & Nesse, 2004), and meanings made (Park, 2010). Because of the substantial effort made by these researchers to adequately account for and describe the various aspects of meaning reconstruction, considerable confusion has been raised as to what constituted 'meaning' itself (Hibberd, 2013). Thus, until the development of a standardized measure to explain the often numerous complex and dynamic components of meaning reconstruction, the ways in which life was affected by grief and loss, both negative and positive in the context of meaning, would remain bleak.

Moving away from the idea that grievers coped with loss by searching for new meaning, Calhoun and Tedeschi (1998; 1999) focused on the integration of lessons learned from loss and the outcome of posttraumatic growth. To these researchers, posttraumatic growth referred to the experience of positive changes that resulted from the death of a loved one. These positive changes ranged from improved relationships, a greater appreciation for life, a greater sense of personal strength and compassion, to more appreciation for the smaller things in life, and spiritual development. Characteristically, posttraumatic growth consisted of four main elements: it occurred in conditions of severe crisis akin to loss or bereavement; it was accompanied by a substantial life change; it presented as an outcome as opposed to a coping mechanism; and it challenged a griever's basic assumptions about the world, their place in it, and how to make

sense of daily life. However, the researchers cautioned that just because grievers experienced significant levels of posttraumatic growth did not mean that they would also experience proportionate levels of decreased emotional distress or increased acceptance of loss. Therefore, Calhoun and Tedeschi suggested that the maintenance of the growth experienced might require periodic cognitive and often unpleasant reminders of what has been lost, as to keep what has been gained in primary focus. For example, when faced with a major loss, grievers customarily became led by their circumstances, which often steered the cognitive engagement of two general domains of bereavement: making sense of loss and making sense of significant elements raised by the loss (Davis, Nolen-Hoeksema, & Larson, 1998). The first domain reflected the process to understand what led to the loss for which the griever must now cope. The second referred to more abstract or existential circumstance such as what constituted the fundamental meaning of life after the trauma of losing a loved one. These two domains, interwoven to some extent, reflected the often unpleasant, iterative, and recursive process of grieving (Tedeschi, Calhoun, & Groleau, 2015). Despite the encouraging applications of this theory in practice, there were some significant limitations. The first setback came from McFarland and Alvaro (2000) who offered the alternate perspective that perceived posttraumatic growth was in fact a coping mechanism and a delusion at best. In multiple studies conducted on individuals who experienced traumatic life-altering events, McFarland and Alvaro found that perceived posttraumatic growth was not reflective of actual growth, rather it was a positive illusion used to protect individuals from the realization that they suffered emotional damage. Another setback came from Frazier et al. (2009) who found that among a sample of individuals who experienced a trauma, perceived posttraumatic growth was unrelated to actual growth, and that perception of growth was associated with increased levels of stress. These findings received further corroboration from

more recent research (Engelhard, Lommen, & Sijbrandij, 2014; Blix, Skogbrott-Birkeland, Bang-Hansen, & Heir, 2016) that has shown that despite initial reports of posttraumatic growth, individuals exposed to traumatic events of death and loss later experience increased psychological distress.

A Population Approach to Grief

Although loss, death, and traumatic disturbances were unavoidable in life, the provision of services received by millions of grievers, specifically those bereaved, was a public health issue that required a population approach. Within the public health framework, a population approach emphasized the community of grievers as a whole and made the notable distinction between normal death-related grief and mental illness due to complicated grief reactions. Defined as episodes of persistent, excessive, and hurtful forms of grief, people exhibited complicated grief reactions through unproductive, maladaptive forms of behavior (Corr & Corr, 2013). With time, these behaviors had the potential to become pathological in nature and could manifest as various forms of mental illness such as chronic depression, suicidal ideation, anxiety, substance abuse, and posttraumatic stress disorder (Stroebe, Schut, & Stroebe, 2007). Given that the CDC (2011) reported that mental illness and clinical forms of depression were associated with multiple chronic diseases such as cardiovascular disease, diabetes, obesity, and cancer, it became essential that public health systems expanded their surveillance to include grief and bereavement as a means of primary, secondary, and tertiary prevention. One way to achieve this goal was to offer grief-related counseling and treatment.

When considering ways to include grief and bereavement as essential elements of public health prevention, Stroebe and Stroebe (1987) noted the necessary distinction between grief-related counseling and grief-related therapy as methods of effective treatment. According to the

authors, grief counseling helped grievers recover from uncomplicated or normal grief experienced through the healthy completion of actions associated with loss acceptance; whereas, grief therapy made use of specialized techniques to help grievers cope with and reduce abnormal or complicated grief reactions. With the understanding that only a small percentage (3-5%) of the grieving population experienced abnormal or complicated grief reactions, and it was these who were most at risk for adverse health effects, Stroebe and Stroebe (1987) established that grief counseling was the more appropriate technique to reduce the long-term burden of health risks in the majority of cases where the grief process was normal. According to Gamino, Sewell, Hogan, and Mason (2010), individuals who experienced normal grief described themselves as having trouble dealing with the death and being distressed by their loss. These individuals also tended to be the least adaptive in their bereavement responses and were more likely to seek professional help such as grief counseling.

Among those who have experienced a normal trajectory of grief and might seek grief counseling, Doka and Martin (2010) suggested the existence of two distinct coping patterns known as the instrumental and intuitive. Grievers who employed an instrumental pattern tended to cognitively approach loss and bereavement through problem-solving and intellectualization of grief; whereas, those who employed an intuitive pattern focused more on the feelings associated with loss and the expression of grief through crying and lamenting (Doka & Martin). A third approach has also been suggested by Stroebe and Shut (2010), where an individual might oscillate between the two processes, resulting in the adaption to loss and eventual recovery. Therefore, Granek (2010) posited that in order for populations to achieve a healthy recovery from both current and future loss, the bereaved must resolve grief experienced through effective and culturally appropriate community-based treatment.

Most existing community-based treatments that aimed to reduce grief in those who have experienced loss have moved away from detachment and stage-based theoretical underpinnings to more accurate models of understanding that recognized the active, acute nature of grief (Bristowe, Marshall, & Harding, 2016). These models have been shown to account for factors that shaped grief such as social mediators, concurrent stressors, and loss acceptance (Worden, 2008). Of current community-based programs, most used models grounded in cognitive behavior theory, group cohesion, and extensive research on the meaning and making of life after death (Klass, Silverman, & Nickman, 1996; Stroebe & Schut, 1999; Jordan & Neimeyer, 2003). Typically, these programs assessed the attitudes and beliefs associated with loss, while simultaneously addressing the relevant needs of the target population through the identification of specific goals and behaviors that influenced grief (Jordan & Neimeyer, 2003). These programs also aimed to support grievers while they navigated through pain and loss towards a restoration of self without the deceased. According to researchers Brown, Pearlman, and Goodman (2004), Fleming and Robinson (2008), as well as Greenberg, Warwar, and Malcom (2008), these programs aided grievers and reduced stress by emphasizing the role of emotion-focused, psychotherapeutic education, which has been established as a necessary component of the grief recovery process.

Research on Community-Based Grief Resolution Programs

Cognitive Behavior Theory

A Cognitive Behavior Theory (CBT) approach to grief resolution was rooted in three assumptions: a griever had the ability to assess and control cognitive processes; a griever's cognitions could be assessed and modified in order to change thought processes; and thought processes created an individual's perspective of and reaction to reality (Dobson & Dozois, 2010;

Epp & Dobson, 2010). Likewise, cognitive-based interventions on grief focused on procedures to identify, challenge, and change thoughts concerning loss and bereavement (Neimeyer, 2014). They did so by incorporating specific techniques to encourage acceptance of loss, to modify maladaptive grief-related appraisals and behaviors, and to reduce avoidance or adverse coping mechanisms (O'Day & Goetter, 2018). CBT interventions were most commonly delivered in group-based or individual settings and usually consisted of multiple sessions based on psychoeducation, cognitive reconstructing, exposure, and behavioral activation.

Using the minimization method in a non-randomized control trial, Boelen, de Keijser, van den Hout, and van den Bout (2007) assessed the effect of a 12-week CBT-based intervention to minimize grief among the bereaved. Participants were assigned to one of three treatment conditions: 1) cognitive reconstructing and exposure therapy; 2) exposure therapy, cognitive reconstructing, and supportive counseling; and 3) supportive counseling. Each treatment condition asked grievers to provide a detailed account of their loss, providing specific information such as thoughts, feelings, or memories. With this information, each griever received targeted treatment and psychoeducation based on his or her loss experience and assigned condition. Results showed that exposure to either one of the CBT-based treatments was more effective than supportive counseling alone in the amelioration of grief.

Relative to a randomized delayed treatment comparison group, a second 12-week intervention based on CBT principles was used to assess the interruption or activation of a post bereavement, pathological grief response (Papa, Sewell, Garrison-Diehn, & Rummel, 2013). In this study, grievers received targeted treatment to identify maladaptive coping strategies referred to as 'grief loops.' With these grief loops identified, individuals were trained on methods to counteract negative cognitions and behaviors through increased social engagement, goal-directed

behavior, and skill development. From pre to post-intervention, Papa et al. reported that participants exposed to the treatment experienced a statistically significant reduction in grief-related pathology identified as posttraumatic stress, prolonged grief, and depression. A significant treatment effect was also found in the intervention group at 12-week follow-up. Upon further analysis, the authors reported that the CBT intervention was most effective at addressing prolonged grief with more modest changes in depression and posttraumatic symptomology. No differences were found among the comparison group.

Due to the positive effect of CBT-based interventions to influence grief, researchers Klimo, Henderson, Varley, Engel, & Pethtel (2013) qualitatively examined the experiences of bereaved individuals who self-selected to receive a CBT-based grief recovery outreach program. In the program, participants were exposed to a 12-week psychoeducation course that involved the thorough examination of thoughts, feelings, and beliefs related to loss, and required each griever to provide a personal written narrative on their loss experience in order to cognitively reconstruct his or her relationship with the deceased and process unresolved grief. According to the researchers, exposure to the CBT-program resulted in a myriad of psychological benefits reported by the participants including greater insight, decreased anxiety, and improved ability to cope with grief. Among the health effects reported, participants stated they experienced decreased physical pain, improved sleep, and overall greater quality of life. Resultant of these findings, researchers posited that exposure to the CBT-based outreach program reduced grief by providing participants with new information and tools on how to understand and cope with significant loss, thereby reducing grief-related symptomology.

More recently, Rosner, Pfoh, Kotoučová, and Hagl (2014) used a stratified randomized control trial to compare a 20-25 week CBT-based treatment to a waitlist control. The

intervention group received targeted CBT treatment that centered on: stabilizing and exploring the individual grief experience; learning appropriate relaxation and cognitive restructuring techniques to address maladaptive appraisals of self, the deceased, and circumstances of the loss; and the creation of future goals towards the maintenance of a healthy relationship with the deceased. Results showed that individuals assigned to the treatment group experienced a reduction in grief pathology relative to the waitlist control group. A significant treatment effect was also found in the CBT-based treatment group one and half years post intervention (Rosner, Bartl, Pfoh, Kotoučová, & Hagl, 2015). To summarize, the findings from this study along with those previously reported served to corroborate Currier, Holland, and Neimeyer (2010) who supported the general efficacy of CBT-based interventions in the treatment of grief and the promotion of grief resolution.

As a dissertation study, Brassil (2015) used a pretest-posttest nonequivalent group, quasi-experimental design to examine the effectiveness of a 12-week CBT-based grief resolution program to influence grief and improve adaption to loss. According to the researcher, the intervention provided grievers with two distinct protocols towards the attenuation of grief defined as psychoeducational components and emotionally focused therapy. Brassil posited that the program taught the bereaved not to grieve based on perceived societal standards or norms, but rather by taking action to resolve the griever's relationship with the deceased and to continue the bond by making sense of loss. Findings showed that participants exposed to the program had a statistically significant increase in scores on adaption to grief and personal growth after a loss when compared to those unexposed. On scores related to the intensity of grief, participants exposed to the program scored significantly lower when compared to those unexposed. Based on these results, Brassil concluded that exposure to the grief resolution program positively impacted

those affected by loss and lent further support to the efficacy of grief-related community-based treatment.

To determine the long-term efficacy of a 10-week CBT-based intervention to mitigate grief among the bereaved, Bryant et al. (2017) conducted a two-year follow-up study of a randomized controlled trial. In the initial study, Bryant, Maccallum, and Aderka (2014) randomized participants to one of two treatment conditions. The first condition was a 10-week CBT program, which also incorporated elements of exposure therapy. The second condition was a 10-week CBT only program identical to the first condition in all ways, except that no exposure-based treatment procedures were used. Psychoeducation used in both treatment conditions focused on grief, cognitive restructuring to reframe maladaptive appraisals, and the expression of unresolved communication with the deceased. To ensure fidelity of the treatment, audiotapes of all sessions were randomly selected and rated by clinical experts in CBT who were independent of the study. The findings from Bryant et al. (2014) showed that an additional therapeutic benefit could be gained by incorporating elements of exposure therapy into CBT-based treatment. Participants in the CBT+exposure therapy group reported greater reductions in both grief and depressive symptoms, as well as increased psychological and social functioning when compared to those in the CBT group alone. This finding seemed consistent with other literature (Bryant et al., 2008a; 2008b), which revealed how exposure therapy further augmented the positive effects of CBT-based treatment in those experiencing grief-related pathology. In the two-year follow-up study, Bryant et al. (2017) used the minimization method to randomize a different sample of grievers that were stratified by gender and grief severity. Participants were assigned to one of the two conditions as before. Measurements were taken post-intervention and at the 6-month and 24-month follow-up by an independent group of researchers who were unaware of participants''

assigned treatment conditions. Consistent with Bryant et al. (2014), findings from the Bryant et al. (2017) showed that individuals who received CBT+exposure therapy reported a greater reduction in grief symptoms than those who received CBT alone at two years post-intervention. An explanation offered for this finding was that successful conceptualization of emotional processing often engaged fear and traumatic memory. However, use of CBT-based strategies within focused exposure treatment allowed the integration of corrective information and action towards the development of adaptive beliefs and behaviors; thereby, further mitigating the traumatic response over time. Researchers concluded that while CBT was effective in both groups, the added element of exposure therapy was essential if optimal treatment was to be achieved and resolution of grief obtained.

Group Cohesion Theory

Festinger et al. (1950) were credited with formalizing the theory of group cohesiveness, which according to Yalom and Leszcz (2005) was a key therapeutic factor in effective group counseling and potentially, grief resolution (Piper, Ogrodniczuk, Joyce, Weideman, & Rosie, 2007). According to Group Cohesion Theory (GCT), group members built and maintained relationships with one another through exerting pressure on each other to adhere to group norms (Festinger). The cohesiveness of these relationships was said to have developed from an initial attraction that later grew into a close bond, where group members self-disclosed information and provided feedback to each other (Braaten, 1991). Accordingly, the concept of group cohesion has been shown to consist of two dimensions: a mutual sense of belonging; and a shared feeling of morale (Bollen & Hoyle, 1990). Despite researchers' in-depth scientific understanding of GCT that has spanned over the last seventy years, the effectiveness of group cohesion in grief resolution was mixed at best. Some studies have reported that GCT was highly effective in

mitigating the burden of grief (Souter & Moore, 1989; Vachon 1983; Wilner & Kaltreider, 1988); while others indicated that GCT in grief resolution was ineffective and potentially harmful (Barrett, 1978; Neimeyer, 2000a; van der Houwen, Stroebe, Schut, Stroebe, & van den Bout, 2010). Therefore, Papa and Litz (2011) established that a great need existed for more rigorous and abundant studies to explore the influence of GCT on grief.

Addressing the need for future investigation on the influence of GCT on grief and grief resolution, researchers Friedrichsen, et al. (2014) used a nonrandomized qualitative pretest-posttest evaluation study to assess the effect of 8-24 week GCT-based intervention on a griever's ability to accept the loss, identify obstacles that may prevent adaption to life without the deceased, and to establish ways to move beyond the loss and to find new meaning for life. Each participant who self-selected to receive the intervention was a provided a diary with semi-structured, open-ended questions to guide expressive writing on his or her loss experience. Individuals within the group were encouraged to verbalize thoughts, express emotions, read letters to the deceased or others, share photos and items that belonged to the deceased, and to visualize their loss. Group facilitators assisted grievers to create a supportive social network, to be more self-confident, and to accept challenges associated with tasks of grieving. Results showed that group members reported emotional and cognitive benefits as a result of their participation. For example, by expressing their loss and relating to the loss of others, grievers felt their experience could serve to benefit others in the group. Grievers reported that although the activities of the group were at times painful, the GCT-based intervention helped them to develop a greater appreciation for life, a deepened sense of loss acceptance, and allowed them to recognize and control maladaptive coping mechanisms. Grievers also reported that hearing the loss experiences of others provided a sense of unity among the group and enabled them to feel

safe and validated. Other benefits reported by grievers included reduced symptoms of grief, reduced feelings of being unusual or alone, and an increased feeling of inner peace.

Due to the usefulness of GCT to provide a sense of community and common moral, researchers Chang, Sequeira, McCord, and Garney (2016) developed a pilot study using videoconference technology to assess the feasibility of an online 8-week community-based grief counseling intervention among a sample of grievers located in a rural, isolated area. By means of psychoeducation delivered in a supportive group format, the intervention explored the traditional five stages of grief proposed by Kübler-Ross (1969) to improve adverse psychosocial outcomes attributable to grief. Results showed that exposure to the GCT-based online intervention improved psychosocial related outcomes and provided a safe space where grievers could openly express their loss experience. Grievers reported they would have gone without services if not for the telehealth program, and that the online grief counseling services they received were equivalent to face-to-face, but were more convenient as the closest mental health provider was located approximately 45 min away from the nearest town center.

Based on the convenience and therapeutic value of accessible grief-related psychoeducation, Knowles, Stelzer, Jovel, and O'Connor (2017) used a pretest-posttest non-randomized controlled pilot study to examine the feasibility of an 8-week GCT-based virtual online support group when compared to the use of a grief educational website to improve psychosocial outcomes among the bereaved. Outcomes assessed in both groups included depression, grief severity, grief cognitions, yearning, loneliness, stress, and sleep quality. Participants assigned to receive the treatment were enrolled into a virtual online support group that consisted of 16 sessions over eight weeks that were moderated by a licensed clinical psychologist. The curriculum of the support group centered on psychoeducation, self-reflection,

and social interaction that addressed topics such as emotional responses to grief, physical health, relaxation, and coping mechanisms. Participants assigned to the control were provided access to a grief website that posted one reading on grief for eight weeks. Results of both groups showed statistically significant improvements in grief severity, grief cognitions, yearning, loneliness, stress, and sleep quality. However, only the treatment group reported a statically significant improvement in depression. An explanation for this finding was that participants exposed to the treatment developed a strong sense of social support due to their social interaction online, which was not reported by the controls. Researchers concluded that the grief education website was equally as effective as the online support group in promoting psychosocial outcomes among the bereaved; but that an overall greater outcome was achieved through the virtual online group as it fostered feelings of social support.

From the critical role that social support was found to play in bereavement, Dartnell, Tahmaseb-McConatha, Kumar, and Treadwell (2017) conducted a qualitative GCT-based intervention study using thematic content analysis to assess the therapeutic benefit of combining psychoeducation with processes of group cohesion. The 7-week intervention consisted of psychoeducation group-based sessions that covered circumstances of the death, role-changes, identification of emotions and coping strategies, relaxation, and the celebration of life after loss. Each week, participants were encouraged to share their bereavement experiences and to identify and express individual needs. Based on participant evaluations, group members acknowledged that he or she sought participation in the group due to an overwhelming sense of loss, recurrent feelings of hopelessness, and a need to talk about the deceased. As a result of their participation, members reported that they benefited from group sessions and described a strong sense of cohesion built among participants as a result of their shared experiences of loss. According to the

researchers, the group experience improved daily functioning among the bereaved by offering a safe space to release pain from loss and discover new hope. Findings from the thematic content analysis of the group processes revealed the following recurrent themes: the need to talk about lost loved ones; hopelessness and loss; self-advocacy; stressors related to change; and reentry into the new normal without the deceased. Taking these narrative themes and participant evaluations into account, researchers concluded that the relational impact of the GCT-based intervention instilled trust among participants by expanding social networks for ongoing support, and showed to be of therapeutic value towards one's emotional recovery from grief.

Meaning Making Theory

Stemming out of postmodern theories of meaning reconstruction, the Meaning and Making Theory (MMT) of life after death was born (Currier, Holland, & Neimeyer, 2008; Fleming & Robinson, 2001; Holland, Neimeyer, Boelen, & Prigerson, 2009). The MMT posited that in the aftermath of a significant loss, such as the death of a loved one, individuals searched for meaning. Within this course of action, which can only be described as practical, relational, spiritual, or an existential process, grievers reconstruct their ecology through use of sense-making and benefit-finding as a means of loss adaptation (Neimeyer, 2011). For example, when the death of a loved one was relatively normative and anticipated, the bereaved evaluated and made sense of loss, both for the better and for the worse (Coleman & Neimeyer, 2010; Neimeyer, 2011). Even when loss or bereavement occurred late-in-life, grievers continued to search for meaning for an extended, sometimes indefinite period (Bonanno, Wortman & Nesse, 2004). This preoccupation to find meaning or make sense of loss has been associated with marked distress among grievers (Holland, Currier, & Neimeyer, 2006). Subsequently, interventions that helped to facilitate the processes of meaning reconstruction following

bereavement offered a means of effective and supportive treatment to grievers struggling with intense or prolonged grief.

Within the last decade, Lichtenthal and Cruess (2010) conducted a randomized control trial of a 1-week bereavement intervention based on MMT that emphasized the role of sense-making and benefit-finding after a death. In the study, researchers compared directed writing that focused on either sense-making or benefit-finding after the loss of a loved one, to traditional, non-directed emotional disclosure as a control condition. Findings showed that physical health improved over time in all treatment groups, and that directed written disclosure on bereavement was a useful tool for grieving individuals to reduce distress attributable to loss. One novel finding produced from the study showed that when directed to write about positive consequences related to their loss, participants reported a significant reduction in on depressive and posttraumatic symptoms. Therefore, the researchers concluded that initial coping with a loss would typically include some element of sense-making, but that grief resolution would ultimately result from deriving benefits and growing from the loss experience over time.

To understand how grievers derived meaning and made sense of loss overtime, Castelli-Dransart (2013) conducted an MMT-based qualitative study in a sample of bereaved persons for whom the time elapsed since loss ranged from three months to nineteen years. In the study, the researcher used open-ended, semi-structured, in-depth interviews to explore the meaning-making process grievers used to process loss over a period of eight years. Findings showed that when the death of a loved one is experienced, grievers become confronted with a total loss of meaning that they are compelled to make sense of. This process typically involved a griever developing an account of the loss through gathering informative elements to explain the cause and reinterpreting events based on his or her metaphysical or spiritual beliefs. Using a different

sample, Castelli-Dransart (2016) qualitatively sought to further explain these findings through the identification of specific patterns and challenges associated with meaning-making and reconstruction among the bereaved. Results of the later study showed that grievers faced four specific challenges following the death of a loved one: the impact of the loss on one's life; the quest for meaning; the clarification of responsibility for the loss; and the reaction styles and coping mechanisms used to process the loss. Accordingly, the researcher stated that four distinct patterns of meaning-making and reconstruction existed among grievers. The first, the vulnerability pattern, was arguably the most destructive and was characterized by intense or prolonged suffering and the reliance upon others to carry on with life. The second pattern, identified as transformation, encompassed growth as its defining characteristic whereby loss had a significant impact upon a griever's life, but that he or she perceived the death as an opportunity to gain self-awareness and live life with a greater sense of purpose. The third pattern, identified as commitment, was marked by an unwavering focus on some other aspect of life where a griever reoriented all of his or her attention towards a social cause or religion. The last and most resilient pattern was defined as a hard blow. In this pattern, a griever defined the loss as a painful ordeal or a hard blow, but one that did not break his or her constitution and vitality for life. Taking into account these various forms of meaning reconstruction, Castelli-Dransart (2016) argued that health and social care providers should provide more specific modalities of treatment to address all patterns of meaning-making.

In another MMT-based intervention study, MacKinnon et al. (2014; 2015) used a pilot randomized controlled trial to evaluate the effectiveness of 12-week group counseling for uncomplicated bereavement. In the program, trained facilitators shared a story of their most recent loss, identifying common and divergent themes in the context of typical bereavement

narratives. Facilitators also focused on the contextual aspects of the loss, such as the nature of the relationship with the deceased. Participants of the program were asked to identify what they hoped to achieve through the intervention and to write down specific therapeutic goals. Of the course of multiple weekly sessions, participants were assigned various tasks such as actualizing the loss, to identify emotions or feelings not expressed, and to examine coping behaviors. Results of the study showed that the intervention was useful in facilitating psychological adjustment to loss among participants experiencing uncomplicated grief. According to the researchers, the program promoted adaptation and insight to loss and that benefit was derived from sharing personal loss experiences and bearing witness to the loss experiences of others.

As a result of the positive effect reported by grievers when sharing their loss experience, Peri, Hasson-Ohayon, Garber, Tuval-Mashiach, and Boelen (2016) conducted a pretest-posttest case study on the implementation of a narrative reconstruction, 12-session, MMT-focused intervention previously shown to reduce posttraumatic and depressive symptoms in those affected by prolonged grief (Peri, 2004; Peri & Gofman, 2014; Peri, Gofman, & Vidan, 2013). The program consisted of exposure therapy, systematic reconstruction and reorganization of the loss through written narrative, loss integration with autobiographical memories, and psychodynamic development of personal meaning with regard to the loss experience. Findings showed a clinically significant decrease in psychopathology measures at posttest and at the 3-month follow-up. The improvement in prolonged grief symptoms was associated with an increase in measures of narrative reconstruction, which seemed to suggest a relationship between the retelling of the loss event and decreased psychopathology. Based on these findings, researchers concluded that exposure to the program resulted in greater loss integration and acceptance, which led to overall improvements in grief-related pathology.

Synthesis of Research Findings on Community-Based Programs

Grievers exposed to most grief-resolution, community-based programs were taught to reconstruct and identify cognitive distortions and maladaptive behaviors attributable to unresolved grief (Yalom, 1991). Coinciding with modern theory that suggested unresolved grief was pathological in nature, Green et al. (2001), along with Zisook and Schuchter (2001), described that the process of reconstruction and identification required that a griever not only discerned how grief impacted his or her quality of life but also required a griever to learn new ways on how to cope with and mourn significant loss. To accommodate this process, curriculum of most community-based grief recovery programs seemed to be delivered over the course of 8-12 weeks or sessions, dependent upon the perceived need within the community and the availability of trained program providers. Programs were found to mostly consist of psychoeducational activities that aimed at the specific identification of goals related to grief and loss, and the maladaptive behaviors or protective factors that could influence grief (Jordan & Neimeyer, 2003). However, the discourse concerning what elements of grief curriculum were required and the appropriate length of time needed for program exposure and goal achievement have been sparsely articulated in terms of population and community health. Concurrently, research conducted by Sallnow, Tishelman, Lindqvist, Richardson, and Cohen (2016) revealed there was a dire lack of evidence demonstrating the efficaciousness of most community-based programs to assist grievers towards grief recovery. In fact, Jordan and Neimeyer (2003) along with Neimeyer and Currier (2009) have shown that most studies on grief-related programs have lacked strong theoretical foundations, had poor sample sizes and failed to assess the fidelity of the intervention. Based on the current review of grief-related programs, these findings seemed to be consistent as many of the interventions discussed were solely based on elements of theory

(CBT, GCT, MMT), but were not acknowledged within the literature as being evidence-based, nor potentially effective in large or diverse populations. Even with improved methodological sophistication in the 21st century, many of the current grief-resolution programs discussed have lacked appropriate control or comparison groups, and were believed to only minimally affect grief as they have historically demonstrated small to medium effect sizes (Allumbaugh & Hoyt, 1999; Jordan & Neimeyer, 2003; Piper, Ogrodniczuk, Joyce, Rosie, & Weideman, 2007; Rosner, Pfoh, & Kotoučová, 2011). Despite the strong criticisms of community-based grief resolution programs, participation in a grief-resolution was still supported within the literature as a potentially effective means to reduce the intensity of grief experienced; thereby, increasing long-term personal growth after a loss.

The Grief Recovery Method® Program

To address the shortcomings of many community-based grief resolution programs, one well-established and widely used intervention that aims to influence grief and promote grief recovery was known as The Grief Recovery Method®. Translated in more than 15 languages worldwide, development of the practice-based grief recovery program did not rely on existing theory or set of curriculum; rather the program was rooted in the developers' lay knowledge and firsthand experience with grief, and grievers over the last 40 years. Prior to the establishment of The Grief Recovery Institute™ in 1977, the developers of the grief recovery program met for several months to discuss and review drafted versions of the intervention for feasibility and applicability to grievers of diverse backgrounds and grief-related experiences. The selection of components used in the program was based on trial and error through the developers' own, unique, individual exposure to grief and grievers. Comments and feedback from grievers exposed to the initial program were used to critique and modify drafts of the program until the

final version was completed. James and Friedman (2009) published the final version of the program as a book, entitled *The Grief Recovery Handbook*. The program handbook consisted of six practice-based, evidence-informed components: (1) cognitive-behavioral processes and educational activities to support the development of appropriate social norms about death, loss, and grief; (2) spiral sequencing to build and reinforce skill development through weekly sessions in which new coping skills are introduced, practiced, and revisited (Fig. 2-1); (3) high use of group-based

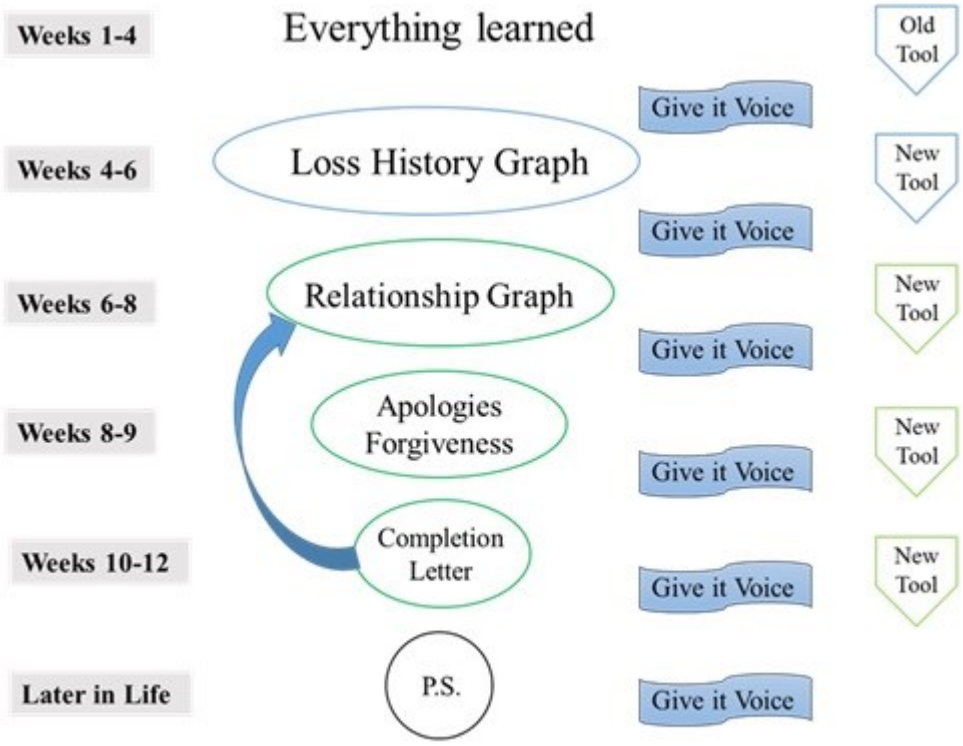

Fig. 2-1. Spiral Sequencing Model

Used with permission from Hall (2011)

participant engagement through guided instruction, role play, and discussion; (4) use of flexible, teaching-learning strategies in conjunction with educational activities that required application of learned skills; (5) culturally appropriate use of language due to the sensitive nature of the topic;

and (6) clear connectivity between adult grievers and resources available within the community to solidify what is learned through the program.

The framework of the grief recovery program was believed to be effective due to the fact that it enabled adult grievers to actively utilize educational ideals and skills inherent to the program, all the while developing a unique, personal understanding of grief, grief recovery and moving beyond loss. The program achieved this course of action through either a 6, 8, 10 or 12-week structured, psycho-educational curriculum delivered in a group format through two-hour weekly sessions. Each session was facilitated by a certified Grief Recovery Specialist® who had been professionally trained in the program through The Grief Recovery Institute™ headquartered in Bend, OR. Each structured program, regardless of duration, aimed to create a safe environment in which grievers were taught to examine attitudes and old beliefs about death and loss, as well as how loss affected their lives. Each program also trained grievers on what appropriate actions to take in order to move beyond loss though: a) understanding the origin and meaning behind associated myths on death, grief, and loss; b) examining knowledge, attitudes, beliefs, and behaviors (appropriate and maladaptive) related to death, grief, and loss; c) making positive, quality of life decisions about future behaviors and actions concerning death, grief, and loss; d) developing and using effective grief recovery skills in day-to-day life, and e) recognizing and addressing opportunities later in life for further realizations and opportunities for grief recovery.

According to James and Friedman (2009), a defining characteristic of the grief recovery program was the ability to promote recovery from grief by targeting variables believed to influence grief. Through this promotion, a new association of death emerged that lent itself towards the natural process of grief recovery. Framed this way, the attractiveness of the grief

recovery program resided in the fact that recovery from grief not only lied in the program's ability to influence associated variables of grief and grief recovery but also through a series of small, correct action choices to complete the pain caused by a death-associated loss (James & Friedman). These actions were identified as a griever: 1) gaining awareness that an incomplete emotional relationship existed with the deceased; 2) accepting responsibility, in part, that a griever was the cause of any incompleteness related to the deceased; 3) identifying recovery communications that the griever did not deliver to the deceased prior to death by writing them down in a clear, concise, organized manner; 4) taking action by stating recovery communications aloud; and 5) moving beyond loss by saying good-bye to undelivered communications and letting go of the pain caused by death. For these reasons, it became essential to evaluate the grief recovery program in order to assess the mechanisms by which the program influenced grief and promoted grief recovery through the establishment of valid and reliable instrumentation to measure hypothesized program variables identified as a griever's knowledge, attitudes, beliefs, behaviors of grief (STERBs), and behaviors of grief recovery as an outcome.

Chapter Summary

Prior research on grief and grief recovery has been mostly qualitative and largely characterized by its associated strengths and weaknesses. Main critiques include that there have not been many research studies designed based on existing theoretical frameworks, or implemented with experimental or quasi-experimental designs that include comparison groups. Despite these limitations, some of the research strengths have been that much of what has been studied thus far has been assessed in real-world, natural settings, and there has been increased interest in theoretical development. Due to the fact that differences commonly existed in the objectives of grief researchers when compared to grievers and practitioners, any interventions

that were implemented to reduce the burden of grief must be evidence-based and beneficial to improve relevant outcomes both in practice and clinical settings. To this end, there has been a dire lack of magnitude and scope of grief-related theoretic research, which has often been associated with limited, and sometimes questionable validity and reliability of findings. Although The Grief Recovery Method® incorporated elements based on behavioral theory that were supported by educational research, the program was an atheoretical practice-based, cross-cultural intervention that has not yet been evaluated for its effectiveness. Because the question of how and to what extent the program produced clinically relevant outcomes among grievers remained largely unknown, limited understanding of how a person's grief received influence through participation in the grief recovery program has been gained. This study aimed to unshroud this mystery through the development and validation of an instrument that is intended to be used in future evaluation of the treatment's construct validity to document the degree of change in the implicit theoretical variables of the program. With the expected use of valid instrumentation, evidence will be gained on the ability of the community-based program to influence variables of knowledge, attitudes, beliefs, and behaviors of grief and grief recovery; thereby gaining crucial insight towards the establishment and validation of the theory of grief recovery.

CHAPTER 3.

STUDY DESIGN AND METHODS

Introduction

The specific aims of this study were: 1) To use a construct validation of the treatment approach to develop an instrument based on The Grief Recovery Method® that measured participants' self-reported knowledge, attitudes, beliefs, behaviors of grief (STERBs), and behaviors of grief recovery as an outcome (KABB); 2) To field test the instrument (GRMI) using expert panel and peer-review to assess the instrument's content and face validity; 3) To conduct pilot and validity tests on the instrument in an independent sample of adult grievers who self-selected to receive the grief recovery program offered by a local office of a national hospice organization; and 4) To test for logical fit of the hypothesized factorial structure (KABB) to the data using confirmatory factor analysis in an independent sample of adult grievers who have completed the grief recovery program. To study the proposed aims of this research, the following methods based on construct validation of the treatment were used: development and validation of an instrument, field testing, pilot and validity assessments, confirmatory factor analysis, and reliability analyses using Cronbach's alpha.

Institutional Review Board Approval and Consent

Approval from Kent State University's Institutional Review Board (IRB) was obtained for the study (protocol # 17-031, (Appendix: A-C).

Procedures

Study Design and Phases

The study design used in this research consisted of instrument construction, development, and validation separated into five unique design phases. The first phase confirmed establishment of a comprehensive understating of programmatic mechanisms and variables through attendance at the three-day Grief Recovery Method® International Conference (October, 2016) and completion of a four-day certification training in the grief recovery program (January, 2017). The grief recovery certification training and program manual was used in tandem with James and Friedman's (2009) program handbook to guide instrument construction and development. The second phase constituted of using a construct validity approach to develop a self-report measure based on targeted program variables of grief and grief recovery that are believed to influence grief and grief recovery (KABB). The third phase incorporated expert panel and peer-review to field test the instrument and assess its content and face validity. The fourth phase encompassed pilot and validity testing of the self-report instrument in an independent sample of adult grievers who self-selected to receive the grief recovery program. The fifth phase involved testing for logical fit of the hypothesized factorial structure (KABB) to data collected using the instrument through confirmatory factor analysis in an independent sample of adult grievers who completed the grief recovery program.

Phase I. Variables and Mechanisms of Grief and Grief Recovery

Knowledge. The first variable addressed by the grief recovery program was *knowledge*. As stated by James and Friedman (2009), one's knowledge about grief and the grieving process was often the result of misinformation or myths socially taught to individuals about how to deal with grief. This misinformation, acquired during childhood, became reinforced with time through

observational learning of family members, peers, and society. Six main examples of misinformation or grief myths communicated to grievers were defined as: 1) don't feel bad; 2) replace the loss; 3) grieve alone; 4) just give it time or time heals all wounds; 5) you must be strong for others; and 6) the best way to heal from grief and loss is to keep busy. According to James and Friedman, it was only through the early identification and eradication of these myths that a griever's ability to effectively deal with grief could become actualized. The present study defined knowledge as facts or information about grief, death, and dying, acquired over the course of one's life.

Attitudes. Similar to knowledge, the second variable addressed by the grief recovery program were individual *attitudes* about grief, death, and dying. These attitudes were thought to develop in childhood at any early age and maintained throughout adulthood (Engel, 1981). For example, Engel found that children's' attitudes towards grief encompassed denial, fear, anxiety, as well as psychological acceptance and distress. The grief recovery program categorized this complex array of emotions into two types of attitudinal grieving labeled *enshrinement* and *bedevilment*. In enshrinement, a griever limited attitudes towards the deceased to only those that were positive, as to solely view his or her relationship with the deceased in a favorable light. Conversely, in bedevilment, a griever limited attitudes towards the deceased to only those that were negative, as to less favorably view his or her relationship with the deceased. James and Friedman (2009) cautioned, however, that if a griever closely clung to either the enshrinement or bedevilment foci, he or she would not adequately view the entirety of the relationship with the deceased. The end result of this inadequate process was incomplete, or unresolved grief. Therefore, the practice of grief recovery required a griever to thoroughly examine both positive and negative aspects of the relationship with the deceased and both positive and negatively held

attitudes towards the deceased. For the purpose of the present study, the researcher defined attitudes as the implicit, often subjective, evaluative or affective response concerning grief, death, and dying.

Beliefs. Regarded as one of the most influential variables affecting the grief recovery process, and grief in general, were individually held *beliefs* towards death and dying (Boyraz, Horne, & Waits, 2015). Individually held beliefs towards death, dying, and more specifically the death of a loved one, helped to characterize one's view of grief recovery as a distinct choice rather than some obscure destination. To make this choice, a griever must decide what could have been different, better, or more of with regard to his or her relationship with the deceased (James & Friedman, 2009). Resultant of this process, an understanding occurred that set into motion a new belief system that death itself was responsible for the pain and distress experienced by the griever, and not the deceased individual. Through this realization, a griever began to shed the fabricated notion that other people (i.e. the deceased) and events (i.e. a loved one dying) were responsible for individually held beliefs, feelings, and emotions towards death (James & Friedman). With these fallacies gone, a griever started to disassociate from the perception of him or herself as a victim of the death, and embarked upon the journey of taking responsibility for one's own process of grief recovery. The present study defined beliefs as feelings or ideas on grief, death, and dying that a griever judged or accepted to be true.

Behaviors of Grief (STERBs). The next variable addressed by the grief recovery program was *behavior*, which referred to the fact that a griever must establish appropriate behaviors and take effective action towards grief recovery. Unfortunately, however, most people were socialized early on to hide or bury grief through a certain set of acceptable self-defeating or coping behaviors like smoking, excessively sleeping, taking drugs, or drinking alcohol. These

behaviors, more commonly referred to as short-term energy releasing behaviors (STERBs), often manifested as public health risk factors. Overtime, these maladaptive coping strategies reinforced the illusion that short-term relief could provide a long-term reprieve from pain caused by death (James & Friedman, 2009). To identify these maladaptive behaviors, the grief recovery program gently guided a griever through a structured process of uncovering how death influenced one's day-to-day functioning and capacity to cope with the loss. Through the identification of how one's suffering manifested through his or her exhibited behavior, a griever must then address which behaviors were appropriate, which served to impede grief recovery, and which required effective action to moderate or to end. For the present study, behaviors were defined as actions or reactions that occurred in response to grief and loss.

Behaviors of Grief Recovery as an Outcome. Once a griever addressed all knowledge, attitudes, beliefs, and behaviors of grief identified by the program that served to support or hinder the grief recovery process, research indicated that some behavioral tasks or actions must be completed in order to achieve the concrete *outcome* of grief recovery (Green et al., 2001; Stroebe, Gergen, & Stroebe, 1992). Through the grief recovery program, grievers learned about what actions to take by completing a loss-history graph that outlined various and significant losses experienced over the course of a lifetime. Respectably, James and Friedman (2009) described over 40 different, generally overlooked, grief-producing events or losses (Table 3-1) that could occur throughout one's adult life. The purpose of the loss-history graph was to engage the griever to actively confront and identify patterns of how he or she has dealt and coped with death, as well as to uncover buried or forgotten losses through the creation of a detailed examination of grief producing events (i.e. death, pet loss, disability, change in health status,

etc.). Through this examination, a griever could come to recognize that some losses had a greater impact when compared to others. For example, a bereaved person might acknowledge that his or

Table 3-1. *Grief Producing Losses and Events**

Grief Producing Loss and Events of Self, Spouse, Family Member, Co-worker, or Friend		
Change in communication	Death of loved one, pet loss	Imprisonment, minor or major
Change of residence or school	Abuse, assault, or trauma (experienced or witnessed)	Work-related issues with co-workers, employee(s), employer(s)
Change in sleeping or eating habits	Sexual or reproductive difficulties	New job, new skill, or begin/end school
Change in health status	Pregnancy, adoption, addition of new family member	Career change or new business venture
Change in financial status (foreclosure, mortgage, loan)	Personal injury, illness, or loss of bodily function	Dismissal, lay-off, retirement, or being fired from employment
Change in responsibilities at work or at home	Caregiving, empty-nest, or child leaving home	Familial issues with spouse, in-laws, or significant other
Change in living arrangements or conditions	Loss of trust, approval, or safety	Marriage, marital reconciliation, divorce, or marital separation
Change in recreation or social activities	Physical or emotional abuse (abandonment or isolation)	Vacation, holidays, anniversaries, days of emotional significance

* Adapted from James & Friedman (2009)

her relationship with the deceased was the most life-limiting, or incomplete. According to the grief recovery program, any incompleteness associated with the deceased or otherwise stemmed from an accumulation of things unsaid, unrecovered, or undone that have held significant emotional value overtime.

After the bereaved completed a thorough examination of losses through the creation of a loss-history graph, the next step in the grief recovery process was to reconstruct the entirety of the relationship with the deceased. To accomplish this task, a relationship graph must be completed in order to visually account for all aspects of the relationship with the deceased, both good and bad. The creation of the relationship graph allowed for the identification of significant things left unsaid, unrecovered, or undone that pertained to the deceased. With his or her relationship graph complete, a griever must then translate any relational aspects discovered in the

graph by placing them into one of three categories: 1) apologies, 2) forgiveness, or 3) significant emotional statements. The last and final task in the grief recovery process was to compose a list of apologies, pardons, or significant emotional statements reflective of the relational aspects found in the relationship graph. Once found, the list of apologies, pardons, or significant emotional statements are used to compose a Grief Recovery Completion Letter®. The intent of the letter was to say good-bye to any pain, things unsaid, hopes, dreams, or expectations associated with the deceased. The last and final stage of this process was to give voice by reading the letter aloud and by acknowledging any new discoveries of unfinished emotional business found later in life, referred to as a postscript (P.S.). In the P.S., a written addendum to the original letter is made in an effort to continually move beyond loss. The present study defined the outcome of grief recovery as the actions of behaviors towards resolution of any incompleteness, things unsaid, unrecovered, or undone related to grief, death, and dying.

Phase II. Instrument Construction and Development.

Using a construct validity of the treatment approach, development of a self-report instrument to measure hypothesized variables (KABB) of the grief recovery program began with an extensive review of grief-related literature and associated programming or community-based interventions used within adult populations. The purpose of literature review was twofold: 1) to understand the diverse operationalization and measurement of targeted program variables; and 2) to assess and review existing instrumentation on grief and grief recovery. To review the empirical body of literature on grief and grief recovery, thirteen databases, including Academic Search Complete, Cochrane Database of Systematic reviews, Dissertation Abstracts, Family Studies Abstracts, MEDLINE, Psychology and Behavioral Sciences Collection, PsychINFO, PubMed (MEDLINE), Social Sciences Citation Index, SocIndex, Sociological Collection,

Cinahl, and ERIC) were searched. Studies included in this review were (a) peer-reviewed, (b) preferably published in 2006 or later, (c) available in the English language, and (d) focused on grief, grief recovery, or grief-related outcomes. To conduct these searches, the following terms were used: (a) grief and grief recovery*; (b) traumatic grief*, complicated grief*, (c) community-based programs; (d) interventions*; (e) grief counseling*, grief therapy, and (f) grief resolution. Identified sources were examined for relevancy and duplicates. All duplicates and sources that did not address grief post bereavement among adult populations were removed. From the remaining sources identified, all abstracts were appraised and received classification into one of two categories: met criteria (include), and did not meet criteria (exclude). Sources that did not meet criteria were removed. For sources categorized as met criteria, the full article was examined and used for the rationale, construction, and development of the self-report instrument to address specific aims of the present study.

Next, a pool of items was generated based on content analysis of the published program handbook. Serving as a codebook, the program handbook was read word by word and text that appeared to capture key characteristics of program variables were highlighted. Next, notes were made that framed the identification of items specific to the program. A certified program expert and national trainer assessed the notes and the generated pool of items for accuracy. The pool of items was guided by the four variables specific to the grief recovery program that are believed to influence grief and promote grief recovery identified as a griever's (1) knowledge; (2) attitudes; (3) beliefs; (4) behaviors of grief (STERBs); and (5) behaviors of grief recovery as an outcome (KABB). Items generated were limited to concepts and specific verbiage used within the published handbook and certification training manual of the grief recovery program. A list of six influencing demographic variables were also created.

The total number of items for each factor included was based on the work of Guilford (1952), who established a minimum of three items per factor. Later, Costello and Osborne (2005) confirmed this identification by showing that a factor with fewer than three items is generally considered to be weak and unstable. Table 3-2 presented the operationalization for variables of grief and grief recovery. For the main study variables of knowledge, attitudes, beliefs, and behaviors of grief recovery as an outcome responses were presented in the form of a 5-point Likert-type scale ranging from one (Strongly disagree) to five (Strongly agree). For the descriptive variable of behaviors of grief (STERBs), responses were presented in the form of a 5-point Likert-type scale, ranging from one (Never [None per week]) to five (Always [Everyday]).

Table 3-2. *Operationalization for Variables of Grief and Grief Recovery*

Term	**Operational definition**
Knowledge	Operationalized as facts or information about grief and death acquired throughout one's life.
Attitudes	Operationalized defined attitudes as the implicit, often subjective, evaluative or affective response concerning grief, death, and dying.
Beliefs	Operationalized as the acceptance or feeling of something as true (pertaining to grief and death).
Behaviors of Grief (STERBs)	Operationalized as the actions or reactions (STERBs) of a person in response to a death-associated loss.
Behaviors of Grief Recovery as an Outcome	Operationalized as a serious of small and correct action choices to move beyond loss (i.e. death).

Scores for each item were averaged, with higher scores that indicated a greater influence the program had on variables of grief and grief recovery. Five items on the main study variables of knowledge, attitudes, and beliefs scales were negatively worded to prevent line-item response. These items were also reverse coded so that higher values indicated the same type of response for each item on the scale. Organization of the items was based on the four factors of the grief recovery program that are believed to influence grief and promote grief recovery (KABB) so that subscale scores could be developed.

For discriminant validity, additional items were generated by reviewing the current literature and modifying two existing valid and reliable subscales believed to influence grief, mood and personal growth after loss. Rationale for inclusion of a mood assessment stemmed from Clore and Huntsinger (2007) who showed that mood could affect evaluative judgment and survey response. For example, a happier mood has been shown to more positively affect survey responses when compared to a sad mood (Clore & Hunstinger, 2007). To assess respondents' current level of mood at the time of taking the instrument, the 6-item short-scale of the Multidimensional Mood Questionnaire (MDMQ-6) was used (Table 3-3). Developed and validated by Wilhelm and Schoebi (2007) the MDMQ-6 consisted of three factors defined as basic dimensions of mood: calmness [C], valence [V], and energetic arousal [E]. According to the researchers, the calmness factor denoted the state or condition of being free from agitation; whereas, the factor of energetic arousal was characterized by tension, nervousness, and high

Table 3-3. *Short-Scale of Multidimensional Mood Questionnaire* (MDMQ-6)

At this moment, I feel…								
Tired	0	1	2	3	4	5	6	Awake
Content	0	1	2	3	4	5	6	Discontent
Agitated	0	1	2	3	4	5	6	Calm
Full of energy	0	1	2	3	4	5	6	Without energy
Unwell	0	1	2	3	4	5	6	Well
Relaxed	0	1	2	3	4	5	6	Tense

*Developed by Wilhelm & Schoebi (2007)

energy. Valence, as described by the researchers, signified the intrinsic positive or negative emotions experienced by an individual found to be representative of one's mood. Each of the three factors had two bipolar items of mood with endpoints from 0-6 that were presented in the following format: tired-awake [E+]; content-discontent [V-]; agitated-calm [C+]; full of energy-

without energy [E-]; unwell-well [V+]; and relaxed-tense [C-]. Cronbach's alpha for the three scales ranged between 0.73 and 0.89.

Personal growth, as defined by Hogan, Greenfield, and Schmidt (2001) and Neimeyer, Hogan, and Laurie (2008), was an element that emerged as an integral component of the healing process post bereavement. It differed from the present study's behavioral-associated outcome of grief recovery in that personal growth was more reflective of the transformation that occurred among a bereaved person into a more compassionate, forgiving, tolerant, and hopeful individual (Hogan et al., 2001). Grief recovery, on the other hand, was a distinct phenomenon believed to only occur after exposure to the grief recovery program, where one's grief and pain from loss became emotionally complete through predefined behaviors or actions (James & Friedman, 2009). The present study used the 7-item personal growth subscale (Table 3-4) of the Grief and Meaning Reconstruction Inventory (GMRI). Developed by Gillies, Neimeyer, and Milman's (2015) as a measure of meaning and making in life after death, the GMRI's subscale of personal growth measured respondents' values, compassion towards others, self-improvement, and self-reflection post bereavement. The GMRI and its associated subscales showed good internal consistency, strong convergent validity, and positive correlations with grief (Gillies, Neimeyer, & Milman, 2015). Accordingly, personal growth items of the GMRI scale showed acceptable internal consistency with Cronbach's alpha that ranged between 0.61 and 0.80. The overall score for the GMRI's personal growth subscale was α=0.83.

The initial stage of instrument development generated 24-items specific to main program variables of grief and grief recovery: 8-items for knowledge; 5-items for attitudes; 6-items for beliefs; and 5-items for behaviors of grief recovery as an outcome. An 11-item, descriptive list of behaviors of grief (STERBs) was also created. Both the valid and reliable mood and personal

Table 3-4. *Grief and Meaning Reconstruction Inventory* (GMRI)

The following statements refer to thoughts, beliefs, feelings, and meanings some bereaved people experience following their loss. Please circle the number that rates the degree to which each of these experiences has been true for you **in the past week,** on a scale from 1 to 5:

1 = Strongly disagree
2 = Disagree
3 = Neither agree nor disagree
4 = Agree
5 = Strongly agree

1. The time I spent with my loved one was a blessing.	1	2	3	4	5
2. I do not see any good that has come from this loss.	1	2	3	4	5
3. Since this loss, I'm more self-reflective.	1	2	3	4	5
4. I value family more.	1	2	3	4	5
5. I will see my loved one again.	1	2	3	4	5
6. Since this loss, I find myself more alone and isolated.	1	2	3	4	5
7. I've been able to make sense of this loss.	1	2	3	4	5
8. Since this loss, I'm a stronger person.	1	2	3	4	5
9. I can't understand this loss.	1	2	3	4	5
10. I was prepared for my loved one to die.	1	2	3	4	5
11. My loved one was a good person; he/she lived a good life.	1	2	3	4	5
12. I value and appreciate life more.	1	2	3	4	5
13. Since this loss, I've changed my lifestyle for the better.	1	2	3	4	5
14. Memories of my loved one bring me a sense of peace and solace.	1	2	3	4	5
15. This death brought my loved one peace.	1	2	3	4	5
16. I've lost my innocence.	1	2	3	4	5
17. This death ended my loved one's suffering.	1	2	3	4	5
18. I miss my loved one.	1	2	3	4	5
19. Since this loss, I make more effort to help others.	1	2	3	4	5
20. I feel empty and lost.	1	2	3	4	5
21. I cherish the memories of my loved one.	1	2	3	4	5
22. Since this loss, I value friendship and social support more.	1	2	3	4	5
23. My loved one was prepared to die.	1	2	3	4	5
24. Whenever I can, I seize the day. I live life to the fullest.	1	2	3	4	5
25. Since this loss, I'm a more responsible person.	1	2	3	4	5
26. I believe my loved one is in a better place.	1	2	3	4	5
27. I feel pain from regrets I have in regard to this loss.	1	2	3	4	5
28. I've come to understand that life is short and it gives us no guarantees.	1	2	3	4	5
29. Since this loss, I've pursued new avenues of knowledge and learning.	1	2	3	4	5

Factor	*Item #'s*
1. Continuing Bonds	1, 5, 11, 14, 18, 21, 26
2. Personal Growth	3, 8, 13, 19, 22, 25, 29
3. Sense of Peace	7, 10, 15, 17, 23
4. Emptiness & Meaninglessness*	2, 6, 9, 16, 20, 27 [*these items are reverse scored]
5. Valuing Life	4, 12, 24, 28

*Only the subscale of personal growth developed by Gillies, Neimeyer, & Milman (2015) was used

growth scales were not subjected to field testing, nor was the 11-item descriptive list of behaviors of grief (STERBs) that was developed in order to provide averages of coping behaviors reported by the sample.

Phase III: Field Testing with Expert Panel and Peer-Review

Validation and assessment of self-report measures are considered to be a critical step in ensuring the generation of scientifically valid knowledge and research findings (Kim, 2009). To determine content and face validity of an instrument developed based on construct validation of the treatment, a field test was conducted using the 24-item pilot version of the instrument (Appendix: D). In the field test, the measure was subjected to a 17-member panel review recruited from a list of certified experts trained in the grief recovery program. This panel of certified experts also served as current facilitators of active community-based groups of the grief recovery program. Each certified expert received a recruitment letter (Appendix: E). Those who agreed to participate were debriefed on the purpose of the study, given definitions for study variables, and received instruction on how to assess the self-report instrument for face validity, content validity, and wording (Appendix: F). Based on the instruction received, face validity was defined as the subjective assessment of whether the instrument made sense at face value, and content validity was an estimate of how much the measure represented content of the grief recovery program. Based on the work of Alreck and Settle (1995), the wording of each item was evaluated for brevity, clarity, grammar, and core language characteristic of the grief recovery program. Expert panel reviewers were encouraged to provide specific feedback, comments, or suggestions to improve the wording of the instrument, and when necessary, offer suggestions for the addition or deletion of existing items. Based on feedback received from the expert panel review, changes were made to the instrument.

After being subjected to expert panel review, four Social Behavioral Sciences researchers consisting of two tenured professors and two doctoral students of the Kent State University, College of Public Health, were recruited to participate in peer-review of the instrument. Using

the same protocol described for the expert panel review, each researcher examined the instrument to ensure that items focused on the core concepts of grief and grief recovery, and that all items were evaluated for their brevity, clarity, and grammar. Based on feedback received from peer-reviewers, additional changes were made to the instrument.

Phase IV: Pilot and Validity Testing

Further assessment of the instrument's content and face validity was conducted through a pilot test in a purposive sample of adult grievers who self-selected to receive the community-based, 12-week (only) grief recovery program. In addition to validity testing, the purpose of the pilot test was to determine the readability, feasibility, and administration time of the self-report instrument (GRMI). To request participation, the Support Services Director of the Northeast Ohio office of a national hospice organization was contacted and asked to identify a Bereavement Coordinator, certified in the grief recovery program, who was willing to administer the instrument at a grief recovery group. Once identified, the Bereavement Coordinator was asked to recruit a one-time, independent sample of 10-15 individuals from a pool of adult grievers scheduled to receive the grief recovery program offered by a local office of the national hospice organization. Eligibility criteria for study participants were identified as individuals: who were ≥18 years of age; 2) who were not currently employed at a hospice or palliative care center; 3) who experienced a death-associated loss 4) who were not currently receiving grief-related or bereavement counseling services; 5) who were able to read, write, and speak English; and 6) who self-selected to receive the grief recovery program. Eligible participants were informed that the decision to participate or not to participate would not affect any benefits to which they were otherwise entitled as registrants of the grief recovery program. No compensation was provided for participation and no identifying information was collected.

Pilot and validity tests on the instrument occurred at the end of the final session of the grief recovery program offered by a local office of the national hospice organization. Prior to pilot and validity testing, the Bereavement Coordinator reviewed the survey administration guidelines (Appendix: G) with eligible participants and passed out a study recruitment letter (Appendix: H). Individuals who agreed to participate were provided with the purpose of the study and instructions for how to complete the self-report instrument. The self-report instrument (GRMI) was administered via paper and pencil format. Each study participant was asked to listen to instruction, carefully read the standardized research information sheet (Appendix: I), and voluntarily agree to participate in the pilot test by completing the instrument. Study participants were also asked to provide specific written feedback on the instrument, noting ease of use, wording or grammar that did not make sense, typos, and time to complete the instrument. After the administration period ended, participants' were instructed to individually place completed instruments into a blank manila folder located outside of the room.

Once the pilot test of the self-report instrument was complete, the same group of participants were asked to complete the validity assessment. Based on the work of Beck and Gable (2001), there was no set clear-cut criteria established for which an instrument achieved validity. Therefore, a revised version of the tool (Appendix: J) developed by Rubio et al. (2003) was used to determine whether the expert panel and peer-reviewers appropriately associated items of the instrument (GRMI) with their respective factors in the field test. Using the tool, the following validity estimates were calculated: Content Validity Index (CVI); Inter-Rater Agreement for Content Validity Index (CVI-IRA); Clarity Index (CI); Inter-Rater Agreement for Clarity Index (CI-IRA); Factorial Validity Index (FVI); and Time Index (TI). No inter-rater agreement is calculated for the TI or FVI. The Bereavement Coordinator sent completed self-

report instruments and validity assessments to the researcher via a pre-paid postage stamped envelope. Based on feedback received from the sample of individuals who participated in the pilot and validity tests, further revisions to the instrument were made.

Phase V: Confirmatory Factor Analysis

Upon conclusion of the pilot and validity tests, a sample was drawn sufficient enough to conduct the confirmatory factor analysis. Generally speaking, previous literature has suggested the ratio of sample size to estimated parameters of at least 10:1 was adequate for confirmatory analyses (Bentler, 1993). However, Gorsuch (1983) and Nunnally and Bernstein (1994) established that as few as five participants per each item was sufficient. Since this finalized version of the instrument subjected to confirmatory analysis consisted of 24 main study variables (KABB) specific to the grief recovery program (excluding mood, personal growth, and descriptive items), 5-10 participants per each of the 24-items equated to an estimated sample size of 120-240 adult grievers. From the total estimated sample size of 240 adult grievers, the researcher prepared to accept a minimum of 120 participants who completed the self-report instrument (GRMI). Based on the work of Fowler (2014), all grief, grief-recovery, personal growth, mood, and descriptive items were developed into one data collection instrument based on construct validation of the treatment with the intent to be completed in one sitting of 30 minutes or less.

Setting

Participants were recruited from an ethnically diverse but mostly Caucasian national sample of grievers who experienced the loss of a loved one and who completed the 6, 8, 10, or 12-week community-based grief recovery program within the last 25 years. Due to the main sampling considerations of this study being that participants were recruited from a large, national

sample of individuals who completed the grief recovery program within the last 25 years, the sampling frame was restricted to individuals recruited by a select group of certified experts (*n*=15) trained in the program. These certified experts also served as current facilitators of active community-based groups of the grief recovery program.

Sampling and Recruitment

To request participation certified program experts (*n*=15) reviewed the survey administration guidelines (Appendix: K) and distributed a research packet via mail or and by hand-delivery to eligible individuals who met inclusion criteria. Each research packet consisted of two items: (1) a standardized research information sheet (Appendix: L) that used language to encourage participation and emphasized the potential significance of this study by providing facts about the research and its purpose; and (2) a validated self-report instrument (GRMI) that measured research variables (Appendix: M). Study participant inclusion criteria was as follows: ≥18 years of age; 2) who were not currently employed at a hospice or palliative care center; 3) who experienced a death-associated loss 4) who were not currently receiving grief-related or bereavement counseling services; 5) who were able to read, write, and speak English; and 6) who self-selected to receive the community-based grief recovery program. Once a certified program expert identified a potential study participant as eligible, he or she provided a research packet to the participant for independent completion upon full receipt of the grief recovery program. Eligible participants were informed that the decision to participate or not to participate would not affect any benefits to which they were otherwise entitled as registrants of the grief recovery program. Individuals were also informed that by completing the validated measure, they agreed to participate in the study, that information about the research was satisfactorily explained to them, and that they could withdraw at any time. Participants who received the research packet

also received a return stamped envelope and instructions on how to return the completed self-report instrument to the researcher via the envelope provided. Due to the confidential, non-anonymous nature of the research, each consenting participant was instructed not to provide any identifying information on the measure so that the researcher was blinded to whom completed the instrument. All study materials were available in English only.

Because a sufficient sample size was not reached using the first sampling strategy, a second independent sample of participants was recruited onetime via email (Appendix: N) from a database of US residents who previously completed the grief recovery program. The database was maintained by certified program experts. Study participant inclusion criteria was as follows: ≥18 years of age; 2) who were not currently employed at a hospice or palliative care center; 3) who experienced a death-associated loss 4) who were not currently receiving grief-related or bereavement counseling services; 5) who were able to read, write, and speak English; and 6) who completed the community-based grief recovery program. To identify eligible individuals who wished to participate in the study, an email was sent by a certified program expert that used language to encourage participation and contained a web link to the online version of the validated instrument. All eligible individuals were informed that by completing the face and content valid measure, they agreed to participate in the study, that information about the research was satisfactorily explained to them, and that they could withdraw at any time. The online version of the instrument was made available through use of sophisticated software platform. Once selected, the web link directed individuals to the standardized research information sheet that provided information about selection into the study, as well as described the purpose of the research. When consent was obtained, participants were required to attest to the fact that they meet inclusion criteria. After a participant attested to meeting inclusion criteria, he or she gained

immediate access to the online instrument. To stop respondents from completing the online instrument more than once, the software platform's '*prevent ballot box option*' was used. No compensation was provided and no identifying information was collected. All study materials were available in English only.

Since a sufficient sample size was not reached using the first and second sampling strategy, the researcher drew a third and final independent sample of participants onetime from a pool of individuals who completed the grief recovery program via a study flyer (Appendix: O) posted to the program's social media sites on Facebook and LinkedIn. Study participant inclusion criteria was as follows: ≥18 years of age; 2) who were not currently employed at a hospice or palliative care center; 3) who experienced a death-associated loss 4) who were not currently receiving grief-related or bereavement counseling services; 5) who were able to read, write, and speak English; and 6) who completed the community-based grief recovery program. The study flyer consisted of language to encourage participation and contained a web link to the online version of the validated instrument. All participants were informed that by completing the valid measure, they agreed to participate in the study, that information about the research was satisfactorily explained to them, and that they could withdraw at any time. The online version of the instrument was made available through use of sophisticated software platform. Once selected, the web link directed individuals to the standardized research information sheet that provided information about selection into the study, as well as described the purpose of the research. When consent was obtained, participants were required to attest to the fact that they meet inclusion criteria. After a participant attested to meeting inclusion criteria, he or she gained immediate access to the online instrument. To stop respondents from completing the online instrument more than once, the software platform's '*prevent ballot box option*' was used. No

compensation was provided and no identifying information was collected. All study materials were available in English only.

Based on the hypothesized factorial structure (KABB), the model was subjected to confirmatory factor analysis to test for logical fit to the data to assess construct validity of the implicit theory of grief recovery (SPSS AMOS, Chicago, IL). Cronbach's alpha was used to assess the internal consistency of the instrument. Because the behaviors of grief scale (STERBs) was a descriptive list of items used to provide averages of potential coping behaviors reported by the sample, it was excluded from the confirmatory factor analysis. Latent variables were allowed to correlate specified at the $p<0.01$ level and all items were modeled to load on their corresponding factor. A path analysis was constructed with the hypothesized model that consisted of a 24-item four factor solution representing variables of knowledge (K1-K8), attitudes (A1-A5), beliefs (Bel1-Bel6), and behaviors of grief recovery as an outcome (GRO1-GRO5). The hypothesized model is presented in Fig. 3-1 with shaded areas that represented a priori item-to-factor loadings ≥0.54. The more stringent criteria of ≥0.54 set for item-to-factor loadings was used to reduce the likelihood of cross-loading. Regression weights, expected parameters of change, and modification indices received examination for areas of model misfit. Modification indices examined included the absolute (chi-square goodness of fit), relative (incremental, Tucker-Lewis, normed), parsimony, and those based on non-centrality (comparative, root mean square error of approximation). Not using an alternative model as a base for comparison, the absolute fit index reflected the implicit maximum likelihood minimization function and covariance matrices of the hypothesized model (Newsom, 2015). The relative fit indices differed from the absolute in that these indicators compared the chi-square of the hypothesized model to that of the null (Newsom, 2015). The parsimony fit indices were adjusted

Item	Description	Factor			
		1	2	3	4
K1	Grief is a not a normal reaction to a loss				
K2	Grief comes from a lifetime accumulation of things unsaid, undone, or unfinished				
K3	Grief is caused by the end of or change in a familiar pattern of behavior				
K4	A common source of grief is the sense of incompleteness related to loss				
K5	Grief recovery is a series of small and correct action choices				
K6	It is not possible to heal from grief				
K7	Grief recovery means feeling better				
K8	Grief is associated with conflicting feelings, such as good and bad memories				
A1	In general, it is appropriate to feel sad about a loss				
A2	The quickest way to recover from a loss is to keep busy				
A3	When applicable, it is good idea to replace a loss. For example: after a pet dies, get a new one				
A4	Overall, it is best to grieve alone				
A5	When someone is experiencing a loss, it is perfectly alright to tell the person "Don't feel bad."				
Bel1	After a loss, I need to be strong for others				
Bel2	Time heals all wounds				
Bel3	Loss is a natural part of life				
Bel4	Loss is something to be afraid of				
Bel5	It is wrong to speak ill of the dead				
Bel6	I am the cause of incompleteness related to loss				
GRO1	I have communicated things unsaid. (For example: an apology or significant emotional statement)				
GRO2	I have taken action to complete things undone. (For example: forgiven or taken responsibility)				
GRO3	I have recovered things unfinished. (For example: written a completion letter or postscript)				
GRO4	I have let go of unmet hopes, dreams, or expectations				
GRO5	I have found new meaning for living to feel better				

Fig. 3-1. Hypothesized Model 24-items. Model excludes 11-items for behaviors of grief (STERBs).

indicators of both relative and absolute indices that penalized a less parsimonious model in favor of a simpler, theoretical solution (Newsom, 2015). Indices based on non-centrality approached model fit using a chi-square equal to the degrees of freedom in the hypothesized model and assumed perfect fit (Newsom, 2015). Based on the work of Byrne (1994; 2001), Hooper, Coughlan, and Mullen (2008), Hu and Bentler (1998), Schumacker and Lomax (2004; 2010), Tabachnick and Fidell (2007), and Wheaton, Muthén, Alwin, and Summers (1977), items in the final model were significant for item-to-factor loadings of ≥0.54 specified at the $p<0.01$ level that resulted in a reasonable non-significant chi-square goodness of fit index (2.00–5.00) specified at the $p<0.05$ level; a normed fit index (≥0.90); a relative fit index (≥0.80); an incremental fit index (≥0.90); a Tucker-Lewis fit index (0.80≤2.00); a comparative fit index (≥0.95); and parsimony goodness of fit indices (≥0.10); as well as an adequate root mean square error of approximation (0–0.10) and its 90% confidence interval. Cronbach's alpha was assessed

at α>.70 to indicate a reliable measure (Cronbach, 1982). Along with the established criteria, model complexity and theoretical considerations were taken into account based on the suggestion of Marsh et al. (2004), who cautioned against strict cut-offs for fit indices.

Research Limitations

Because this study consisted of instrument development and validation based on construct validation of the treatment, the researcher acknowledged that individuals who received and completed the grief recovery program were likely different from individuals among the national sample of grievers who did not receive or complete the program.

Protection of Human Subjects

Eligible participants reviewed the purpose, risks and benefits of participation at the time of data collection through informed consent using a standardized research information sheet (Appendix: I; L). Potential risks included the possibility of becoming upset and emotional discomfort due to questions about one's personal experience with loss. Eligible participants were informed that the decision to participate or not to participate would not affect any benefits to which they were otherwise entitled. All participants were informed that by completing the valid measure, they voluntarily agreed to participate in the study, that the information about the research was satisfactorily explained to them, and that they could withdraw at any time. Each participant received or reviewed a standardized research sheet with contact information for the principal investigator, co-investigator, and Institutional Review Board, along with a copy of the consent form. No identifying information was collected.

Data Collection

Measure

The GRMI consisting of 24 main study variables (8-items for knowledge; 5-items for attitudes; 6-items for beliefs; and 5-items for behaviors of grief recovery as an outcome) along with 11 descriptive items for behaviors of grief (STERBs) along with an open-ended response form was used with the MDMQ-6 and the 7-item personal growth (PG) subscale of the GMRI (Appendix: M).

Demographic Variables

Demographic items were used to describe the sample (Appendix: M). Variables were defined as: year of participation in the grief recovery program; year that the loss occurred for which you participated in the grief recovery program; year of birth; certified program expert status; gender; and ethnic origin. This research did not control for any covariates as potential confounders of the data.

Procedures

After obtaining informed consent, data were collected with the GRMI during a single 10 to 15-minute session. Data were collected online and in-person via paper and pencil format from individuals who received and completed the 6, 8, 10, or 12-week community-based grief recovery program and met inclusion criteria.

Data Management, Verification and Protection

No identifying information was collected. Data collection was overseen by the researcher. Data were entered into IBM SPSS (version 23) for analyses and were subjected to appropriate cleansing, verification and consistency checks. Errors found were corrected. No sharing of data occurred. Completed hard-copies of the self-report instrument were stored in a

locked filing cabinet housed in the office of the researcher accessed by key-card entry (only). Data were encrypted and stored in a password protected, locked computer located in the office of the researcher accessed by key-card entry (only).

Data Analysis Plan

Data Cleansing

Based on the work of Tabachnick and Fidell (2007) data cleansing was conducted. Univariate descriptive statistics were assessed for accuracy by inspecting out-of-range values, univariate outliers, and likelihood of means and standard deviations. An examination of missing data was undertaken. Data missing were less than one percent.

Data Analysis

Descriptive statistics, including means, standard deviations, and frequencies depending on level of data, were calculated for demographic and main study variables. Preliminary analyses were undertaken to assess psychometric properties of all scales. Prior to conducting the factor analyses, data were assessed using Weston and Gore's (2006) criteria for univariate and multivariate normality, linearity and homoscedasticity. Data were screened for outliers and variables were evaluated for multicollinearity and singularity.

CHAPTER 4.

RESULTS

Introduction

The specific aims of this study were: 1) To use a construct validation of the treatment approach to develop an instrument based on The Grief Recovery Method® that measured participants' self-reported knowledge, attitudes, beliefs, behaviors of grief (STERBs), and behaviors of grief recovery as an outcome (KABB); 2) To field test the instrument (GRMI) using expert panel and peer-review to assess the instrument's content and face validity; 3) To conduct pilot and validity tests on the instrument in an independent sample of adult grievers who self-selected to receive the grief recovery program offered by a local office of a national hospice organization; and 4) To test for logical fit of the hypothesized factorial structure (KABB) to the data using confirmatory factor analysis in an independent sample of adult grievers who have completed the grief recovery program.

Field Testing with Expert Panel and Peer-Review

A total of 21 individuals participated in the field test comprised of expert panel and peer-review. Recommendations from the expert panel and peer-review included the rewording of several items on the instrument, condensing and clarifying instructions, restructuring existing items to improve readability, and reformatting the order of items to be more concise and user

friendly. Members from the expert panel and peer-review reported acceptable content and face validity.

Pilot and Validity Testing

Table 4-1 presented the findings from the validity assessment. Eleven individuals were selected from a group of adult grievers scheduled to receive the grief recovery program to

Table 4-1. *Validity Assessment*

Items	Content Validity Index (CVI)	CVI Inter-rater Agreement (Yes=1)	Clarity Index (CI)	CI Inter-rater Agreement (Yes=1)	Factorial Validity Index (FVI)
K1	1.00	1	1.00	1	1.00
K2	1.00	1	1.00	1	0.67
K3	1.00	1	1.00	1	0.67
K4	1.00	1	1.00	1	0.83
K5	1.00	1	1.00	1	0.67
K6	0.83	1	1.00	1	0.83
K7	1.00	1	1.00	1	0.83
K8	1.00	1	1.00	1	0.83
Average	0.97	1.00	1.00	1.00	0.79
A1	1.00	1	1.00	1	0.50
A2	0.83	1	1.00	1	0.33
A3	0.83	1	1.00	1	0.33
A4	1.00	1	1.00	1	0.67
A5	0.83	1	1.00	1	0.67
Average	0.90	1.00	1.00	1.00	0.50
Bel1	1.00	1	1.00	1	0.67
Bel2	1.00	1	1.00	1	0.83
Bel3	1.00	1	1.00	1	0.83
Bel4	0.83	1	1.00	1	0.67
Bel5	0.67	0	1.00	1	1.00
Bel6	0.83	1	1.00	1	0.83
Average	0.88	0.83	1.00	1.00	0.81
GRO1	1.00	1	1.00	1	1.00
GRO2	1.00	1	1.00	1	1.00
GRO3	1.00	1	0.83	1	1.00
GRO4	0.83	1	1.00	1	0.83
GRO5	1.00	1	1.00	1	0.83
Average	0.96	1.00	0.96	1.00	0.93
TOTAL	93.75	95.83	99.31	100	75.76

Participant ID	Time Index (TI) min.
P1	6
P2	6
P3	3
P4	4
P5	6
P6	7
P7	7
P8	8
P9	8
P10	7
P11	12
Average	6.72

participate in the pilot and validity tests. Upon receipt of the grief recovery program, all eleven individuals pilot tested the self-report instrument (GRMI), but only six of the individuals

completed the validity assessment. Each participant provided feedback on how much time it took to complete the instrument, as well as made suggestions for minor grammatical and visual changes to improve readability. Based on the feedback received, changes were made to the instrument. Participants who completed the pilot and validity tests reported acceptable content and face validity. Because the behaviors of grief scale (STERBs) was a descriptive list of potential coping behaviors, it was excluded from the validity assessment.

Time Index (TI). The time to complete the scale was acceptable at 6.73 (*SD*=2.22) minutes. That is to say, the length of time it took for participants (*n*=11) to complete the self-report instrument ranged from 3-12 minutes with an average time of approximately seven minutes.

Content Validity Index (CVI). Content validity for the scale of knowledge, attitudes, beliefs, and behaviors of grief recovery as an outcome was acceptable at 0.94. That is to say, there was consistent agreement among participants (*n*=6) that items of the scale adequately represented content appropriate to grief and grief recovery. Content validity for each of the four subscales was also acceptable at 0.98 (knowledge), 0.90 (attitudes), 0.89 (beliefs), and 0.97 (behaviors of grief recovery as an outcome). The CVI for each item was calculated by counting the number of participants who rated the items as three or four and dividing that number by the total number of participants. The result was the proportion of participants who deemed the items as content valid. The CVI for the scale was estimated by calculating the average CVI across all items. Similarly, the CVI for each of the subscales was estimated by separately calculating the average CVI across items for each of the four subscales. According to Davis (1992), Lynn (1986), and Rubio et al. (2003), content valid items should exhibit a CVI of 0.80 or greater.

Inter-rater Agreement for Content Validity Index (CVI-IRA). According to Rubio et al. (2003) two methods existed for calculating the inter-rater agreement (IRA) of scaled items. The conservative approach used items rated as perfect with a score of four across all participants. However, when the number of participants exceeded five, a less conservative approach was recommended that used items rated as reliable with a score of three or more. In order to determine the IRA, the number of reliable items was divided by the total number of scaled items (items of behavior were excluded). Using this method, the CVI-IRA for the scale was 0.96. That is to say, participants (n=6) consistently rated items as having content that was representative and appropriate to grief and grief recovery. Content validity IRA for each of the four subscales was also acceptable with perfect scores for all but one subscale, 0.83 (beliefs).

Clarity Index (CI). Using the same criteria for the CVI established by Davis (1992), Lynn (1986), and Rubio et al. (2003), the clarity of items should exhibit a CI of 0.80 or greater. The CI for the scale was acceptable at 0.99. That is to say, there was consistent agreement among participants (n=6) that items of the scale were easy to read and understand. The CI for each of the four subscales was also acceptable with perfect scores for all but one subscale, 0.97 (behaviors of grief recovery as an outcome). The CI for each item, the four subscales, and the full measure was calculated using the same method as was used to calculate the CVI. The result was the proportion of participants who deemed the items as clear, easy to read and understand.

Inter-rater Agreement for the Clarity Index (CI-IRA). IRA for the Clarity Index (CI) was also calculated using the same method as was used to calculate the CVI-IRA. The CI-IRA for the full measure was 100. That is to say, participants (n=6) consistently rated items as easy to read and understand. The CI-IRA for each of the subscales was also acceptable with perfect scores for all four subscales.

Factorial Validity Index (FVI). Because no established criteria existed to assess FVI, Rubio et al. (2003) suggested that, similar to the CVI, items should exhibit a FVI of 0.80 or greater. For the full measure, the average FVI score was 0.76, indicating that more than half of the participants (n=6) were able to correctly assign each of the 24-items to their respective factor. For the subscales, two of the four factors averaged FVI scores of 0.81 (beliefs), and 0.93 (behaviors of grief recovery as an outcome). Average FVI scores for the two additional factors were 0.79 (knowledge) and 0.50 (attitudes). The low FVI score for the attitudes subscale indicated that less than half of the participants were able to correctly assign the five items associated with this subscale to their respective factor, and that this subscale might need revised. However, it was noted that participants who evaluated this instrument were not certified in the grief recovery program, nor were they proficient in programmatic language and content.

Results of Main Study

Sample. Table 4-2 summarized sample characteristics. A national, non-randomized, convenience sample of 301 adult grievers were recruited into the study. However, only 279 individuals agreed to participate in the confirmatory factor analysis portion of the study representing a response rate of 93%. These adult grievers were surveyed between the months of March and August of 2017. No significant differences were found between men and women on age (t(275)=0.23; p=0.82), age at loss (t(275)=1.08; p=0.28), year of loss (t(276)=1.15; p=0.25), and years since loss (t(276)= -1.15; p=0.25), which represented the difference between the year of loss and the survey administration year of 2017. A significant difference was found between men (M=2011; SD=7.94) and women (M=2013; SD=5.35) for the first year of program participation (t(75.96)=2.16; p=0.03). Levene's test indicated unequal variances (F=11.72; p=<0.01). However, no significant difference (t(276)= -0.07; p=0.95) was found between men

and women on the number of years between when the loss occurred and participation in the grief recovery program. The sample was composed of mostly women (77.8%) with a sample mean age of 54.39 (*SD*=14.3). In the sample, the majority of participants identified as White/Caucasian (82.4%), followed by Black/African American (7.9%), Hispanic/Latino (3.2%),

Table 4-2. *Sample Characteristics**

		n	**%**	**Mean**	**SD**	**Min / Max**	***df***	***t***	***p***
Age in Years							275	0.23	0.82
	Female	216	77.8%	54.56	14.47	22-85			
	Male	61	21.9%	54.10	13.61	21-80			
	Sample	278	100%	54.39	14.29	21-85			
Age at Loss									
	Female	216	77.8%	42.00	19.36	0-85	275	1.08	0.28
	Male	61	21.9%	38.97	19.22	5-77			
	Sample	278	100%	41.28	19.32	0-85			
Year of Loss							276	1.15	0.25
	Female	217	77.8%	2004	15.52	1948-2017			
	Male	61	21.9%	2002	15.11	1960-2017			
	Sample	279	100%	2004	15.42	1948-2017			
Years Since Loss							276	-1.15	0.25
	Female	217	77.8%	12.56	15.52	0-69			
	Male	61	21.9%	15.13	15.11	0-57			
	Sample	279	100%	13.10	15.42	0-69			
Participation Year							75.96	2.16	0.03
	Female	217	77.8%	2013	5.35	1982-2017			
	Male	61	21.9%	2011	7.94	1983-2017			
	Sample	279	100%	2013	6.07	1982-2017			
Years Between Loss and Program Participation									
	Female	217	77.8%	8.69	14.46	0-69	276	-0.07	0.95
	Male	61	21.9%	8.82	10.97	0-46			
	Sample	279	100%	8.69	13.74	0-69			
Race/Ethnicity									
	White/Caucasian	230	82.4%						
	Black/African American	22	7.9%						
	Hispanic/Latino	9	3.2%						
	Asian	8	2.9%						
	Other race or ethnicity	7	2.5%						
	Am. Indian/Alaskan Native	2	0.7%						
	Mid. Eastern/North African	1	0.4%						
	Sample	279	100%						

*Significance determined at the $p<0.05$ level

Asian (2.9%), Other (2.5%), American Indian/Alaskan Native (0.7%), and Middle Eastern/North African (0.4%). Most participants (79.9%) in the sample reported that they were not program experts and that they first participated in the grief recovery program in the year 2013 (*SD*=6.07). The average loss in the sample occurred in 2004 (*SD*=15.42), which on average occurred 8.69 (*SD*=13.74) years prior to participation in the grief recovery program and 13.10 (*SD*=15.42) years prior to survey administration in 2017.

Mood. Table 4-3 summarized respondents' mood prior to completing the self-report instrument (GRMI). No significant difference ($t(275)=0.23$; $p=0.82$) was found between women and men on mood data. Total possible scores for the mood scale ranged from 0-36, with an average respondent score of 24.91 (*SD*=6.08) and higher scores that indicated an elevated mood. Based on the sample mean age of 54 years, scores on mood for respondents less than 54 years of age (*M*=24.28; *SD*=6.10) were compared to those aged 54 and older (*M*=25.37; *SD*=5.99). No significant difference ($t(276)= -1.49$; $p=0.14$) was found between the two groups. Using the sample mean of 13 years since the loss, scores on mood for respondents with less than 13 years since the loss (*M*=25.28; *SD*=6.08) were compared to those whose loss occurred 13 years ago and later (*M*=24.17; *SD*=6.03). No significant difference ($t(277)=1.45$; $p=0.15$) was found between the two groups. Cronbach's alpha for the mood scale was acceptable at $\alpha=0.74$.

Table 4-3. *Mood of the Sample**

	n	Mean	SD	Min / Max	*df*	*t*	*p*
Mood					276	0.98	0.33
Female	217	25.07	6.09	8-36			
Male	61	24.21	6.01	8-33			
Sample	279	24.91	6.08	8-36			

*Significance determined at the $p<0.05$ level

Confirmatory Factor Analysis

Hypothesized Model. The 24-item hypothesized model (see Fig. 3.1) was subjected to confirmatory factor analysis. An exploratory factor analysis was not performed since the four hypothesized factors of the program were based on empirical literature and the implicit theoretical structure of the grief recovery program. Using a construct validation of the treatment approach, both the empirical literature and implicit theoretical structure were used to develop the instrument. All items were modeled to load on their corresponding factor and all latent variables were allowed to correlate. In this model, all 24-items of grief and grief recovery were expected to load on their respective factor: 8-items for knowledge (K1-K8); 5-items for attitudes (A-A5); 6-items for beliefs (Bel1-Bel6); and 5-items for behaviors of grief recovery as an outcome (GRO1-GRO5). Because the behaviors of grief scale (Beh1-11) was a descriptive list of items used to provide averages of coping behaviors reported by the sample, it was excluded from the confirmatory analysis. Likewise, the previously validated and reliable measures of mood and personal growth were also excluded for the confirmatory factor analysis.

Final Model and Fit. Amos (Version 22.0) was used to conduct the confirmatory factor analysis. Prior to conducting the confirmatory factor analysis, data were screened for univariate normality and multivariate outliers. Because the behaviors of grief scale (Beh1-11) was a descriptive list of items used to provide averages of coping behaviors reported by the sample, it was excluded from the confirmatory analysis. None of the distributions for main study variables (*knowledge*: skewness=-1.05, kurtosis 1.85; *attitudes*: skewness=-0.98, kurtosis 2.64; *beliefs*: skewness=-0.90, kurtosis 0.34; and *behaviors of grief recovery as an outcome*: skewness=-1.31, kurtosis 2.27) departed from univariate normality based on the criteria of skewness ≥3.0 and kurtosis ≥10.0 established by Weston and Gore (2006). The sample size of 279 participants

satisfied Bentler's (1993) recommendation of a 10:1 respondent-to-item ratio, the 5:1 respondent-to-item ratio set forth by Gorsuch (1983) and Nunnally and Bernstein (1994), and Kline's (2005) suggestion of a sample size >200 in order to conduct for confirmatory factor analysis. The 19-item final model had 77 data points and 14 estimable parameters (four regression coefficients, six covariances, and four error variances). Based on the work of Byrne (2001), the model was over identified and ideal for analysis since the number of estimable parameters was less than the number of data points. A more stringent a priori criteria of ≥0.54 was set for item-to-factor loadings to reduce the likelihood of cross-loading. All items in the final model are presented in Fig. 4-1 with shaded areas that represented item-to-factor loadings ≥0.54

		Factor			
Item	Description	1	2	3	4
K2	Grief comes from a lifetime accumulation of things unsaid, undone, or unfinished	0.65	0.06	0.11	0.10
K3	Grief is caused by the end of or change in a familiar pattern of behavior	0.55	0.09	0.38	0.13
K5	Grief recovery is a series of small and correct action choices	0.74	0.17	0.06	0.14
K8	Grief is associated with conflicting feelings, such as good and bad memories	0.55	0.24	0.22	0.13
K6	It is not possible to heal from grief	0.22	0.63	-0.14	0.12
A2	The quickest way to recover from a loss is to keep busy	0.04	0.55	0.40	0.20
A3	When applicable, it is good idea to replace a loss. For example: after a pet dies, get a new one	0.08	0.55	0.40	0.06
A4	Overall, it is best to grieve alone	0.03	0.59	-0.01	0.08
A5	When someone is experiencing a loss, it is perfectly alright to tell the person "Don't feel bad."	0.20	0.58	0.09	-0.03
Bel1	After a loss, I need to be strong for others	0.01	0.64	0.28	0.22
Bel4	Loss is something to be afraid of	0.09	0.66	-0.01	0.02
Bel5	It is wrong to speak ill of the dead	0.06	0.54	0.24	0.10
K4	A common source of grief is the sense of incompleteness related to loss	0.45	0.09	0.58	0.16
A1	In general, it is appropriate to feel sad about a loss	0.16	-0.04	0.56	0.09
Bel2	Time heals all wounds	0.00	0.53	0.59	0.08
GRO2	I have taken action to complete things undone. (For example: forgiven or taken responsibility)	0.01	0.06	0.19	0.82
GRO3	I have recovered things unfinished. (For example: written a completion letter or postscript)	0.11	0.13	0.11	0.85
GRO4	I have let go of unmet hopes, dreams, or expectations	0.14	0.21	-0.07	0.82
GRO5	I have found new meaning for living to feel better	0.08	0.07	-0.05	0.84

Fig. 4-1. Final Model and Fit 19-items. Model excludes 11-items for behaviors of grief (STERBs).

Factor Structure. Using a construct validation treatment approach, a 4-factor model based on the implicit program theory was specified with items of grief and grief recovery constrained to load on their respective factors of knowledge, attitudes, beliefs, and behaviors of grief recovery as an outcome (KABB). Based on the a priori criteria of ≥0.54 for item-to-factor loadings, two items of knowledge (K1, K7), two items of beliefs (Bel3, Bel6), and one item of

behaviors of grief recovery as an outcome (GRO1) dropped out of the final model. Items K2, K3, K5, and K8 loaded as expected on Factor 1, signifying that Factor 1 measured knowledge. Items A2, A3, A4, and A5 loaded as expected on Factor 2, consistent with a measure of attitudes; however, items K6, Bel1, Bel4, and Bel5 also loaded on this factor. Item Bel2 loaded as expected on Factor 3 indicating a measure of beliefs; however, items K4 and A1 also loaded on this factor. Items GRO2, GRO3, GRO4, and GRO5 loaded as expected on Factor 4, representing that Factor 4 measured behaviors of grief recovery as an outcome.

The path analysis is presented in Fig. 4-2. The model was tested with 63 degrees of freedom, with the program variable of attitudes (32.84) that accounted for most of the variance in the model, followed by knowledge (16.82), behaviors of grief recovery as an outcome (16.53) and beliefs (13.22). The chi-square goodness of fit index (CMIN; 2.00-5.00; $p<0.05$) was used to determine the fit of the data to the hypothesized model. The CMIN=7.26 was significant ($p=0.03$) with two degrees of freedom (CMIN/df = 3.63), which suggested an area of misfit within the hypothesized model. The normed fit index (NFI; ≥0.90) was the proportion of improvement to the overall fit of the hypothesized model when compared to the data. The NFI=0.97 indicated an adequate fit of the data. The relative fit index (RFI; ≥0.80) compared the

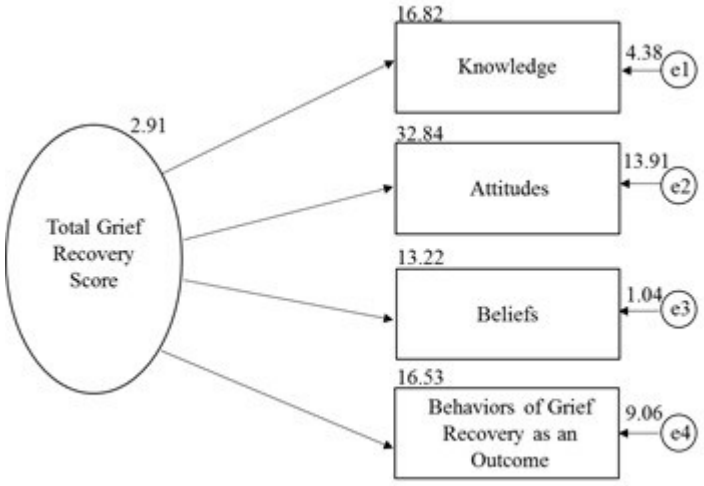

Fig. 4-2. Path Analysis

chi-square of the data to the hypothesized model. The RFI=0.83 indicated an adequate fit of the data. The incremental fit index (IFI; ≥0.90) was a measure that adjusted the NFI based on sample size and degrees of freedom. The IFI=0.97 indicated an adequate fit of the data. The Tucker-Lewis index (TLI; 0.80≤2.00) was used to evaluate discrepancy between the chi-square of the hypothesized model and that of the data. Although low, the TLI=0.87 indicated an adequate fit of the data. The comparative fit index (CFI; ≥0.95) was used to compare the fit of the data to the hypothesized model, which is assumed to be uncorrelated. The CFI=0.98 indicated an adequate fit of the data. The parsimony goodness of fit indices compromised of the PNFI (based on the NFI; ≥0.10) and the PCFI (based on the CFI≥0.10) assessed the least number of variables accounting for the variance between the data and the hypothesized model. The PNFI=0.19 and the PCFI=0.20 indicated an adequate fit of the data. The root mean square error of approximation (RMSEA: 0–0.10) assessed differences between corresponding elements of the data to the hypothesized model. The RMSEA=0.09 and its 90% confidence interval suggested an adequate fit of the data. Based on these overall findings, it was concluded that the model fit the data well and no alternate models were tested.

Reliability. In the final model, internal consistencies for the subscales of knowledge, attitudes, beliefs, behaviors of grief recovery as an outcome, personal growth, and mood are presented in Table 4-4. Because the behaviors of grief scale (STERBs) was an itemized list of potential coping behaviors to provide averages reported by the sample, it was excluded from the reliability analyses. Cronbach's alphas for the subscales of knowledge (α=0.72), attitudes (α=0.79), behaviors of grief recovery as an outcome (α=0.87), personal growth (α=0.91), and mood (α=0.74) were acceptable and exceeded the 0.70 criteria. The lowest Cronbach's alpha was for the subscale of beliefs (α=0.49). Internal consistency for the full measure, which included the

subscales of knowledge, attitudes, beliefs, and behaviors of grief recovery as an outcome, was acceptable with Cronbach's α=0.86.

Correlation Matrix. The correlation matrix is presented in Table 4-4. Specified at the $p<0.05$ level, age was significantly associated with program participation year and years between loss and program participation. At the $p<0.01$ level, age was significantly associated with years since loss, personal growth, and the knowledge, attitudes, beliefs, and behaviors of grief recovery as an outcome (KABB) subscales and their combined sum as the total grief recovery score. No association was found between age and mood. Years since loss was significantly correlated ($p<0.01$) with all variables except mood. Program participation year was significantly correlated ($p<0.01$) with the KABB subscales and their combined sum as the total grief recovery score. Years between loss and program participation was significantly correlated ($p<0.01$) with personal growth and the KABB subscales, along with the KABB subscales combined sum as the total grief recovery score. Mood was significantly correlated ($p<0.05$) with the subscale of knowledge and the combined sum of the KABB subscales as the total grief recovery score. Personal growth was significantly correlated ($p<0.01$) with the KABB subscales and their combined sum as the total grief recovery score. All KABB subscales were significantly correlated ($p<0.01$) with each other and their combined sum as the total grief recovery. Because the behaviors of grief scale (STERBs) was a descriptive list used to provide averages of coping behaviors (STERBs) reported by the sample, it was excluded from the correlation matrix.

Table 4-4. *Correlation Matrix for Subscales in the Final Model*

	Age	Years Since Loss (YSL)	Program Participation Year (PPY)	Years between Loss and Program Participation (YBLPP)	Total[+] Mood (TM)	Total[+] Personal Growth (TPG)	Total[+] Knowledge (TK)	Total[+] Attitudes (TA)	Total[+] Beliefs (TBel)	Total[+] Behaviors of GRO[ł] (TBeGR)	TOTAL Grief Recovery[†] (TGRec)
Age	-										
	n=278										
YSL	**0.16	-									
	<0.01										
	n=278	*n*=279									
PPY	*-0.13	**-0.45	-								
	0.04	<0.01									
	n=278	*n*=279	*n*=279								
YBLPP	*0.13	**0.92	-0.07	-							
	0.04	<0.01	0.27								
	n=278	*n*=279	*n*=279	*n*=279							
TM	0.03	-0.10	0.06	-0.09	*α*=0.74						
	0.60	0.08	0.30	0.15							
	n=278	*n*=279	*n*=279	*n*=279	*n*=279						
TPG	**0.37	**-0.28	0.09	**-0.27	0.05	*α*=0.91					
	<0.01	<0.01	0.11	<0.01	0.38						
	n=272	*n*=273	*n*=273	*n*=273	*n*=273	*n*=273					
TK	**0.44	**-0.41	**0.16	**-0.39	*0.14	**0.39	*α*=0.72				
	<0.01	<0.01	0.01	<0.01	0.02	<0.01					
	n=275	*n*=276	*n*=276	*n*=276	*n*=276	*n*=270	*n*=276				
TA	**0.50	**-0.54	**0.28	**-0.47	0.09	**0.22	**0.35	*α*=0.79			
	<0.01	<0.01	<0.01	<0.01	0.13	<0.01	<0.01				
	n=273	*n*=274	*n*=274	*n*=274	*n*=274	*n*=270	*n*=271	*n*=274			
TBel	**0.45	**-0.43	**0.24	**-0.37	0.06	**0.26	**0.52	**0.53	*α*=0.49		
	<0.01	<0.01	<0.01	<0.01	0.36	<0.01	<0.01	<0.01			
	n=274	*n*=275	*n*=275	*n*=275	*n*=275	*n*=269	*n*=272	*n*=270	*n*=275		
TBeGR	**0.45	**-0.34	0.08	**-0.35	0.09	**0.76	**0.31	**0.31	**0.27	*α*=0.87	
	<0.01	<0.01	0.16	<0.01	0.14	<0.01	<0.01	<0.01	<0.01		
	n=276	*n*=276	*n*=275	*n*=276	*n*=276	*n*=270	*n*=273	*n*=271	*n*=272	*n*=276	
TGRec	**0.64	**-0.64	**0.31	**-0.59	*0.15	**0.55	**0.68	**0.85	**0.71	**0.66	*α*=0.86
	<0.01	<0.01	<0.01	<0.01	0.02	<0.01	<0.01	<0.01	<0.01	<0.01	
	n=264	*n*=264	*n*=264	*n*=264	*n*=264	*n*=260	*n*=264	*n*=264	*n*=264	*n*=264	*n*=264

[+]Total is the sum of all final items in the subscale

łTotal behaviors of grief recovery as an outcome (GRO)

**Pearson correlation is significant at the $p<0.05$ level (2-tailed)

*Pearson correlation is significant at the $p<0.01$ level (2-tailed)

[†]The combined sum of the knowledge, attitudes, beliefs, and behaviors of grief recovery as an outcome (KABB) subscales and represents the total KABB scale

Program Variables of Grief and Grief Recovery.

Table 4-5 summarized results for the program and main study variables of grief and grief recovery in the final model.

Table 4-5. *Results for Program Variables of Grief and Grief Recovery in the Final Model**

		n	Mean	SD	Min / Max	*df*	*t*	*p*
Personal Growth						270	-0.02	0.98
	Female	212	28.10	5.58	7-35			
	Male	60	28.12	4.84	13-35			
	Sample	273	28.10	5.41	7-35			
Behaviors of Grief (STERBs)						172	-0.45	0.65
	Female	139	40.97	4.19	27-49			
	Male	35	41.31	3.10	35-48			
	Sample	174	41.04	3.99	27-49			
Knowledge								
	Female	215	16.90	2.75	4-20	273	0.63	0.53
	Male	60	16.65	2.54	9-20			
	Sample	276	16.83	2.71	4-20			
Attitudes								
	Female	213	33.18	4.32	21-40	271	1.93	0.06
	Male	60	31.82	6.32	8-40			
	Sample	274	32.88	4.84	8-40			
Beliefs						272	1.46	0.15
	Female	214	13.32	1.70	7-15			
	Male	60	12.95	1.80	9-15			
	Sample	275	13.23	1.73	7-15			
Behaviors of (GRO)ǂ						273	-0.75	0.45
	Female	214	16.48	3.41	4-20			
	Male	61	16.84	2.85	7-20			
	Sample	276	16.55	3.30	4-20			
TOTAL Grief Recovery†						261	1.41	0.16
	Female	205	80.23	9.05	55-95			
	Male	58	78.29	9.86	49-95			
	Sample	264	79.77	9.25	49-95			

ǂTotal Behaviors of grief recovery as an outcome (GRO)
†The combined sum of the knowledge, attitudes, beliefs, and behaviors of grief recovery as an outcome (KABB) subscales
*Significance determined at the $p<0.05$ level

Personal Growth after Loss. In the final model, no significant difference ($t(270)= -0.02$; $p=0.98$) was found between men and women on the outcome variable of personal growth after loss. Total possible scores for the outcome of personal growth ranged from 7-35, with an average respondent score of 28.10 ($SD=5.41$) and higher scores that indicated greater personal growth after loss. Based on the sample mean age of 54 years, scores on personal growth for respondents

less than 54 years of age (*M*=26.23; *SD*=5.30) were compared to those aged 54 and older (*M*=29.86; *SD*=4.63). A significant difference (*t*(250.48)= -5.97; *p*=<0.01) was found between the two groups, with individuals aged 54 and older who scored higher on personal growth. Using the sample mean of 13 years since the loss, scores on personal growth for respondents with less than 13 years since the loss (*M*=29.02; *SD*=5.44) were compared to those whose loss occurred 13 years ago and later (*M*=26.22; *SD*=4.85). A significant difference (*t*(196.66)= 4.31; *p*=<0.01) was found between the two groups, with individuals having less than 13 years since the loss who scored higher on personal growth. Cronbach's alpha for the personal growth scale was acceptable at α=0.91.

Behaviors of Grief (STERBs). In the final model, no significant difference (*t*(172)= -0.85; *p*=0.40) was found between men and women on the descriptive variable for behaviors of grief (STERBs). Based on the sample mean age of 54 years, scores on the behaviors of grief (STERBs) scale for respondents less than 54 years of age (*M*=40.81; *SD*=3.59) were compared to those aged 54 and older (*M*=41.18; *SD*=4.30). No significant difference (*t*(171)= -0.61; *p*=0.54) was found between the two groups. Using the sample mean of 13 years since the loss, scores on the behaviors of grief (STERBs) scale for respondents with less than 13 years since loss (*M*=40.85; *SD*=4.10) were compared to those whose loss occurred 13 years ago and later (*M*=41.38; *SD*=3.82). No significant difference (*t*(172)= -0.85; *p*=0.40) was found between the two groups. On this scale, respondents were asked to assess the frequency at which they engaged in the identified coping behavior(s) after their participation in the grief recovery program. Total possible scores for the behaviors of grief scale ranged from 27-49, with an average respondent score of 41.04 (*SD*=3.99) and higher scores that indicated less engagement in the identified coping behavior(s) after participation in the grief recovery program. In the sample,

the most frequently reported behaviors that respondents *engaged in less* after participation in the grief recovery program were nicotine use in the form of e-cigarettes, vapes, or chewing tobacco (*M*=4.32; *SD*=0.99), smoking (*M*=4.08; *SD*=1.20), misuse of prescriptions drugs (*M*=3.89 *SD*=1.55), illicit drug use (*M*=3.83 *SD*=1.35), overeating (*M*=3.76; *SD*=1.30), alcohol abuse (*M*=3.76; *SD*=1.17), and gambling (*M*=3.66; *SD*=1.33). In the sample, the most frequently reported behavior that respondents *engaged in more* after participation in the grief recovery program were exercise (*M*=3.62; *SD*=1.17), sleeping (*M*=3.50; *SD*=1.41), shopping (*M*=3.38; *SD*=1.42), and meditation or prayer (*M*=2.87; *SD*=1.36). The open response form indicated that additional behaviors grievers engaged in to cope with a loss included participation at Alcohol Anonymous® meetings, time spent with family and friends, escaping in books or television, sexual activity, use of social media and support groups, cleaning, working excessively, crying, cooking, daydreaming, gardening, hiking, keeping busy, online dating, playing games, and isolation. Because the behaviors of grief (STERBs) scale was a descriptive list of potential coping behaviors used to provide averages reported by the sample, no Cronbach's alpha was calculated.

Knowledge. In the final model, no significant difference ($t(273)=0.63$; $p=0.53$) was found between men and women on the main study variable of knowledge. Total possible scores for the knowledge scale ranged from 4-20, with an average respondent score of 16.83 (*SD*=2.71) and higher scores that indicated greater influence of the program on the variable of knowledge. Based on the sample mean age of 54 years, scores on knowledge for respondents less than 54 years of age (*M*=15.87; *SD*=2.57) were compared to those aged 54 and older (*M*=17.73; *SD*=2.30). A significant difference ($t(253.72= -6.30$; $p=<0.01$) was found between the two groups, with individuals aged 54 and older who scored higher on knowledge. Using the sample

mean of 13 years since the loss, scores on knowledge for respondents with less than 13 years since loss (M=17.54; SD=2.41) were compared to those whose loss occurred 13 years ago and later (M=15.40; SD=2.72). A significant difference (t(161.14)=6.37; p=<0.01) was found between the two groups, with individuals having less than 13 years since the loss who scored higher on knowledge. Cronbach's alpha for the knowledge scale was acceptable at α=0.72.

Attitudes. In the final model, no significant difference (t(271)=1.93; p=0.06) was found between men and women on the main study variable attitudes. Total possible scores for the attitudes scale ranged from 8-40, with an average respondent score of 32.88 (SD=4.84) and higher scores that indicated greater influence of the program on the variable of attitudes. Based on the sample mean age of 54 years, scores on attitudes for respondents less than 54 years of age (M=30.88; SD=4.17) were compared to those aged 54 and older (M=34.52; SD=4.74). A significant difference (t(270.55= -6.75; p=<0.01) was found between the two groups, with individuals aged 54 and older who scored higher on attitudes. Using the sample mean of 13 years since the loss, scores on attitudes for respondents with less than 13 years since when the loss occurred (M=34.56; SD=3.80) were compared to those whose loss occurred 13 years ago and later (M=29.39; SD=4.95). A significant difference (t(139.54)=8.69; p=<0.01) was found between the two groups, with individuals having less than 13 years since when the loss occurred who scored higher on attitudes. Cronbach's alpha for the attitudes scale was acceptable at α=0.79.

Beliefs. In the final model, no significant difference (t(272)=1.46; p=0.15) was found between men and women on the main study variable beliefs. Total possible scores for the beliefs scale ranged from 7-15, with an average respondent score of 13.23 (SD=1.73) and higher scores that indicated greater influence of the program on the variable of beliefs. Based on the sample

mean age of 54 years, scores on beliefs for respondents less than 54 years of age (M=12.63; SD=1.71) were compared to those aged 54 and older (M=13.80; SD=1.47). A significant difference (t(250.45= -6.01; p=<0.01) was found between the two groups, with individuals aged 54 and older who scored higher on beliefs. Using the sample mean of 13 years since the loss, scores on beliefs for respondents with less than 13 years since loss (M=13.65; SD=1.54) were compared to those whose loss occurred 13 years ago and later (M=12.37; SD=1.77). A significant difference (t(156.27)=5.90; p=<0.01) was found between the two groups, with individuals having less than 13 years since the loss who scored higher on beliefs. Cronbach's alpha for the beliefs scale was insufficient at α=0.49.

Behaviors of Grief Recovery as an Outcome. In the final model, no significant difference (t(273)= -0.75; p=0.45) was found between men and women on the outcome variable of behaviors of grief recovery. Total possible scores for the behavioral outcome of grief recovery ranged from 4-20, with an average respondent score of 16.55 (SD=3.30) and higher scores that indicated greater influence of the program on the variable of behaviors of grief recovery as an outcome. Based on the sample mean age of 54 years, scores on behaviors of grief recovery for respondents less than 54 years of age (M=15.15; SD=3.29) were compared to those aged 54 and older (M=17.74; SD=2.80). A significant difference (t(248.83= -6.98; p=<0.01) was found between the two groups, with individuals aged 54 and older who scored higher on behaviors of grief recovery. Using the sample mean of 13 years since the loss, scores on behaviors of grief recovery for respondents with less than 13 years since loss (M=17.24; SD=3.11) were compared to those whose loss occurred 13 years ago and later (M=15.16; SD=3.23). A significant difference (t(176.14)=5.10; p=<0.01) was found between the two groups, with individuals having

less than 13 years since the loss who scored higher on behaviors of grief recovery. Cronbach's alpha for the behaviors of grief recovery scale was acceptable at α=0.87.

Total Grief Recovery. As the combined sum of respondents' scores on the four subscales of knowledge, attitudes, beliefs, and behaviors of grief recovery as an outcome in the final model, no significant difference (t(261)=1.41; p=0.16) was found between men and women on the combined sum of the KABB subscales as the total grief recovery score. Total possible scores for the combined sum of the KABB subscales as total grief recovery ranged from 49-95, with an average respondent score of 79.77 (SD=9.25) and higher scores that indicated greater influence of the program on the variables of knowledge, attitudes, beliefs, and behaviors of grief recovery as an outcome. Based on the sample mean age of 54 years, scores on the combined sum of the KABB subscales as total grief recovery for respondents less than 54 years of age (M=74.71; SD=6.98) were compared to those aged 54 and older (M=84.06; SD=8.77). A significant difference (t(261.08= -9.64; p=<0.01) was found between the two groups, with individuals aged 54 and older who scored higher on the combined sum of the KABB subscales. Using the sample mean of 13 years since the loss, scores on the combined sum of the KABB subscales as total grief recovery for respondents with less than 13 years since loss (M=83.07; SD=7.40) were compared to those whose loss occurred 13 years ago and later (M=72.20; SD=8.64). A significant difference (t(131.69)=9.80; p=<0.01) was found between the two groups, with individuals having less than 13 years since the loss who scored higher on the combined sum of the KABB subscales. Cronbach's alpha for the combined sum of the KABB subscales as total grief recovery was acceptable at α=0.86.

Chapter Summary

Of the 279 individuals who agreed to participate in the main study, most were White/Caucasian (82.4%) women (77.8%) with a sample mean age of 54.9 (*SD*=14.3). Most participants (79.9%) in the sample reported that they were not grief recovery program experts and that they first participated in the grief recovery program in the year 2013. A significant difference ($t(75.96)=2.16$; $p=0.03$) was found on participation year with men (*M*=2011; *SD*=7.94) having first participated in the grief recovery program earlier than women (*M*=2013; *SD*=5.35). Levene's test indicated unequal variances ($F=11.72$; $p=<0.01$). However, no significant difference ($t(276)= -0.07$; $p=0.95$) was found between men and women on the number of years between when the loss occurred and participation in the grief recovery program. The average loss in the sample for which respondents first participated in the grief recovery program occurred in 2004, which was on average 8.69 (*SD*=13.74) years prior participation in the grief recovery program and 13.10 (*SD*=15.42) years prior to the survey administration in 2017. At the time prior to completing the instrument, the mood of the sample was elevated of 24.91 (*SD*=6.08) with no significant difference ($t(275)=0.23$; $p=0.82$) found between women and men, or those less than 54 years of age when compared to those aged 54 and older ($t(276)= -1.49$; $p=0.14$). Likewise, based on the mean number of years since the loss occurred, no significant difference $t(277)=1.45$; $p=0.15$) was found on mood for respondents with less than 13 years since the loss occurred when compared to those whose loss occurred 13 years ago and later. Cronbach's alpha for the mood scale was acceptable at $\alpha=0.74$.

A total of 21 individuals participated in the expert panel and peer-review, all reported acceptable content and face validity of the self-report instrument (GRMI). Of the eleven individuals who pilot tested the GRMI, each individual took an average of 6.73 (*SD*=2.22)

minutes to complete the instrument. Of the six individuals who completed the validity assessment of the GRMI, all validity indices for content (CVI=0.94) and clarity (CI=0.99) were acceptable. Factorial validity indices for the subscales of beliefs (FVI=0.81) and behaviors of grief recovery as an outcome (FVI=0.93) were acceptable. However, factorial validity indices for the subscales of knowledge (FVI=0.79) and attitudes (FVI=0.50) were less than ideal, suggesting that these subscales might need further refinement.

Using a construct validation of the treatment approach, results of the confirmatory factor analysis revealed a 4-factor solution with a normed fit index (NFI=0.97), relative fit index (RFI=0.83), incremental fit index (IFI=0.97), Tucker-Lewis index (TLI =0.87), comparative fit index (CFI=0.98), root mean square error of approximation and its 90% confidence interval (RMSEA=0.09), as well as parsimony goodness of fit indices (PNFI=0.19; PCFI=0.20) that all indicated an adequate fit of the data. However, the chi-square goodness of fit index (CMIN=7.26; p=0.03) was large and significant, which suggested a potential area of misfit within the hypothesized model. Results of the path analysis showed that the main study variable of attitudes (32.84) accounted for most of the variance in the model, followed by knowledge (16.82), behaviors of grief recovery as an outcome (16.53) and beliefs (13.22). Items of main study variables in the final model were significant for item-to-factor loadings ≥0.54 specified at the p<0.01 level. Two items of knowledge (K1, K7), two items of beliefs (Bel3, Bel6), and one item of behaviors of grief recovery as an outcome (GRO1) dropped out of the final model based on the stringent criteria (≥0.54) set for item-to factor loadings. Items K2, K3, K5, and K8 loaded as expected on Factor 1 representative of the knowledge subscale. Items A2, A3, A4, and A5 loaded as expected on Factor 2 characteristic of an attitudes measure; however, items K6, Bel1, Bel4, and Bel5 also loaded on this factor. Item Bel2 loaded as expected on Factor 3 indicative of

a beliefs measure; however, items K4 and A1 also loaded on this factor. Items GRO2, GRO3, GRO4, and GRO5 loaded as expected on Factor 4 consistent with a measure of behaviors of grief recovery as an outcome. Reliability analyses on the final model revealed internal consistency for the full measure (α=0.86), which consisted of the four subscales of knowledge (α=0.72), attitudes (α=0.79), beliefs (α=0.49), and behaviors of grief recovery as an outcome (α=0.87). However, concern was raised over the low reliability of the beliefs subscale.

Bivariate correlations for the final model revealed statistically significant (p<0.01), positive, weak to moderate correlations between age and years since loss (0.16), personal growth (0.37), and the subscales of knowledge (0.44), attitudes (0.50), beliefs (0.45), behaviors of grief recovery as an outcome (0.45), and the combined sum of the four subscales (KABB) for the total grief recovery score (0.64). A significant (p<0.05), weak, negative correlation was found between age and program participation year (-0.13), as well as a weak, positive correlation found between age and years between loss and program participation (0.13). Negative, weak to moderate correlations were found between years since loss and the subscales of knowledge (-0.41), attitudes (-0.54), beliefs (-0.43), behaviors of grief recovery as an outcome (-0.34), and the combined sum of the four subscales (KABB) for the total grief recovery score (-0.64), as well as personal growth (-0.28). A significant (p<0.01), positive, strong correlation (0.92) was found between years since loss and years between loss and participation in the grief recovery program. Statistically significant (p<0.01), positive, weak correlations (0.16 to 0.31) were found between program participation year and the four KABB subscales, as well as their combined sum for the total grief recovery score. Years between loss and participation in the grief recovery program was significant (p<0.01), negative, and weak to moderately correlated with personal growth (-0.27), the four KABB subscales (-0.35 to -0.47) and their combined sum as the total grief

recovery score (-0.59). Mood was statistically significant (p<0.05), positive, but weakly correlated with knowledge (0.14) and the combined KABB subscale score of total grief recovery (0.15). Weak to strong, significant (p<0.01), positive correlations were found between the four KABB subscales (0.22 to 0.76), their combined sum as the total grief recovery score (0.55), and personal growth. The four KABB subscales were all significant (p<0.01), weak to strongly correlated (0.27 to 0.85) with each other.

In the final model, no significant difference (t(270)= -0.02; p=0.98) was found between men and women on the outcome variable of personal growth after loss, with an average respondent score of 28.10 (SD=5.41) and higher scores that indicated greater personal growth. However, a significant difference (t(250.48)= -5.97; p=<0.01) was found between individuals less than 54 years of age (M=26.23; SD=5.30) when compared to those aged 54 and older (M=29.86; SD=4.63), with individuals aged 54 and older who scored higher on personal growth. Likewise, a significant difference (t(196.66)= 4.31; p=<0.01) was found between respondents with less than 13 years since when the loss occurred (M=29.02; SD=5.44) when compared to those whose loss occurred 13 years ago and later (M=26.22; SD=4.85); with individuals with less than 13 years since when the loss occurred who scored higher on personal growth.

In the final model, no significant difference (t(172)= -0.85; p=0.40) was found between men and women, nor individuals less than 54 years of age when compared to those aged 54 and older (t(171)= -0.61; p=0.54), nor those with less than 13 years since loss when compared to those whose loss occurred 13 years ago and later (t(172)= -0.85; p=0.40) on the descriptive variable of behaviors of grief (STERBs). The average respondent score was 41.04 (SD=3.99), with higher scores that indicated less engagement in the identified coping behavior(s) after participation in the grief recovery program. Because the descriptive variable of behaviors of grief

(STERBs) was an itemized list of potential coping behaviors that was used to provide averages reported by the sample, the most frequently reported behaviors that respondents *engaged in less* after participation in the grief recovery program were nicotine use in the form of e-cigarettes, vapes, or chewing tobacco, smoking, misuse of prescriptions drugs, illicit drug use, overeating, alcohol abuse, and gambling. In the sample, the most frequently reported behavior that respondents *engaged in more* after participation in the grief recovery program were exercise, sleeping, shopping, meditation, and prayer. The open response form indicated that additional behaviors grievers engaged in to cope with a loss included participation at Alcohol Anonymous® meetings, time spent with family and friends, escaping in books or television, sexual activity, use of social media and support groups, cleaning, working excessively, crying, cooking, daydreaming, gardening, hiking, keeping busy, online dating, playing games, and isolation.

In the final model, no significant difference ($t(273)=0.63$; $p=0.53$) was found between men and women on knowledge, with an average respondent score of 16.83 ($SD=2.71$) and higher scores that indicated greater knowledge. However, a significant difference ($t(253.72= -6.30$; $p=<0.01$) was found between individuals less than 54 years of age ($M=15.87$; $SD=2.57$) when compared to those aged 54 and older ($M=17.73$; $SD=2.30$), with individuals aged 54 and older who scored higher on knowledge. Likewise, a significant difference ($t(161.14)=6.37$; $p=<0.01$) was found between respondents with less than 13 years since loss occurred ($M=17.54$; $SD=2.41$) when compared to those whose loss occurred 13 years ago and later ($M=15.40$; $SD=2.72$); with individuals with less than 13 years since when the loss occurred who scored higher on knowledge.

No significant difference ($t(271)=1.93$; $p=0.06$) was found between men and women on attitudes, with an average respondent score of 32.88 ($SD=4.84$) and higher scores that indicated

better attitudes. However, a significant difference (t(270.55= -6.75; p=<0.01) was found between individuals less than 54 years of age (M=30.88; SD=4.17) when compared to those aged 54 and older (M=34.52; SD=4.74), with individuals aged 54 and older who scored higher on attitudes. Likewise, a significant difference (t(139.54)=8.69; p=<0.01) was found between individuals with less than 13 years since the loss occurred (M=34.56; SD=3.80) when compared to those whose loss occurred 13 years ago and later (M=29.39; SD=4.95); with individuals having less than 13 years since when the loss occurred who scored higher on attitudes

In the final model, no significant difference (t(272)=1.46; p=0.15) was found between men and women on beliefs, with an average respondent score of 13.23 (SD=1.73) and higher scores that indicated improved beliefs. However, a significant difference (t(250.45= -6.01; p=<0.01) was found between individuals less than 54 years of age (M=12.63; SD=1.71) when compared to those aged 54 and older (M=13.80; SD=1.47), with individuals aged 54 and older who scored higher on beliefs. Likewise, a significant difference (t(156.27)=5.90; p=<0.01) was found between individuals with less than 13 years since loss (M=13.65; SD=1.54) when compared to those whose loss occurred 13 years ago and later (M=12.37; SD=1.77); with individuals having less than 13 years since when the loss occurred who scored higher on beliefs.

In the final model, no significant difference (t(273)= -0.75; p=0.45) was found between men and women on the outcome variable of behaviors of grief recovery, with an average respondent score of 16.55 (SD=3.30) and higher scores that indicated greater behaviors of grief recovery. However, a significant difference (t(248.83= -6.98; p=<0.01) was found between individuals with less than 54 years of age (M=15.15; SD=3.29) when compared to those aged 54 and older (M=17.74; SD=2.80); SD=1.47), with individuals aged 54 and older who scored higher on behaviors of grief recovery. Likewise, a significant difference (t(176.14)=5.10; p=<0.01) was

found between individuals with less than 13 years since when the loss occurred (*M*=17.24; *SD*=3.11) when compared to those whose loss occurred 13 years ago and later (*M*=15.16; *SD*=3.23); with individuals having less than 13 years since when the loss occurred who scored higher on behaviors of grief recovery.

As a combined score of the four subscales of knowledge, attitudes, beliefs, and behaviors of grief recovery as an outcome (KABB) in the final model, no significant difference ($t(261)=1.41$; $p=0.16$) was found between men and women on the total grief recovery score, with an average respondent score of 79.77 (*SD*=9.25) and higher scores that indicated greater influence of the program on the four KABB subscales of grief and grief recovery. However, a significant difference ($t(261.08= -9.64$; $p=<0.01$) was found between individuals with less than 54 years of age (*M*=74.71; *SD*=6.98) when compared to those aged 54 and older (*M*=84.06; *SD*=8.77), with individuals aged 54 and older who scored higher on the combined sum of the four KABB subscales. Likewise, a significant difference ($t(131.69)=9.80$; $p=<0.01$) was found between individuals with less than 13 years since when the loss occurred (*M*=83.07; *SD*=7.40) when compared to those whose loss occurred 13 years ago and later (*M*=72.20; *SD*=8.64); with individuals having less than 13 years since when the loss occurred who scored higher on the combined sum of the KABB subscales.

CHAPTER 5.

DISCUSSION

Introduction

The aims of the current study were: 1) To use a construct validation of the treatment approach to develop an instrument based on the grief recovery program that measured participants' self-reported knowledge, attitudes, beliefs, behaviors of grief (STERBs), and behaviors of grief recovery as an outcome (KABB); 2) To field test the instrument (GRMI) using expert panel and peer-review to assess the instrument's content and face validity; 3) To conduct pilot and validity tests on the instrument in an independent sample of adult grievers who self-selected to receive the grief recovery program offered by a local office of a national hospice organization; and 4) To test for the logical fit of the hypothesized factorial structure (KABB) to the data using confirmatory factor analysis in an independent sample of adult grievers who have completed the grief recovery program. The final development stage of The Grief Recovery Method® Instrument (GRMI) resulted in the retention of 19-items specific to grief and grief recovery (8-items attitudes; 4-items knowledge; 3-items beliefs; and 4-items for behaviors of grief recovery as an outcome), along with 6-items of mood, and 4-demographic items.

Discussion of Study Findings

Many grief-related social science and behavioral interventions have used implicit theoretical variables in the design of their programs. Yet, these interventions have not assessed the expected degree of change in variables based on the program's implicit theoretical structure. The present study addressed the need for valid and reliable instrumentation in the evaluation of implicit programmatic theory and its associated variables, as well as the need to develop an empirical measure (GRMI) based on construct validation of the treatment to evaluate the theoretical structure of the practice-based, evidence informed, grief recovery program known as The Grief Recovery Method®. Although previously developed empirical instrumentation existed within the literature that measured grief and its associated outcomes, these scales were primarily based on MMT, CBT, and GCT theory and better served as proxy measures that were not specific to the grief recovery program. Likewise, because the development of these instruments was not based on the implicit theoretical structure of the grief recovery program, and that the program most closely aligned with elements of PE, it was felt that existing measures based on MMT, CBT, and GCT would not accurately assess the construct validity unique to the intervention.

Historically, establishing construct validity for instrumentation based on implicit theoretical structures of programs has used exploratory factor analysis to verify that a measure produced empirical evidence of programmatic constructs (Hallam & Petosa, 2004). In contrast, a construct validity of the treatment approach used impact evaluation methods to link intervention components with targeted theoretical outcomes. This linkage occurred through the use of programmatic components designed to influence theoretical constructs and the assessment of the corresponding effects that exposure to the program had on the targeted theoretical constructs

(Hallam & Petosa, 2004). According to Hallam and Petosa (2004), a construct validation of the treatment approach enabled researchers to carefully test implicit theoretical assumptions of an educational experience (i.e. exposure to the grief recovery program) to produce changes in programmatic constructs and the importance of these constructs in supporting behavioral change. The result of this approach allowed researchers and program evaluators to make more precise determinations in the ability of a program to produce desired change in implicit theoretical constructs and behavioral outcomes.

Although few in number, previous researchers who have used a construct validation of the treatment approach have reported that the method substantively contributed to the empirical base of social science and behavioral research in that direct tests of how a theory promoted change has led to an estimated magnitude of intervention resources needed to produce desired behavioral change (Hallam & Petosa, 2004; McCaul & Glasgow, 1985; and Newman, 1981). Likewise, using a construct validation of the treatment approach has allowed researchers to impact program curriculum and efficiency through the identification, refinement, modification, or removal of ineffective program components and practices (Hallam & Petosa, 2004; McCaul & Glasgow, 1985; and Newman, 1981). On the other hand, these same researchers cautioned on the failure to assess the level of change programmatic exposure had on theoretical constructs could yield several methodological problems. For example, in the current grief-related context, researchers and program evaluators who did not employ a construct validation of the treatment approach might not be able to determine whether the intervention was of sufficient intensity to enhance the implicit theoretical constructs of the program. Likewise, in the event exposure to the program did produce desired change in theoretical constructs, researchers might not be able to discern if changes were sufficient enough to reduce the level of grief in those who have

experienced a death-associated loss. All in all, without the benefit of a construct validation of the treatment approach, it would not be possible to conclude whether the implicit theoretical structure of the grief recovery program, including variables of knowledge, attitudes, beliefs, and behaviors of grief recovery as an outcome, was causally linked to overall changes in grief and the promotion of grief recovery. Therefore, these findings are what guided the development and rationale behind the creation of the GRMI measure.

Within the developed and finalized GRMI measure, all items of personal growth loaded as expected on their respective factor. Because the personal growth subscale was used to establish discriminant validity, items from the scale could be removed with future use of the final measure. Similarly, having achieved its sole purpose to provide averages of coping behaviors reported by the sample, the descriptive behaviors of grief (STERBs) scale could be removed. Because future use of the GRMI measure in theoretic validation of the program would require that griever's had no previous exposure to the intervention, one demographic item that pertained to the receipt of program certification training was removed from the instrument. Another demographic item that applied to a griever's year of birth was collapsed into a unique identifier that, in future theoretic and evaluative use of the GMRI measure, respondents would be asked to create in order to match responses from pre to posttest. Excluding the descriptive list of behaviors of grief (STERBs), the completed measure modified from the original 24-items (8-items for knowledge; 5-items for attitudes; 6-items for beliefs; and 5-items for behaviors of grief recovery as an outcome) represented a parsimonious pool of 19-items that adequately represented each of the four factors of the grief recovery program. The final GRMI measure was user friendly, content and face valid, overall reliable and required a minimal amount of time and instruction to administer.

In the sample, a significant difference was found on the program participation year between men and women, with men having reported earlier participation in the grief recovery program. These findings have previously been supported by Doka and Martin (2010) who showed that in the comparison of grief based on sex, men grieved more instrumentally, approaching loss through direct problem-based solution finding and rationalization, which influenced the timely establishment of help-seeking behaviors such as the participation in a grief recovery program. Women, on the other hand, grieved more intuitively and for longer periods of time, focusing on feelings and the expression of grief; thereby abating or prolonging the need for immediate assistance with grief. No other significant differences were found with regard to sample characteristics and mood.

Overall, the confirmatory factor analysis showed an adequate fit of the data to the hypothesized factorial structure of the program. The chi-square goodness of fit was large and significant; however, Bielby and Hauser (1977) identified that the power or ability of the chi-square static to reject the null hypothesis (Type II error) with implicit theoretic evaluation was unknown, or limited at best. Along these lines, Bentler (1995), Hu and Bentler (1999), McDonald and Ho (2002), as well as Satorra and Bentler (1994) have shown that larger sample sizes (n>200) often produced statistically significant larger chi-squares, even when other indices suggested decent fitting models. For example, these researchers established that model size and complexity had an increased effect on the chi-square value, and that models with many parameters tended to have larger chi-squares even when the models were accurate. Moreover, McIntosh (2006) showed that because the chi-square goodness of fit assumed multivariate normality, any deviation from normality within the distribution would likely result in model rejection despite proper specification. Notwithstanding, it could also be concluded that these

results occurred by chance or by error, and that a better fit of the model to the data could be obtained with further revision and testing of an alternate model.

Reliability analyses on the final GRMI measure revealed that the full measure and the subscales of knowledge, attitudes, and behaviors of grief recovery as an outcome were internally consistent. However, the low reliability of the beliefs subscale was believed to be the result of chance or an issue with syntax. Of the 3-items that represented the beliefs scale, all moderately (0.56 to 0.59) loaded on the single factor (Factor 3). Bivariate correlations on these three items revealed that they were all significant (p<0.01), positive, and weakly correlated (0.17 to 0.32) to each other. The mean scores on these items were relatively high ranging from 4.21 to 4.66, but the variance on item Bel2 (i.e. Time heals all wounds) was greater (SD=0.98; s^2=0.97) in comparison to K4 (i.e. A common source of grief is the sense of incompleteness related to loss) with variance that was (SD=0.81; s^2=0.66), and A1 (i.e. In general, it is appropriate to feel sad about a loss) with variance that was (SD=0.61; s^2=0.37). Because participants' scores were distributed across the scale without the corresponding response one would expect for each item, discord occurred between expected versus observed responses and led to insufficient internal consistency of the scale.

Bivariate correlations for the final model revealed that the older a respondent was, the more recent he or she participated in the grief recovery program. Similarly, the older a respondent was, the greater his or her scores were on the on the KABB subscales, the combined sum of the KABB subscales as the total grief recovery score, and personal growth. For the variable of years since loss, the greater the number of years since the loss occurred, the lower the scores were on the KABB subscales, the combined sum of the KABB subscales as the total grief recovery score, and personal growth. A similar finding was found with regard to years between

loss and program participation with the greater time that passed between the loss and program participation, the lower the scores were on the KABB subscales, the combined sum of the KABB subscales as the total grief recovery score, and personal growth. Because personal growth was the most strongly correlated with behaviors of grief recovery as an outcome, the findings suggested that greater engagement in behaviors of grief recovery might ultimately lead to greater attainment of personal growth with time.

Using a construct validation of the treatment approach, review of the grief-related literature and content specific to the grief recovery program identified four general domains of intervention impact that were used to develop the implicit theoretical structure of the program (KABB). However, in the operationalization of grief recovery program variables, there might have been some overlap or leeway that influenced the interpretation of affective and instrumental beliefs items. For example, of the original 5-items believed to represent attitudes, only four loaded as expected on their respective factor, and one item (i.e. In general, it is appropriate to feel sad about a loss) loaded on the beliefs scale. Borrowing from Fishbein and Ajzen (1975), the researcher defined attitudes as the implicit, often subjective, evaluative or affective response concerning grief, death, and dying. By contrast, beliefs provided the basis for the formation of attitudes and were directly tied to the stimulus of the death or loss of a loved one. Stated this way, beliefs were formed as soon as the exposure to the stimulus occurred and reflected the ideas or thoughts on grief, death, and dying that a griever judged or accepted to be true. Upon further examination of the hypothesized attitudinal item that failed to load as expected, it was determined that most grievers accepted or perceived death as a sorrowful, mournful event associated with direct feelings of sadness. Because this affective judgment served as an accepted belief, it more appropriately loaded on the confirmed scale of beliefs.

From the original 6-items believed to represent beliefs, one item loaded as expected on its respective factor, three items (i.e. After a loss, I need to be strong for others; Loss is something to be afraid of; It is wrong to speak ill of the dead) loaded on the attitudes scale, and two items failed to load and were dropped from the scale. Further examination on the items that failed to load as expected revealed that respondents evaluated their loss experiences based on their affective responses to death. For example, an individual who has experienced a significant loss might encounter intrapsychic feelings of grief that lead to physiological changes such as weight loss, or insomnia. These changes, in turn, would motivate or precipitate an action or behavioral response such as fear (loss is something to be afraid of), resilience (I must be strong), or anger (speaking ill of the dead). Therefore, conceptually and theoretically, these items may have been intended to reflect beliefs. Yet, the actual operationalization of said items overlooked the affective impact on attitudinal aspects of grieving; and thus, more appropriately reflected attitudes.

Of the two items (i.e. Loss is a natural part of life. I am the cause of incompleteness related to loss) that failed to load and were dropped from the beliefs scale, it was anticipated that exposure to the program would result in the acceptance of new knowledge, which in turn, would evolve into the adoption of a new belief system. However, Roehler, Duffy, Herrmann, Conley, and Johnson (1988) identified that beliefs often fostered schools of thought bounded by non-neutral emotional auras and imagery from past loss experiences. These elements influenced the translation and adoption of new beliefs, as well as created intuitive lenses through which grievers' filtered new knowledge. Because belief systems were by their very nature less disputable, more inflexible, and less dynamic than knowledge, these researchers argued that beliefs represented eternal truths that remained static, and for the most part, unchanged with new

information. Perceived this way, loss was not believed to be a natural part of life; rather, death was. Moreover, the death itself was responsible for the incompleteness related to loss, and not the griever.

Aside from the interplay between attitudes and beliefs on items of grief and grief recovery, semantics may have played a role in the misconception of the full knowledge scale. Of the original 8-items believed to represent knowledge, only four loaded as expected on their respective factor, two failed to load and were dropped from the scale, and two items (i.e. A common source of grief is the sense of incompleteness related to loss; It is not possible to heal from grief) independently loaded on the separate scales of attitudes and beliefs. In the examination of the knowledge scale, the majority of items believed to represent this program variable were direct and intuitive. For example, of those that loaded as expected, the phraseology was, "grief is…," or "grief recovery is...," which left little room for interpretation. However, the hypothesized knowledge item that loaded on the attitudinal scale (i.e. It is not possible to heal from grief) was acknowledged as more inferential, and better reflected the affective power or capacity a griever perceived him or herself as having to heal from the loss. By contrast, the hypothesized knowledge item that loaded on the beliefs scale (i.e. A common source of grief is the sense of incompleteness related to loss) more accurately reflected the true nature of grief that a griever came to accept as a result of exposure to the program. Better stated, the program used knowledge to instill new beliefs on grief and grief recovery. Though this item was characteristic of knowledge taught to grievers who received the program, the intervention, itself, required that a griever accepted this sense of incompleteness as true before he or she could move beyond the loss towards grief recovery. For as James and Friedman (2009) have stated, failure to accept this reality would result in continued incompleteness related to loss and future unresolved grief.

Additionally, a griever must recognize that he or she was at least, in part, responsible for the incompleteness in order to take ownership of behaviors, thoughts, and actions associated with the grief recovery process.

Of the two items (i.e. Grief is not a normal reaction to a loss; Grief recovery means feeling better) that failed to load and were dropped from the knowledge scale, further examination suggested that distinctions existed between the meaning and symbolism of grief and grief recovery. As an example, Eraut (1985) wrote that both creation and recreation of knowledge relied upon personal experiences and photographic images stored within long term memory. Given this fact, individuals who have experienced a significant loss, such as a death, might not identify that severe or prolonged physical and emotional distress were abnormal reactions to loss. For example, Worden (1991) found that death commonly produced disorientation and confusion among grievers. More concerning, however, death was also shown to generate symptomology characteristic of posttraumatic stress such as intrusive thoughts, intense or irrational fear, disturbing flashbacks, severe anxiety, insomnia, nightmares, and emotional detachment. Because grievers may have perceived these signs of distress as typical or systemic among grievers who have experienced a significant loss, they may not have identified these grief-based reactions as atypical. Moreover, because these prolonged or extreme grief-based reactions were perceived as a matter of course, the normal and natural process of healing or recovery may not have provided any source of respite from such infirmity. In fact, the only way these symptoms may have been inhibited was through therapeutic or pharmacologic intervention.

With the understanding that some courses of bereavement might require intermediation from the medical and psychiatric community of professions, grievers, nevertheless, were still

accountable for their unique grief recovery process. Of the 5-items related to behaviors of grief recovery as an outcome, four loaded as expected on their respective factor and one item (i.e. I have communicated things unsaid. For example: an apology or significant emotional statement) failed to load and was dropped from the scale. Further examination of this item suggested that because grief recovery was an enduring process, and that the death of a loved might be perceived as something from which an individual could never fully recover, a griever felt that he or she was incapable of adequately expressing in words the impact of such loss, or say all that needed to be said to the deceased. Hall (2011) inferred this finding through research that showed deceased loved ones served as role models to whom the bereaved turned to for ongoing guidance. Hall, amid other researchers (Dartnell, Tahmaseb-McConatha, Kumar, & Treadwell, 2017; Raphael & Nunn, 1988; Stroebe, Gergen, Gergen, and Stroebe (n.d.); Valiant, 1986), have also contended the need among grievers to continue to talk about the deceased, visit the grave, or participate in rituals of remembrance throughout the course of one's life. Therefore, communicating things unsaid was not a singular event, but an ongoing dialogue.

Strengths and Limitations

Although several methodological strengths existed in the present study such as a construct validation of the treatment approach, field testing with expert panel and peer-review, pilot and validity testing, response rate, and sample size, there were some significant limitations that must be taken into consideration. Individuals who received and completed the grief recovery program were likely different from individuals among the national sample of grievers who did not receive or complete program. This inherent limitation did not allow for the generalization of study results to all adult grievers who have completed the grief recovery program. Therefore, the

findings from this research should be interpreted within the limits of the study's boundaries of generalizability.

Participants in the sample were predominantly White/Caucasian middle-aged females who voluntarily agreed and consented to take part in this study, which signified some degree of self-selection bias. Because participants answered all 24-items of the hypothesized model, it was unknown whether responses would be different in the final 19-item model presented. Items that were dropped from the final model might have been retained if additional rewording or restructuring had been performed. Completion of the instrument was not likely influenced by participants' mood. However, results on the differences in mean scores on variables of grief and grief recovery demonstrated that age and years since loss played a significant role in how respondents scored on KABB subscales and personal growth. These factors could serve as potential confounders in future research and should be addressed.

Future Directions and Conclusions

These results added to the growing body of literature that suggests participation in a grief-related program could be a necessary and effective component of the healing process after significant loss or the death of a loved one (Greenberg, Warwar, & Malcolm, 2008). Because respondents of this GRMI measure scored high with regard to the maximum possible scores for each variable, results of this study implied that participation in The Grief Recovery Method® might be an effective program to promote grief recovery. Results from the path analysis in the final model showed that grievers' attitudes (32.84) accounted for most of the variance, followed by knowledge (16.82), behaviors of grief recovery as an outcome (16.53) and beliefs (13.22). These findings suggested that the grief recovery program might focus on grievers' attitudes in order to have the greatest impact on grief recovery, and that the least amount of change would

likely occur in griever's beliefs. Two potential areas of improvement might exist in the main tenets of the program that emphasized, 'Loss is a natural part of life' and 'I am the cause of incompleteness related to loss.' Grievers in the present study who completed the instrument demonstrated an enduring perception that death was a natural part of life, but that loss was not. Moreover, responses indicated that grievers did not perceive themselves as culpable for any incompleteness related to loss, suggesting that death alone was responsible. Though this conveyed knowledge and element of responsibility were both characteristic of program curriculum delivered to grievers, individuals who completed the instrument did not demonstrate acceptance of these principles through their responses. For The Grief Recovery Institute™ staff, certified program trainers and facilitators, these findings might warrant future consideration on stressing the importance that a griever was at least, in part, responsible for any incompleteness related to loss and that loss, itself, was in fact a natural part of life.

With established valid and reliable instrumentation based on construct validation of the treatment, future research is warranted to validate the implicit theoretical structure of the grief recovery program. This research should utilize a pretest-posttest design in order to show how grievers' scores compared on variables both before (pre) and after (post) completion of the grief recovery program in order to confirm the implicit programmatic theory and determine the level influence the program has on variables of grief and grief recovery. Based on the results of this future study, more knowledge will be gained on how and to what extent the program influences variables of grief and grief recovery, thereby building a body of empirical evidence on how well the implicit programmatic theory holds. Empirical evidence that validates the implicit programmatic theory and demonstrates the level of influence the program has on variables of grief and grief recovery has the potential to lead to increased exposure and implementation of the

intervention, thereby greatly reducing the burden of grief experienced by millions of grievers nationwide.

Considering the newly established epidemic in America known as, '*Deaths of Desperation*,' Segal, De Biasi, Mueller, May, and Warren (2017) cautioned that if the nation continued along recent trajectories, death rates could double to over six million by 2025. More troubling, was that the majority of these could have been prevented, especially those attributed to grief and mourning. For example, of the ten leading causes of death, all have decreased except for suicide (CDC, 2015). Identified as the number one cause of death among persons aged 0-34 after accidents, suicide deaths have reached epidemic proportions (CDC, 2015). Among US adults aged 18 and older, one committed suicide every 13 minutes (CDC, 2015). Far more startling was that in Ohio alone, more than 19% of youth aged 0-18 have seriously considered suicide, and one in five have attempted it (National Violent Death Reporting System, 2016). For completed suicides, the death toll among Northeast Ohio youth aged 10-14 has more than tripled in last three years by an increase of 136% (National Violent Death Reporting System, 2016); thereby exceeding the national average, and receiving the proclamation that youth have taken their own lives in Northeast Ohio more than anywhere else in country (Schaefer, 2018). According to the CDC (2015), the main causes for these unpresented number of suicidal deaths were prolonged grief and depression. Consequently, a significant and looming need existed to make interventions of grief recovery more accessible to all those who have experienced grief and would experience in the future. For the institutions, medical centers, and hospice organizations that did not currently offer any grief-related programming, as more individuals and their families seek end of life treatment and care, having organizations who offered grief recovery

programming, or at the very least, referrals to those certified in grief recovery, might serve as an effective public health initiative as a means of primary, secondary, and tertiary prevention.

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APPENDICIES

RE: Protocol #17-031 - entitled "Evaluative Research of the Grief Recovery Method"

We have assigned your application the following IRB number: **17-031**. Please reference this number when corresponding with our office regarding your application.

The Kent State University Institutional Review Board has reviewed and approved your Application for Approval to Use Human Research Participants as Level I/Exempt from Annual review research. Your research project involves minimal risk to human subjects and meets the criteria for the following category of exemption under federal regulations:

- Exemption 2: Educational Tests, Surveys, Interviews, Public Behavior Observation

This application was approved on February 7, 2017.
***Submission of annual review reports is not required for Level 1/Exempt projects. We do NOT stamp Level I protocol consent documents.*

For compliance with:

- DHHS regulations for the protection of human subjects (Title 45 part 46), subparts A, B, C, D & E

If any modifications are made in research design, methodology, or procedures that increase the risks to subjects or includes activities that do not fall within the approved exemption category, those modifications must be submitted to and approved by the IRB before implementation. Please contact an IRB discipline specific reviewer or the Office of Research Compliance to discuss the changes and whether a new application must be submitted. Visit our website for modification forms.
Kent State University has a Federal Wide Assurance on file with the Office for Human Research Protections (OHRP); FWA Number 00001853.

To search for funding opportunities, please sign up for a free Pivot account at http://pivot.cos.com/funding_main

If you have any questions or concerns, please contact us at Researchcompliance@kent.edu or by phone.

Doug Delahanty | IRB Chair |330.672.2395 | ddelahan@kent.edu
Tricia Sloan | Coordinator |330.672.2181 | psloan1@kent.edu
Kevin McCreary | Assistant Director | 330.672.8058 | kmccrea1@kent.edu
Paulette Washko | Director |330.672.2704| pwashko@kent.edu

KENT STATE
UNIVERSITY

Exempt From Annual Review Research Application

(LEVEL I projects)

THIS SECTION FOR USE BY IRB

Name of discipline-specific reviewer: Mark A. James, PhD

Date Received by Office of Research Compliance:

Date of Final Approval:

☑ **Application meets Exemption from Annual review requirements**

Please specify one or more category:

- ☐ - #1 - Educational Settings
- ☑ - #2 -Educational Tests, Surveys, Interviews, Public Behavior Observation
- ☐ - #3 - Educational Tests, Surveys, Interviews, Public Behavior Observation of PUBLIC OFFICIALS
- ☐ - #4 - Existing Data, Documents, Specimens
- ☐ - #5 - For Public Benefit or Service Programs (Federal)
- ☐ - #6 - For Taste and Food Quality and Consumer Acceptance Studies

Mark A. James 01-19-17

☐ **Application does NOT meet Exemption from Annual review requirements**

Reason:

INSTRUCTIONS for INVESTIGATORS:

Please read these instructions prior to completing this form.

1. Complete this form to request an exemption determination for your study.
2. Review the *Categories of Research Activities that are Exempt* document prior to completing this application. ALL procedures and instruments used in your study must meet the exemption criteria to receive the exemption determination. If your study does not meet the exemption criteria, you will be asked to complete the Level II/III USE OF HUMAN SUBJECTS IN RESEARCH application.
3. Submit this completed document and any needed Appendices, materials (i.e. copies of survey/interview questions, focus group scripts/protocols, recruitment emails, etc.), and consent forms via email attachment to an IRB discipline specific reviewer. To submit the form with a typed signature, the form must be submitted from the Investigator's @kent.edu email account. Handwritten forms will not be accepted.
4. Do NOT begin data collection prior to receiving notification from the KSU IRB that the study meets the exemption criteria.
5. ***To complete this form: Single left-click to complete text fields. To check a box, double left-click on the box, then click "checked". Click OK.***

Section 1 – TITLE & PRINCIPAL INVESTIGATOR (PI) INFORMATION

Title of Study: Evaluative Research of the Grief Recovery Method®

Estimated begin and end dates for the project	**01/2017** to **06/2018**
Name: **Jeffrey S. Hallam**	Status: ☒ Faculty ☐ Staff
Phone: (330) - 672 - 0679 or extension	Department: **Social and Behavioral Sciences**
Purpose of Research: ☐ Faculty Research ☒ Student Thesis/Dissertation → Complete Appendix A ☐ Other: Specify:	PI Email: jhallam1 @kent.edu
Please provide keywords that best describe your research: Evaluative Research	
Email address(es) for others that should be notified regarding the status of this application (i.e., student(s) conducting research, program administrators, etc.):	CI Email: rnolan1 @kent.edu

KENT STATE UNIVERSITY

IRB LOG NUMBER: 16-

Exempt From Annual Review Research Application

(LEVEL I projects)

THIS SECTION FOR USE BY IRB		
Name of discipline-specific reviewer:	Date Received by Office of Research Compliance:	
Application meets Exemption from Annual review requirements *Please specify one or more category:* - #1 - Educational Settings - #2 -Educational Tests, Surveys, Interviews, Public Behavior Observation - #3 - Educational Tests, Surveys, Interviews, Public Behavior Observation of PUBLIC OFFICIALS - #4 - Existing Data, Documents, Specimens - #5 - For Public Benefit or Service Programs (Federal) - #6 - For Taste and Food Quality and Consumer Acceptance Studies	Date of Final Approval:	
Application does NOT meet Exemption from Annual review requirements *Reason:*		

INSTRUCTIONS for INVESTIGATORS:

Please read these instructions prior to completing this form.

1. Complete this form to request an exemption determination for your study.
2. Review the *Categories of Research Activities that are Exempt* document prior to completing this application. ALL procedures and instruments used in your study must meet the exemption criteria to receive the exemption determination. If your study does not meet the exemption criteria, you will be asked to complete the Level II/III USE OF HUMAN SUBJECTS IN RESEARCH application.
3. Submit this completed document and any needed Appendices, materials (i.e. copies of survey/interview questions, focus group scripts/protocols, recruitment emails, etc.), and consent forms via email attachment to an IRB discipline specific reviewer. To submit the form with a typed signature, the form must be submitted from the investigator's @kent.edu email account. Handwritten forms will not be accepted.
4. Do NOT begin data collection prior to receiving notification from the KSU IRB that the study meets the exemption criteria.
5. ***To complete this form: Single left-click to complete text fields. To check a box, double left-click on the box, then click "checked". Click OK.***

Section 1 – TITLE & PRINCIPAL INVESTIGATOR (PI) INFORMATION

Title of Study: Evaluative Research of the Grief Recovery Method®		
Estimated begin and end dates for the project		01/2017 to 06/2018
Name: Jeffrey S. Hallam		Status: ☒ Faculty ☐ Staff
Phone: (330) - 672 - 0679 or extension		Department: Social and Behavioral Sciences
Purpose of Research	☐ Faculty Research ☒ Student Thesis/Dissertation → Complete Appendix A ☐ Other: Specify:	PI Email: jhallam1 @kent.edu
Please provide keywords that best describe your research: Evaluative Research		
Email address(es) for others that should be notified regarding the status of this application (i.e., student(s) conducting research, program administrators, etc.):		CI Email: molan1 @kent.edu

KENT STATE UNIVERSITY

IRB LOG NUMBER: 16-

a. Are there any Kent State University affiliated co-investigators or key personnel on this protocol?	☒ Yes → Complete Appendix A ☐ No
b. Are there any external (non-Kent State University affiliated) co-investigators or key personnel *engaged* in the research?	☐ Yes → Complete Appendix B ☒ No
c. Has the Principal Investigator (PI) completed/updated the required web-based courses (CITI training) in the protection of human research subjects?	☒ Yes → Attach Copy of completion certificate ☐ No
d. Is this protocol a continuation of or linked to a previously reviewed IRB protocol? **If Yes →** Please list the protocol number(s)	☐ Yes ☒ No

Section 2 – FUNDING INFORMATION

2a. Does this research have external or internal funding, or have you requested funding for this research? **If Yes →** Specify sponsor: Protocol/Proposal #: Institution (if not KSU): **If No →** Please provide a short description of barriers to applying for, or receiving funding so that our Division can try to help you in future efforts.	☐ Yes ☒ No
2b. Have you created an account and search for research funding opportunities at Pivot.cos.com?	☒ Yes ☐ No
2c. Is any support other than monetary (e.g., drugs, equipment, supplies, etc.) being provided for the study? **If Yes →** Specify support and provider: Attach a copy of the grant application or funding proposal.	☐ Yes ☒ No
2d. Does the PI for this research or their immediate family members (i.e. *spouse, domestic partner, or dependent children*) have a financial interest that would reasonably be affected by the research, or a financial interest in any entity whose financial interest would reasonably appear to be affected by the research?	☐ Yes → Complete Appendix Z ☒ No
2e. Does the PI for this research or their immediate family members (i.e. *spouse, domestic partner, or dependent children*) have a non-financial Conflict of Interest that would reasonably be affected by the research?	☐ Yes → Complete Appendix Z ☒ No

If Yes → Specify sponsor:

Protocol/Proposal # Institution (if not KSU):

Have all Kent State University investigators and key personnel completed the required COI disclosure for externally funded research for the purposes of *this* research project? ☐ Yes ☐ No

Section 3 – QUALIFYING STATEMENTS

1. The research will not expose participants to discomfort or distress beyond that normally encountered in daily life (minimal risk).	True ☐ Not True
2. The research will not include collection of sensitive data (i.e., sexual behavior, alcohol or drug use) where the responses, if disclosed outside of the research, would place the participants at risk of criminal or civil liability or be damaging to participants' financial standing, employability, or reputation.	True ☐ Not True
3. The research will not involve individuals that are prisoners (involuntarily confined or detained in a penal institution), with restricted ability to leave the institution.	True ☐ Not True
4. If there is interaction with subjects there will be a verbal consent process or a document that is given to participants to disclose the information: • That the activity involves research • Subject rights • The procedures/what they are being asked to do • Duration of subject's participation • That participation is voluntary • Confidentiality statement • Incentives or payments (if applicable) • Name and contact information for the investigator • Contact information for the KSU IRB (330-672-2704)	☒ True ☐ Not True ☐ N/A (category 4 – existing data or documents)
5. The research is not subject to FDA regulations.	True ☐ Not True

Section 4 – PURPOSE OF RESEARCH

a) Briefly summarize the purpose of the proposed research below using ***non-technical*** language that can be readily understood by someone outside of your discipline. ***Use complete sentences (limit 1500 words).***

Most people face at least one life-threatening or death-related incident during the course of their lives (Ozer, Best, Lipsey, & Weiss, 2003). These people are increasingly met with the deaths of friends, family, mentors, and loved ones from which a wide range of emotions ensue. Empirically, responses to such loss vary greatly ranging from unrecoverable, acute distress to mild grief or discomfort. For some, recovering from such adversity comes with time, while others experience unexpected, prolonged suffering that results in psychopathology and poor health.

The importance and prevention of these factors associated with death-related loss is well established (Taylor, Kemeny, Reed, Bower, & Gruenewald, 2000). Key features include human resilience and the distinct process of grief recovery. The term recovery, as it relates to grief, denotes a trajectory in which normal functioning temporarily gives way to psychopathology, producing symptoms of stress, depression, or sadness. However, full abatement or recovery from grief-associated symptoms may take as long as several years, if ever (Bonanno, 2004; Shear, et al., 2011).

The National Institutes of Health (2009) estimates that for each death in the United States, 4 to 5 grieving survivors remained, totaling to almost 13 million Americans annually who cope and mourn significant loss. In order to reduce the public health burden of grief, it is important to understand the determinants that

influence adults' knowledge, attitudes, beliefs and behaviors associated with death-related grief.

Presently, no evidence-based grief recovery intervention exists, nor has any grief-related program been evaluated to determine the program's capacity to produce population wide changes in the burden of grief. Of the many community-based grief recovery programs offered, it is suggested that one program holds significant promise. This program, entitled the Grief Recovery Method® (GRM) aims to promote grief recovery in persons who have experienced a death-related loss by influencing the knowledge, attitude, beliefs, and behaviors associated with death.

Although research instruments are available that measure grief as it relates to death, to date, none exist that specifically target the theoretical variables of the GRM. For this reason, the current study will involve the development and testing of a self-report combined survey to measure targeted theoretical variables of the GRM defined as knowledge, attitudes, beliefs, and behaviors called the Greif Recovery Questionnaire (GRQ), as well as the outcome of grief recovery called the Grief Recovery Outcome Instrument (GROI).

Purpose

The purpose of this study is to develop a self-report survey, consisting of the GRQ and GROI, to measure factors associated with grief which have been theoretically proposed to influence grief recovery in persons who have experienced a death-related loss. A secondary purpose of this study is to assess the validity and reliability of the survey to measure the hypothesized theoretical variables of the GRM.

b) Will individually identifiable Protected Health Information (PHI) from a covered entity and subject to the HIPAA Privacy Rule requirements be accessed, used, or disclosed in the research study? **Only aggregated data will be used or disclosed.**	☒ No ☐ Yes → **Check all that apply below:**

☐ Written Authorization → **Provide a copy of the Authorization Form.** See template.

☐ Partial Waiver of authorization (recruitment purposes only; preparatory to research) → Complete Appendix

☐ Full Waiver of authorization (limited data set with no direct identifiers and with a data use agreement; information on descendant's) → Complete Appendix

Section 5 – CATEGORY OF EXEMPTION

☒ Category 1 - Educational Settings

1. The research will only be conducted in established or commonly-accepted educational settings including, but not limited to, schools and colleges.	☒ True ☐ Not True → Research is not exempt. Complete a Level II/III
2. The research will involve *only normal educational practices*, such as (i) research on regular and special education instructional strategies, or (ii) research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.	True ☐ Not True → Research is not exempt. Complete a Level II/III

3. Provide an overview of the population being studied (e.g. high school students, college students) and the procedures that apply to this category. Explain how your research is considered to take place in a commonly accepted education setting, and involves normal educational practices.

Adults aged 18 and older who are able to read, write, and speak English.

The survey will be administered via paper and pencil format in a community-setting or online through Qualtrics

☒ Category 2 - Educational Tests, Surveys, Interviews, Public Behavior Observation

1. The subject population includes ADULTS (>18 years old) and the research will involve only the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior.	☒True ☐ Not True →Research is not exempt. Complete a Level II/III ☐N/A
2. The subject population includes CHILDREN (<18 years old) and the research procedures is limited to the observation of public behavior where the investigator will NOT participate in the activities being observed.	☒N/A ☐True → Complete Appendix I ☐ Not True →Research is not exempt. Complete a Level II/III

3. Provide a brief overview of the procedures that apply to this category. Include where/how the research will be administered (e.g. Internet anonymous survey, telephone interviews, mail, etc.). Describe how the proposed research methodology meets the criteria of involving either 1) education tests (cognitive, diagnostic, aptitude, achievement); 2) survey procedures; 3) interview procedures; or 4) observation of public behavior.

The study involves survey construction and development. All collection of data will occur through the subject's completion of the survey. The human research portion of this study divided into three phases is as follows:

The first phase involves field testing a survey that consists of two combined instruments that were previously developed to measure the hypothesized theoretical structure of the Grief Recovery Method (GRM) identified as (1) knowledge; (2) attitudes; (3) beliefs; and (4) behaviors (KABB), as well as the outcome of grief recovery. The first instrument is the 23-item Grief Recovery Method Questionnaire (GRQ) and the second is the 12-item Grief Recovery Outcome Instrument (GROI). The second phase involves testing the factorial structure of the GRQ and the GROI instruments through exploratory and confirmatory factor analysis. The final phase involves pilot testing the GRQ and GROI for test/retest reliability.

Study procedures are as follows:

Field Testing (Phase One)

The field testing phase will involve one certified GRM coordinator of a local hospice organization to select an independent sample of 10-15 adults from a group of individuals who have self-selected to receive the GRM. No compensation will be given for study participation. The certified GRM will administer the survey via paper and pencil format. Each subject will be asked to read the research information sheet and voluntarily agree to participate in the field testing phase of the instruments by completing the combined GRQ and GROI survey. Subjects will be asked to give written feedback on the survey, noting any wording that does not make sense, ease of use, typos, and the time needed to complete the survey. After survey administration, the GRM coordinator will send completed surveys to the researcher via a pre-paid postage envelope. The instrument will

be edited accordingly. No compensation will be provided.

Main Study (Phase Two)

A certified GRM coordinator will select participants from an independent sample of adults who reside in Ohio and have gone through the GRM within the last 10 years. Participants will also be selected from an independent sample of adult employees of Kent State University (KSU). Participants will be selected at a ratio of five participants per one item (n=350). To identify participants who may wish to participate at KSU, an email will sent by the researcher to KSU employees that provides information about participant selection into the study and describes the purpose of the research. To identify adult Ohio residents who may wish to participate in the study, an email will be sent by the certified GRM coordinator to participants who previously went through the GRM within the last ten years that provides information about participant selection into the study and describes the purpose of the research. Both emails will also contain a link to the online version of the GRQ and GROI survey via Qualtrics. The link provided will first direct individuals to an online version of the research information sheet where participants will be notified that by completing the survey, they agree to participate in the study and that information about the research has been satisfactorily explained to them. Once participants click that they agree to participate, they will then be directed to the online survey. Once the survey has been completed, participants will be randomly assigned into one of two groups. Group 1 will be used for the exploratory factor analysis and Group 2 for the confirmatory factor analysis. The exploratory factor analysis will be conducted to determine emerging factors. Items that do not fit into the factor structure will be removed. Confirmatory factor analysis and descriptive statistics will be performed to assess construct validity. No compensation will be provided.

Pilot Testing for Test/Retest Reliability (Phase Three)

Once the factor analysis is completed, the researcher will recruit 20 participants who have experienced a death-related loss within the last ten years via a study flyer posted to the social media sites Facebook and LinkedIn. The study flyer will describe the purpose of the research and will ask individuals to participate in the study. Each participant who agrees will provide the researcher with his or her email address. Each participant will receive an email from the researcher with instruction on how to access the online version of the GRQ and GROI survey via the Qualtrics link. The email will also inform participants that they will be asked to complete the survey on two separate occasions. The link provided will first direct individuals to an online version of the research information sheet where participants will be notified that by completing the survey, they agree to participate in the study and that information about the research has been satisfactorily explained to them. Once participants click that they agree to participate, they will then be directed to the online survey. The researcher will distribute a second email with instruction on how to access the online version of the GRQ and GROI survey via the Qualtrics link approximately ten-days later. Test-retest reliability and internal consistency using Cronbach's alpha will be determined. No compensation will be provided.

☐ **Category 3 - Educational Tests, Surveys, Interviews, Public Behavior Observation of PUBLIC OFFICIALS**

1. The research will involve only the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior	☐ True ☐ Not True →Research is not exempt. Complete a Level II/III
2. AND (one of the following is true) a) The human subjects are elected or appointed public officials or candidates for public office. (Applies to senior officials such as mayor or school superintendent rather than a police officer or teacher.)	☐ N/A ☐ True ☐ Not True →Research is not exempt. Complete a Level II/III
b) Federal statute(s) require without exception that the confidentiality of the personally identifiable information will be maintained throughout the research and thereafter.	☐ N/A ☐ True ☐ Not True →Research is not exempt. Complete a Level II/III

3. Provide a brief overview of the procedures that apply to this category. Include where/how the research will be administered (e.g. Internet anonymous survey, telephone interviews, mail, in person focus groups, etc.).

☐ **Category 4 –Existing Data, Documents, Specimens**

1. The research will involve only the collection or study of *existing* data, documents, records, pathological specimens, or diagnostic specimens	☐ True ☐ Not True→Research is not exempt. Complete a Level II/III
2. The sources of the existing data, documents, records or specimens are publicly available OR the information will be recorded by the investigator in such a manner that participants cannot be readily identified either directly or through identifiers (such as a code) linked to them.	☐ True ☐ Not True→Research is not exempt. Complete a Level II/III

3. Provide an overview of the data/records that will be accessed that apply to this category. Include the source and purpose for which they were originally collected. If personal identifiers are associated with the data, please describe the de-identification procedures.

☐ **Category 5 –For Public Benefit or Service Programs (Federal)**

1. The project is a research or demonstration project conducted by or subject to the approval of a (federal) Department or Agency head and which is designed to study, evaluate, or otherwise examine: (i) public benefit (e.g., financial or medical benefits as provided under the Social Security Act) or service programs (e.g., social, supportive, or nutrition services as provided under the Older Americans Act); (ii) procedures for obtaining benefits or services under those programs; (iii) possible changes in or alternatives to those programs or procedures; or (iv) possible changes in methods or levels of payment for benefits or services under those public benefit or service programs.	☐ True ☐ Not True→Research is not exempt. Complete a Level II/III

2. Provide a brief overview of the procedures that apply to this category. Include where/how the research will be administered (e.g. Internet anonymous survey, telephone interviews, mail, in person focus groups, etc.).

☐ **Category 6 –For Taste and Food Quality and Consumer Acceptance Studies**

1. The research involves only a taste and food quality evaluation or a food consumer acceptance study in which i. wholesome foods without additives will be consumed OR ii. food will be consumed that contains a food ingredient, agricultural chemical or environmental contaminant that is at or below the level found to be safe by the Food and Drug Administration or is approved by the Environmental Protection Agency or the Food Safety and Inspection Service of the U.S. Department of Agriculture.	☐ N/A ☐ True ☐ Not True→Research is not exempt. Complete a Level II/III

2. Provide a brief overview of the procedures that apply to this category. Explain how the research will not pose a risk to subjects. Identify the types and quantity of foods to be consumed.

Section 6 – RESEARCH DESIGN

a. Will research activities be conducted at a site where approval from an IRB (in addition to, or instead of, the KSU IRB) will be sought?	☐ Yes → Complete Appendix O ☒ No

b. Is any of this research being conducted outside of the U.S.A? ☐ Yes → Complete Appendix ☒ No

c. What do you perceive as the foreseeable risks for subjects that participate in this research?

There are no anticipated risks associated with this study. However, some of the questions asked are about personal experience with loss. These questions may be upsetting or may make participants feel uncomfortable when answering them. The phone number for the grief recovery hotline will be included in the survey if participants wish to call.

Section 7 – PARTICIPANT IDENTIFICATION, RECRUITMENT, & SELECTIO

a. Specify the recruitment methods for this study and *attach copies of any of the below (written documents and/or scripts)* to this application: Copy of verbiage for email and letter

☐	Personal contact	☐	Flyers
☒	Contact or approach letters	☒	Internet
☐	Telephone calls (attach copy of script)	☐	Home visits
☐	Brochures	☐	Radio or TV (include written text of the advertisement and brief layout of images)
☐	Printed advertisements	☒	Email (include copy of text to be used)
☐	Student research pools (e.g., psychology, sociology, communication) → Complete Appendix Y	☐	Other Specify:

Who will approach or recruit potential participants?

☐ Principal Investigator
☐ Research Staff
☒ Other →please describe: Email will be sent via a certified GRM coordinator

b. When/how often will participants be recruited? (e.g., via email with 3 reminders sent at specific intervals)

Field Testing (*Phase One*): An independent sample of 10-15 subjects will be recruited one time by a certified GRM coordinator of a local hospice organization from a pool of individuals who have self-selected to receive the GRM offered by the hospice organization. Subjects will be 18 years and older. The decision to participate or not to participate will not affect any benefits to which the subjects are entitled. Subject inclusion criteria is as follows: (1) not a current hospice employee (2) of the age 18 and older (3) persons who self-select to receive the GRM and (3) have experienced a death-related loss within the last five years.

Main Study (*Phase Two*): An independent sample of approximately 350 adults will be recruited one time from a database of Ohio residents who have gone through the GRM within the last 10 years by a certified GRM coordinator via email. If a sufficient sample size is not reached using the first sampling strategy, a second independent sample of subjects will be drawn one time by the researcher from a pool of identified KSU faculty via email. The ratio of five subjects per one item will be used to recruit a sufficient number of persons to conduct both the exploratory and confirmatory factor analyses (n=350). Subject inclusion criteria is as follows: (1) not a current hospice employee (2) of the age 18 and older and (3) have experienced a death-related loss within the last five years.

Pilot Testing for Test/Retest Reliability (*Phase Three*): An independent, community sample of approximately 20 subjects who have experienced a death-related loss within the last 5 years will be recruited one time by the researcher via a study flyer posted to the social media sites Facebook and LinkedIn. Subject inclusion criteria is as follows: (1) not a current hospice employee (2) of the age 18 and older and (3) have experienced a death-related loss within the last 5 years.

c. Where will participants be recruited? (e.g., doctor's office, classroom, online)

Field Testing (*Phase One*): Participants for the field testing will be recruited from a pool of who have self-selected to receive the GRM offered at a local hospice organization.

Main Study (*Phase Two*): Participants for the main study will be recruited from a sample of adults who reside in Ohio and have gone through the GRM within the last 10 years. Additional subjects may be sampled from a pool of current KSU faculty via email.

Pilot Testing for Test/Retest Reliability (*Phase Three*): Participants for the pilot testing will be recruited via a study flyer posted to the social media sites Facebook and LinkedIn.

d. What steps will be taken to avoid coercion or undue influence in the *recruitment* of research participants? (e.g., will the potential participants be afforded the opportunity to take material home and discuss the study with family members and/or primary care providers?)

If a person does not wish to answer a question, he or she may skip and go on to the next question, or may stop at any time. Participation in the study is voluntary. No compensation will be provided, and participants have the right to withdraw or discontinue participation at any time without penalty or loss of benefits to which they are otherwise entitled.

KENT STATE UNIVERSITY

Section 8 - INCENTIVES or COMPENSATION TO PARTICIPATE

a. Will participants receive compensation or other incentives (e.g., free services, cash payments, gift certificates, parking, classroom credit, travel reimbursement) to participate in the research study? ☐ Yes ☒ No

If Yes → Describe the compensation/incentive. Include the amount and timing of all payments.

b. Have you reviewed and complied with the *Procedures for Compensating Research Participants* policy that is available on our website at: https://sites.google.com/a/kent.edu/division-of-research-and-sponsored-programs-intranet/home/office-of-research-compliance/irb/forms ☒ Yes ☐ No.

Section 9 – PARTICIPANT POPULATION

a. What is the total number of participants (or number of participant records, specimens, etc.):

Field Testing (*Phase One*): 10-15 participants
Main Study (Phase Two): 175 participants for the exploratory factor analysis and 175 participants for the confirmatory factor analysis (*n*=350)
Pilot Testing for Test/Retest Reliability (Phase Three): 20 participants

b. Describe the individuals who may participate in the research :

Field Testing (*Phase One*): Adult individuals who have self-selected to receive the GRM and meet inclusion criteria.

Main Study (*Phase Two*): Adult Ohio residents who have gone through the GRM within the last 10 years and meet inclusion criteria. Additional sampling may include adult faculty members currently employed at KSU who meet inclusion criteria.

Pilot Testing for Test/Retest Reliability (*Phase Three*): Adults who have experienced a death-related loss within the last 5 years and meet inclusion criteria.

Age(s): **18 and older**

Section 10 – CONFIDENTIALITY OF DATA

a. What format will be used to store participant information? Check all that apply.

☐ Hardcopy paper documentation
☒ Database system
☐ Other
☐ Disk (CD ROM, flash drive, floppy disk)
Specify:

b. How will the information obtained be identified? (Choose one)

☒ There will be no identifiers associated with the information obtained.
☐ Names and other identifying information (e.g., email addresses, photographs) are obtained but not shared with anyone except the study staff.
☐ Names and other identifying information are obtained and potentially used in publications.

c. How will the participant information be kept secure and confidential?

Data will be encrypted and stored on a password protected computer.

d. Will you be retaining identifying information for purposes of another research project (e.g. keeping participants' contact information to recruit them for future research)? ☐ Yes ☒ No

If Yes → Describe what information will be retained. The information must also be described in the consent form.

Section 11 – ASSURANCE: PRINCIPAL INVESTIGATOR

I agree to follow all applicable policies and procedures of Kent State University and federal, state, and local laws and guidance regarding the protection of human subjects in research, as well as professional practice standards and generally accepted good research practice guidelines for investigators, including, but not limited to, the following:

- Perform the research as approved by the IRB under the direction of the Principal Investigator by appropriately trained and qualified personnel with adequate resources;
- Understand that the parameters of the research cannot be modified without approval by the KSU IRB (except where necessary to eliminate apparent immediate hazards to participants);
- Agree to maintain research-related records (and source documents) in a manner that documents the validity of the research and integrity of the data collected, while protecting the confidentiality of the data and privacy of participants;
- Will retain research-related records for audit for a period of at least three years after the research has ended (or longer, according to sponsor or publication requirements) even if I leave the University;
- Will contact the Office of Research Compliance for assistance in amending (to request a change in Principal Investigator) or terminating the research if I leave the University or am unavailable to conduct or supervise the research personally (e.g., sabbatical or extended leave);
- Agree to inform all Co-Investigators, research staff, employees, and students assisting in the conduct of the research of their obligations in meeting the above commitments.

I verify that the information provided in this Use of Human Subjects in Research application is accurate and complete.

Jeffrey S. Hallam

Signature of Principal Investigator Date

Typing your name on the signature line will serve as your signature when submitting from your @kent.edu email account.

KENT STATE UNIVERSITY

KSU Co-Investigator(s) or Key Personnel

INSTRUCTIONS for INVESTIGATORS:

1. Complete this form to add KSU-affiliated Co-Investigator's or Key Personnel to research that involves human subjects.
2. Submit this completed document with your application via email attachment. To submit the form with a typed signature, the form must be submitted from the Investigator's @kent.edu email account. If completed form is signed and then scanned as a PDF attachment, the @kent.edu email requirement does not apply.
3. Do NOT begin data collection prior to receiving notification from the KSU IRB that the study/modification has been fully approved.

DEFINITIONS

Key personnel:
Individuals who participate in the design, conduct, or reporting of human subjects research. At a minimum, include individuals who recruit participants, obtain consent, or who collect study data.

Conflict of Interest is a financial interest or other opportunity for tangible personal benefit of an individual or his/her immediate family that may exert a substantial and improper influence on the individual's professional judgment in exercising any institutional duty or responsibility, including the conduct or design of research.

Financial Conflict of Interest:
An interest of an individual (or his/her immediate family) of monetary value that would reasonably appear to be affected by the research or an individual's interest in any entity whose financial interests would reasonably appear to be affected by the research. Financial interests include (but are not limited to) salary or other payments for services (e.g., consulting fees or honoraria), equity interests (e.g., stocks, stock options, or other ownership interests), and intellectual property rights (e.g., patents, copyrights, and royalties from such rights).

Non-Financial Conflict of Interest:
An interest other than monetary of an individual (or his/her immediate family) in the design, conduct, or reporting of the research or other interest that competes with the obligation to protect research participants and potentially compromises the objectivity and credibility of the research process.

Immediate Family:
An Investigator's or Key personnel's spouse or domestic partner and dependent children.

IRB LOG #: 16

IRB Office use only

AGENDA DATE	
Date received	
Date of IRB Determination email to investigator	

To complete this form: Single left-click to complete text fields. To check a box, double left-click on the box, then click "checked". Click OK.

Section I - KSU PRINCIPAL INVESTIGATOR INFORMATION

Last Name: Jeffrey First Name: Hallam

KENT STATE UNIVERSITY

KSU Co-Investigator(s) or Key Personnel

Title or, IRB log number of Research (should match Human Subjects Research Application)

Evaluative Research of the Grief Recovery Method®

KSU CO-INVESTIGATOR(S) and/or KEY PERSONNEL (#1)

☒ Co-Investigator Status:

☐ Key Personnel ☐ Faculty ☒ Graduate Student ☐ Undergraduate Student ☐ Staff

Name (Last, First, MI): Nolan, Rachael D

E-mail: Rnolan1 @kent.edu Phone: 3306726500

a. Have Co-Investigator(s)/Key personnel completed the CITI online (or equivalent) training?
☒ Yes → **attach copy of completion certificate.**
☐ *No*

b. Describe the role/activities that this Co-investigator or Key Personnel will perform for this study (e.g., subject recruitment, informed consent):

The Co-investigator will perform and assist with all aspects of this study including but not limited to, instrument development and testing, informed consent, subject recruitment, and data analysis.

c. Will research activities be conducted at a site where approval from an additional IRB (other than KSU IRB) is needed?
☐ Yes → **complete** Appendix O
☒ No

d. Does Co-Investigator or Key personnel have a Conflict of Interest related to the research?
☐ Yes → **provide explanation below**
☒ No

Explanation:

e. Does Co-Investigator or Key personnel have a patent or, pending patent, or current patent idea that could be conceivably related to this research project?
☐ Yes → **provide explanation below.**
☒ No

Explanation:

f. Has/will Co-Investigator or Key personnel receive funds or, other resources (including equipment,
☐ Yes → **provide explanation below.**
☒ No

APPENDIX A1 – Co-Investigator(s) or Key Personnel

KENT STATE UNIVERSITY

KSU Co-Investigator(s) or Key Personnel

devices, etc...) from a Sponsor or funding agency/entity for purposes of this research project?

Explanation:

I agree to follow all applicable policies and procedures of Kent State University and federal, state, and local laws and guidance regarding the protection of human subjects in research, as well as professional practice standards and generally accepted good research practice guidelines for investigators, including, but not limited to, the following:

- Perform the research as approved by the IRB under the direction of the Principal Investigator (or Advisor) by appropriately trained and qualified personnel with adequate resources;
- Initiate the research after written notification of IRB approval has been received;
- Obtain and document (unless waived) informed consent and HIPAA research authorization from human subjects (or their legally authorized representatives) prior to their involvement in the research using the currently IRB-approved consent form(s) and process;
- Promptly report to the IRB events that may represent unanticipated problems involving risks to subjects or others;
- Provide significant new findings that may relate to the subjects willingness to continue to participate;
- Inform the IRB of any proposed changes in the research or informed consent process before changes are implemented, and agree that no changes will be made until approved by the KSU IRB (except where necessary to eliminate apparent immediate hazards to participants);
- If applicable, complete and submit a Continuing Review of Human Subjects Research application before the deadline for review at intervals determined by the IRB to be appropriate to the degree of risk (but not less than once per year) to avoid expiration of IRB approval and cessation of all research activities;
- Maintain research-related records (and source documents) in a manner that documents the validity of the research and integrity of the data collected, while protecting the confidentiality of the data and privacy of participants;
- Retain research-related records for audit for a period of at least three years after the research has ended (or longer, according to sponsor or publication requirements) even if I leave the University;

I verify that the information provided in this form is accurate and complete.

Signature _____ Date 1/18/17

KENT STATE UNIVERSITY
College of Public Health

Dear (study participant):

You are being asked to participate in a research study on grief recovery by completing a survey that asks questions about your personal experience with grief, death, and loss.

You have two options for completing the survey. You may complete the paper and pencil survey that is included with this letter, or you can visit www.---------- to complete the survey online.

If you complete the paper and pencil survey included with this letter, please mail the completed survey in the return stamped envelope provided.

The survey should take about 10 minutes to complete.

To complete the survey:

- Please review the attached research information sheet and statement of consent.
- Please follow the directions and complete the survey.
- Please complete the survey only once.

If you have any questions regarding this study or how to complete the survey, please feel free to contact me at the email or phone number listed below. Thank you in advance for your participation.

Ms. Rachael Nolan
Kent State University, College of Public Health
750 Hilltop Drive, Lowry Hall
3rd Floor, Ste. #340
Kent, OH 44242
Phone: (330) 672-6500 Fax: (330) 672-6505
Email: rnolan1@kent.edu Web: www.kent.edu/publichealth
LinkedIn: www.linkedin.com/pub/rachael-nolan/48/a34/39b

KENT STATE UNIVERSITY
College of Public Health

Research Information Sheet & Statement of Consent (main study)

You are being invited to participate in a research study. This form provides you with information on the study and the associated risks and benefits of the research. Please read this form carefully. It is important that fully understand the research in order to make an informed decision.

Study Title: Evaluative Research of the Grief Recovery Method® in those who have experienced death-related loss.

Principal Investigator: Jeffrey S. Hallam, PhD **Co-Investigator:** Rachael D. Nolan, MPH, CPH

Purpose: The purpose of the research is to evaluate the Grief Recovery Method® in those who have experienced death-related loss.

Procedures and Time Involvement: Please review and complete the attached survey. It should take 5-10 minutes of your time.

Benefits: You will not receive any direct benefit from participating in the study. However, your participation is vital to our overall study results.

Risks and Discomforts: There are no anticipated risks associated with this study. Some of the questions asked are about your personal experience with death. These questions may be upsetting or make you feel uncomfortable when answering them. If you do not wish to answer a question, you may skip it and go on to the next question, or you may stop at any time.

Compensation: No compensation is provided for participation in this study.

Voluntary Participation and Consent: By completing this survey, you voluntarily agree to participate in the study and that the information about this research has been satisfactorily explained to you. You understand you have the right to withdraw or discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled.

Notice of Privacy Practice and Confidentiality: By completing this survey, you understand that information collected will only be used for the research purposes outlined by this research information sheet. No identifying information will be collected.

Contact Information
This study has been approved by the Kent State University Institutional Review Board. If you have any questions or concerns about this research, please feel free to contact the principal investigator, Dr. Jeffrey S. Hallam at 330-672-0679 or the Institutional Review Board at 330-672-2704.

For more information about the program, or to speak with someone regarding your grief, please contact the Grief Recovery Method® toll-free at 800-334-7606.

KENT STATE UNIVERSITY
College of Public Health

Dear (study participant):

As current recipients of the Grief Recovery Method® (GRM) offered at Crossroads Hospice, you are being asked to participate in a study to review a newly developed survey on the GRM. Attached you will find directions for how to complete the review of the survey and a research information sheet that provides the purpose of the study and a statement of consent.

The review should take about 10 minutes to complete.

To review the survey:

- Please complete the attached survey
- Please assess the survey for clarity, readability, ease of use, time to complete, and wording.
- Please provide specific feedback, comments, or suggestions for the addition or deletion of existing items, words, or phrases used.
- You are encouraged to write on this survey, but please do not reveal any identifying information such as your name or date of birth.

If you have any questions regarding this study or how to review the survey, please feel free to contact me at the email or phone number listed below. Thank you in advance for your participation.

Ms. Rachael Nolan
Kent State University, College of Public Health
750 Hilltop Drive, Lowry Hall
3rd Floor, Ste. #340
Kent, OH 44242
Phone: (330) 672-6500 Fax: (330) 672-6505
Email: rnolan1@kent.edu Web: www.kent.edu/publichealth
LinkedIn: www.linkedin.com/pub/rachael-nolan/48/a34/39b

KENT STATE UNIVERSITY
College of Public Health

Research Information Sheet & Statement of Consent (field study)

You are being invited to participate in a research study. This form provides you with information on the study and the associated risks and benefits of the research. Please read this form carefully. It is important that fully understand the research in order to make an informed decision.

Study Title: Evaluative Research of the Grief Recovery Method® in those who have experienced death-related loss.

Principal Investigator: Jeffrey S. Hallam, PhD **Co-Investigator**: Rachael D. Nolan, MPH, CPH

Purpose: The purpose of the research is to evaluate the Grief Recovery Method® in those who have experienced death-related loss.

Procedures and Time Involvement: Please review and complete the attached survey. It should take 10 minutes of your time.

Benefits: You will not receive any direct benefit from participating in the study.

Risks and Discomforts: There are no anticipated risks associated with this study. However, some of the questions asked are about your personal experience with death. These questions may be upsetting or make you feel uncomfortable when answering them. If you do not wish to answer a question, you may skip it and go on to the next question, or you may stop at any time.

Compensation: No compensation is provided for participation in this study.

Voluntary Participation and Consent: By completing this survey, you voluntarily agree to participate in the study and that the information about this research has been satisfactorily explained to you. You understand you have the right to withdraw or discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled.

Notice of Privacy Practice and Confidentiality: By completing this survey, you understand that information collected will only be used for the research purposes outlined by this research information sheet. No identifying information will be collected.

Contact Information
This study has been approved by the Kent State University Institutional Review Board. If you have any questions or concerns about this research, please feel free to contact the principal investigator, Dr. Jeffrey S. Hallam at 330-672-0679 or the Institutional Review Board at 330-672-2704.

For more information about the program, or to speak with someone regarding your grief, please contact the Grief Recovery Method® toll-free at 800-334-7606.

KENT STATE UNIVERSITY
College of Public Health

Dear (Kent State Faculty Member):

I am a doctoral student in the College of Public Health at Kent State University.

For my dissertation, I am conducting evaluative research on a grief recovery program with the intent to establish programmatic effectiveness.

You are being asked to complete a survey about your personal experience with grief, death, and loss.

Please complete the survey only once.

The survey should take about 10 minutes.

To complete the survey:

- Please access the survey via the provided Qualtrics link www.————
- Review the research information sheet and statement of consent.
- Please follow the directions and complete the survey.

If you have any questions regarding this study or how to complete the survey, please feel free to contact me at the email or phone number listed below. Thank you in advance for your participation.

Ms. Rachael Nolan
Kent State University, College of Public Health
750 Hilltop Drive, Lowry Hall
3rd Floor, Ste. #340
Kent, OH 44242
Phone: (330) 672-6500 Fax: (330) 672-6505
Email: molan1@kent.edu Web: www.kent.edu/publichealth
LinkedIn: www.linkedin.com/pub/rachael-nolan/48/a34/39b

Dear (previous GRM recipient):

As a past recipient of the Grief Recovery Method® training, you are being asked to participate in a research study on grief recovery.

In the study, each participant will be asked to complete an online survey about his or her personal experience with grief, death, and loss.

The survey should take about 10 minutes to complete.

To complete the survey:

- Please access the survey via the link www.----------
- Review the research information sheet and statement of consent.
- Please follow the directions and complete the survey
- You may complete the survey only once.

If you have any questions regarding this study or how to complete the survey, please feel free to contact me or the lead researcher on this study.

Rachael Nolan, Lead Researcher
Email: rnolan1@kent.edu

Thank you in advance for your participation.

Lois Hall
Certified Grief Recovery Specialist® - Trainer
www.griefrecoverymethod.com

Toll-free 1-800-334-7606

The Grief Recovery Method ®

Have you ever experienced the loss of a loved one, family member, friend, pet, or colleague?

If so, you are being asked to participate in a research study on grief recovery by completing an online survey that asks about your personal experience with grief, death, and loss.

The survey should take about 10 minutes to complete.

If you would like to participate by completing the online survey, or if you have any questions regarding this study, please feel free to contact me at the email listed below.

Email: rnolan1@kent.edu

Thank you in advance for your participation.

Ms. Rachael Nolan
Kent State University, College of Public Health
750 Hilltop Drive, Lowry Hall
3rd Floor, Ste. #340
Kent, OH 44242

COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COURSEWORK REQUIREMENTS REPORT*

* NOTE: Scores on this Requirements Report reflect quiz completions at the time all requirements for the course were met. See list below for details. See separate Transcript Report for more recent quiz scores, including those on optional (supplemental) course elements.

- **Name:** Rachael Nolan (ID: 3246279)
- **Email:** rnolan1@kent.edu
- **Institution Affiliation:** Akron General Medical Center (ID: 1772)
- **Institution Unit:** SBS
- **Phone:** 3306726500

- **Curriculum Group:** IRB Members - Basic/Refresher
- **Course Learner Group:** Same as Curriculum Group
- **Stage:** Stage 1 - Basic Course
- **Description:** This Basic Course is appropriate for IRB or Ethics Committee

- **Report ID:** 17840417
- **Completion Date:** 01/05/2016
- **Expiration Date:** 01/04/2019
- **Minimum Passing:** 80
- **Reported Score*:** 86

REQUIRED AND ELECTIVE MODULES ONLY	DATE COMPLETED	SCORE
Populations in Research Requiring Additional Considerations and/or Protections (ID: 16680)	10/14/15	4/5 (80%)
Belmont Report and CITI Course Introduction (ID: 1127)	01/21/13	3/3 (100%)
Cultural Competence in Research (ID: 15166)	01/05/16	5/5 (100%)
Students in Research (ID: 1321)	01/21/13	9/10 (90%)
History and Ethical Principles - SBE (ID: 490)	01/21/13	4/5 (80%)
History and Ethics of Human Subjects Research (ID: 498)	10/14/15	4/7 (57%)
Defining Research with Human Subjects - SBE (ID: 491)	01/21/13	5/5 (100%)
The Federal Regulations - SBE (ID: 502)	01/21/13	5/5 (100%)
Basic Institutional Review Board (IRB) Regulations and Review Process (ID: 2)	10/14/15	5/5 (100%)
Assessing Risk - SBE (ID: 503)	01/21/13	3/5 (60%)
Informed Consent - SBE (ID: 504)	01/21/13	4/5 (80%)
Informed Consent (ID: 3)	10/14/15	5/5 (100%)
Privacy and Confidentiality - SBE (ID: 505)	01/21/13	5/5 (100%)
Social and Behavioral Research (SBR) for Biomedical Researchers (ID: 4)	01/05/16	4/4 (100%)
Records-Based Research (ID: 5)	01/05/16	3/3 (100%)
Genetic Research in Human Populations (ID: 6)	01/05/16	4/5 (80%)
Vulnerable Subjects - Research Involving Prisoners (ID: 8)	01/05/16	4/4 (100%)
Vulnerable Subjects - Research Involving Children (ID: 9)	01/05/16	3/3 (100%)
Vulnerable Subjects - Research Involving Pregnant Women, Human Fetuses, and Neonates (ID: 10)	01/05/16	3/3 (100%)
FDA-Regulated Research (ID: 12)	01/05/16	5/5 (100%)
Research and HIPAA Privacy Protections (ID: 14)	01/05/16	4/5 (80%)
Vulnerable Subjects - Research Involving Workers/Employees (ID: 483)	01/05/16	2/4 (50%)
Conflicts of Interest in Research Involving Human Subjects (ID: 488)	01/22/13	3/5 (60%)

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid independent Learner.

CITI Program
Email: citisupport@miami.edu
Phone: 305-243-7970
Web: https://www.citiprogram.org

COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COURSEWORK TRANSCRIPT REPORT**

** NOTE: Scores on this Transcript Report reflect the most current quiz completions, including quizzes on optional (supplemental) elements of the course. See list below for details. See separate Requirements Report for the reported scores at the time all requirements for the course were met.

- **Name:** Rachael Nolan (ID: 3246279)
- **Email:** rnolan1@kent.edu
- **Institution Affiliation:** Akron General Medical Center (ID: 1772)
- **Institution Unit:** SBS
- **Phone:** 3306726500

- **Curriculum Group:** IRB Members - Basic/Refresher
- **Course Learner Group:** Same as Curriculum Group
- **Stage:** Stage 1 - Basic Course
- **Description:** This Basic Course is appropriate for IRB or Ethics Committee

- **Report ID:** 17840417
- **Report Date:** 01/05/2016
- **Current Score**:** 87

REQUIRED, ELECTIVE, AND SUPPLEMENTAL MODULES	MOST RECENT	SCORE
History and Ethics of Human Subjects Research (ID: 498)	10/14/15	4/7 (57%)
Students in Research (ID: 1321)	01/21/13	9/10 (90%)
Informed Consent (ID: 3)	10/14/15	5/5 (100%)
History and Ethical Principles - SBE (ID: 490)	01/21/13	4/5 (80%)
Social and Behavioral Research (SBR) for Biomedical Researchers (ID: 4)	01/05/16	4/4 (100%)
Defining Research with Human Subjects - SBE (ID: 491)	01/21/13	5/5 (100%)
Belmont Report and CITI Course Introduction (ID: 1127)	01/21/13	3/3 (100%)
Records-Based Research (ID: 5)	01/05/16	3/3 (100%)
The Federal Regulations - SBE (ID: 502)	01/21/13	5/5 (100%)
Genetic Research in Human Populations (ID: 6)	01/05/16	4/5 (80%)
Assessing Risk - SBE (ID: 503)	01/21/13	3/5 (60%)
Vulnerable Subjects - Research Involving Prisoners (ID: 8)	01/05/16	4/4 (100%)
Informed Consent - SBE (ID: 504)	01/21/13	4/5 (80%)
Vulnerable Subjects - Research Involving Children (ID: 9)	01/05/16	3/3 (100%)
Privacy and Confidentiality - SBE (ID: 505)	01/21/13	5/5 (100%)
Vulnerable Subjects - Research Involving Pregnant Women, Human Fetuses, and Neonates (ID: 10)	01/05/16	3/3 (100%)
Research with Prisoners - SBE (ID: 506)	01/21/13	3/4 (75%)
Research with Children - SBE (ID: 507)	01/21/13	3/4 (75%)
FDA-Regulated Research (ID: 12)	01/05/16	5/5 (100%)
Research in Public Elementary and Secondary Schools - SBE (ID: 508)	01/21/13	3/4 (75%)
International Research - SBE (ID: 509)	01/22/13	3/3 (100%)
Internet-Based Research - SBE (ID: 510)	01/22/13	4/5 (80%)
Research and HIPAA Privacy Protections (ID: 14)	01/05/16	4/5 (80%)
Vulnerable Subjects - Research Involving Workers/Employees (ID: 483)	01/05/16	4/4 (100%)
Conflicts of Interest in Research Involving Human Subjects (ID: 488)	01/22/13	3/5 (60%)
Cultural Competence in Research (ID: 15166)	01/05/16	5/5 (100%)
Basic Institutional Review Board (IRB) Regulations and Review Process (ID: 2)	10/14/15	5/5 (100%)
Populations in Research Requiring Additional Considerations and/or Protections (ID: 16680)	10/14/15	4/5 (80%)

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid independent Learner.

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COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COURSEWORK REQUIREMENTS REPORT*

* NOTE: Scores on this Requirements Report reflect quiz completions at the time all requirements for the course were met. See list below for details. See separate Transcript Report for more recent quiz scores, including those on optional (supplemental) course elements.

- **Name:** Rachael Nolan (ID: 3246279)
- **Email:** rnolan1@kent.edu
- **Institution Affiliation:** Akron General Medical Center (ID: 1772)
- **Institution Unit:** SBS
- **Phone:** 3306726500

- **Curriculum Group:** Biomedical Research - Basic/Refresher
- **Course Learner Group:** Same as Curriculum Group
- **Stage:** Stage 1 - Basic Course
- **Description:** Choose this group to satisfy CITI training requirements for investigators and staff involved primarily in biomedical research with human subjects.

- **Report ID:** 18268747
- **Completion Date:** 01/06/2016
- **Expiration Date:** 01/05/2019
- **Minimum Passing:** 80
- **Reported Score*:** 86

REQUIRED AND ELECTIVE MODULES ONLY	DATE COMPLETED	SCORE
Populations in Research Requiring Additional Considerations and/or Protections (ID: 16680)	01/05/16	4/5 (80%)
Belmont Report and CITI Course Introduction (ID: 1127)	01/05/16	3/3 (100%)
Cultural Competence in Research (ID: 15166)	01/05/16	5/5 (100%)
History and Ethics of Human Subjects Research (ID: 498)	10/14/15	4/7 (57%)
Basic Institutional Review Board (IRB) Regulations and Review Process (ID: 2)	10/14/15	5/5 (100%)
Informed Consent (ID: 3)	10/14/15	5/5 (100%)
Social and Behavioral Research (SBR) for Biomedical Researchers (ID: 4)	01/05/16	4/4 (100%)
Records-Based Research (ID: 5)	01/05/16	3/3 (100%)
Genetic Research in Human Populations (ID: 6)	01/05/16	4/5 (80%)
Vulnerable Subjects - Research Involving Prisoners (ID: 8)	01/05/16	4/4 (100%)
Vulnerable Subjects - Research Involving Children (ID: 9)	01/05/16	3/3 (100%)
Vulnerable Subjects - Research Involving Pregnant Women, Human Fetuses, and Neonates (ID: 10)	01/05/16	3/3 (100%)
FDA-Regulated Research (ID: 12)	01/05/16	5/5 (100%)
Research and HIPAA Privacy Protections (ID: 14)	01/05/16	4/5 (80%)
Vulnerable Subjects - Research Involving Workers/Employees (ID: 483)	01/05/16	4/4 (100%)
Conflicts of Interest in Research Involving Human Subjects (ID: 488)	01/06/16	1/5 (20%)

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COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COURSEWORK TRANSCRIPT REPORT**

** NOTE: Scores on this Transcript Report reflect the most current quiz completions, including quizzes on optional (supplemental) elements of the course. See list below for details. See separate Requirements Report for the reported scores at the time all requirements for the course were met.

- **Name:** Rachael Nolan (ID: 3246279)
- **Email:** rnolan1@kent.edu
- **Institution Affiliation:** Akron General Medical Center (ID: 1772)
- **Institution Unit:** SBS
- **Phone:** 3306726500

- **Curriculum Group:** Biomedical Research - Basic/Refresher
- **Course Learner Group:** Same as Curriculum Group
- **Stage:** Stage 1 - Basic Course
- **Description:** Choose this group to satisfy CITI training requirements for investigators and staff involved primarily in biomedical research with human subjects.

- **Report ID:** 18268747
- **Report Date:** 01/06/2016
- **Current Score**:** 90

REQUIRED, ELECTIVE, AND SUPPLEMENTAL MODULES	MOST RECENT	SCORE
History and Ethics of Human Subjects Research (ID: 498)	10/14/15	4/7 (57%)
Informed Consent (ID: 3)	10/14/15	5/5 (100%)
Social and Behavioral Research (SBR) for Biomedical Researchers (ID: 4)	01/05/16	4/4 (100%)
Belmont Report and CITI Course Introduction (ID: 1127)	01/05/16	3/3 (100%)
Records-Based Research (ID: 5)	01/05/16	3/3 (100%)
Genetic Research in Human Populations (ID: 6)	01/05/16	4/5 (80%)
Vulnerable Subjects - Research Involving Prisoners (ID: 8)	01/05/16	4/4 (100%)
Vulnerable Subjects - Research Involving Children (ID: 9)	01/05/16	3/3 (100%)
Vulnerable Subjects - Research Involving Pregnant Women, Human Fetuses, and Neonates (ID: 10)	01/05/16	3/3 (100%)
FDA-Regulated Research (ID: 12)	01/05/16	5/5 (100%)
Research and HIPAA Privacy Protections (ID: 14)	01/05/16	4/5 (80%)
Vulnerable Subjects - Research Involving Workers/Employees (ID: 483)	01/05/16	4/4 (100%)
Conflicts of Interest in Research Involving Human Subjects (ID: 488)	01/06/16	4/5 (80%)
Cultural Competence in Research (ID: 15166)	01/05/16	5/5 (100%)
Basic Institutional Review Board (IRB) Regulations and Review Process (ID: 2)	10/14/15	5/5 (100%)
Populations in Research Requiring Additional Considerations and/or Protections (ID: 16680)	01/06/16	4/5 (80%)

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COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COURSEWORK REQUIREMENTS REPORT*

* NOTE: Scores on this Requirements Report reflect quiz completions at the time all requirements for the course were met. See list below for details. See separate Transcript Report for more recent quiz scores, including those on optional (supplemental) course elements.

- **Name:** Rachael Nolan (ID: 3246279)
- **Email:** rnolan1@kent.edu
- **Institution Affiliation:** Akron General Medical Center (ID: 1772)
- **Institution Unit:** SBS
- **Phone:** 3306726500

- **Curriculum Group:** CITI Conflicts of Interest
- **Course Learner Group:** Conflicts of Interest
- **Stage:** Stage 1 - Stage 1

- **Report ID:** 17840419
- **Completion Date:** 01/05/2016
- **Expiration Date:** 01/04/2019
- **Minimum Passing:** 80
- **Reported Score*:** 93

REQUIRED AND ELECTIVE MODULES ONLY	DATE COMPLETED	SCORE
CITI Conflict of Interest Course - Introduction (COI-Basic) (ID: 15177)	01/05/16	No Quiz
Financial Conflicts of Interest: Overview, Investigator Responsibilities, and COI Rules (COI-Basic) (ID: 15070)	01/05/16	4/5 (80%)
Institutional Responsibilities as They Affect Investigators (COI-Basic) (ID: 15072)	01/05/16	5/5 (100%)
Conflicts of Interest Institution-Specific Policies (ID: 15254)	01/05/16	5/5 (100%)

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COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COURSEWORK TRANSCRIPT REPORT**

** NOTE: Scores on this Transcript Report reflect the most current quiz completions, including quizzes on optional (supplemental) elements of the course. See list below for details. See separate Requirements Report for the reported scores at the time all requirements for the course were met.

- **Name:** Rachael Nolan (ID: 3246279)
- **Email:** rnolan1@kent.edu
- **Institution Affiliation:** Akron General Medical Center (ID: 1772)
- **Institution Unit:** SBS
- **Phone:** 3306726500

- **Curriculum Group:** CITI Conflicts of Interest
- **Course Learner Group:** Conflicts of Interest
- **Stage:** Stage 1 - Stage 1

- **Report ID:** 17840419
- **Report Date:** 01/05/2016
- **Current Score**:** 93

REQUIRED, ELECTIVE, AND SUPPLEMENTAL MODULES	MOST RECENT	SCORE
CITI Conflict of Interest Course - Introduction (COI-Basic) (ID: 15177)	01/05/16	No Quiz
Conflicts of Interest Institution-Specific Policies (ID: 15254)	01/05/16	5/5 (100%)
Financial Conflicts of Interest: Overview, Investigator Responsibilities, and COI Rules (COI-Basic) (ID: 15070)	01/05/16	4/5 (80%)
Institutional Responsibilities as They Affect Investigators (COI-Basic) (ID: 15072)	01/05/16	5/5 (100%)

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CITI Collaborative Institutional Training Initiative

Students conducting no more than minimal risk research Curriculum Completion Report
Printed on 1/22/2013

Learner: Rachael Nolan (username: molan1)
Institution: Kent State University
Contact Information 2734 Orchard Park Street NW
Canton, Ohio 44718 United States
Department: College of Public Health
Phone: 3306036888
Email: molan1@kent.edu

Students - Class projects: This course is appropriate for students doing class projects that qualify as "No More Than Minimal Risk" human subjects research.

Stage 1. Basic Course Passed on 01/21/13 (Ref # 9542170)

Required Modules	Date Completed	Score
Belmont Report and CITI Course Introduction	01/21/13	3/3 (100%)
Students in Research	01/21/13	9/10 (90%)
Kent State University	12/17/12	no quiz

For this Completion Report to be valid, the learner listed above must be affiliated with a CITI participating institution. Falsified information and unauthorized use of the CITI course site is unethical, and may be considered scientific misconduct by your institution.

Paul Braunschweiger Ph.D.
Professor, University of Miami
Director Office of Research Education
CITI Course Coordinator

Return

CITI Collaborative Institutional Training Initiative

Social & Behavioral Research - Basic/Refresher Curriculum Completion Report
Printed on 1/22/2013

Learner: Rachael Nolan (username: molan1)
Institution: Kent State University
Contact Information 2734 Orchard Park Street NW
Canton, Ohio 44718 United States
Department: College of Public Health
Phone: 3306036888
Email: molan1@kent.edu

Social & Behavioral Research - Basic/Refresher: Choose this group to satisfy CITI training requirements for Investigators and staff involved primarily in Social/Behavioral Research with human subjects.

Stage 1. Basic Course Passed on 01/22/13 (Ref # 9542416)

Required Modules	Date Completed	Score
Belmont Report and CITI Course Introduction	01/21/13	3/3 (100%)
Students in Research	01/21/13	9/10 (90%)
History and Ethical Principles - SBR	01/21/13	4/5 (80%)
Defining Research with Human Subjects - SBR	01/21/13	5/5 (100%)
The Regulations and The Social and Behavioral Sciences - SBR	01/21/13	5/5 (100%)
Assessing Risk in Social and Behavioral Sciences - SBR	01/21/13	3/5 (60%)
Informed Consent - SBR	01/21/13	4/5 (80%)
Privacy and Confidentiality - SBR	01/21/13	5/5 (100%)
Research with Prisoners - SBR	01/21/13	3/4 (75%)
Research with Children - SBR	01/21/13	3/4 (75%)
Research in Public Elementary and Secondary Schools - SBR	01/21/13	3/4 (75%)
International Research - SBR	01/22/13	3/3 (100%)
Internet Research - SBR	01/22/13	4/5 (80%)
Conflicts of Interest in Research Involving Human Subjects	01/22/13	3/5 (60%)
Kent State University	12/17/12	no quiz

For this Completion Report to be valid, the learner listed above must be affiliated with a CITI participating institution. Falsified information and unauthorized use of the CITI course site is unethical, and may be considered scientific misconduct by your institution.

COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COURSEWORK REQUIREMENTS REPORT*

* NOTE: Scores on this Requirements Report reflect quiz completions at the time all requirements for the course were met. See list below for details. See separate Transcript Report for more recent quiz scores, including those on optional (supplemental) course elements.

- **Name:** Rachael Nolan (ID: 3246279)
- **Email:** rnolan1@kent.edu
- **Institution Affiliation:** Akron General Medical Center (ID: 1772)
- **Institution Unit:** SBS
- **Phone:** 3306726500

- **Curriculum Group:** Social and Behavioral Responsible Conduct of Research
- **Course Learner Group:** Same as Curriculum Group
- **Stage:** Stage 1 - RCR
- **Description:** This course is for investigators, staff and students with an interest or focus in **Social and Behavioral** research. This course contains text, embedded case studies AND quizzes.

- **Report ID:** 17840418
- **Completion Date:** 01/05/2016
- **Expiration Date:** N/A
- **Minimum Passing:** 80
- **Reported Score*:** 84

REQUIRED AND ELECTIVE MODULES ONLY	DATE COMPLETED	SCORE
Responsible Conduct of Research (RCR) Course Introduction (ID: 1522)	01/05/16	No Quiz
Research Misconduct (RCR-Basic) (ID: 16604)	01/05/16	5/5 (100%)
Data Management (RCR-Basic) (ID: 16600)	01/05/16	5/5 (100%)
Authorship (RCR-Basic) (ID: 16597)	01/05/16	4/5 (80%)
Peer Review (RCR-Basic) (ID: 16603)	01/05/16	4/5 (80%)
Mentoring (RCR-Basic) (ID: 16602)	01/05/16	5/5 (100%)
Using Animal Subjects in Research (RCR-Basic) (ID: 13301)	01/05/16	5/5 (100%)
Conflicts of Interest (RCR-Basic) (ID: 16599)	01/05/16	5/5 (100%)
Collaborative Research (RCR-Basic) (ID: 16598)	01/05/16	5/5 (100%)
Research Involving Human Subjects (RCR-Basic) (ID: 13566)	01/05/16	0/5 (0%)
Responsible Conduct of Research (RCR) Course Conclusion (ID: 1043)	12/17/12	No Quiz

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COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COURSEWORK TRANSCRIPT REPORT**

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- **Name:** Rachael Nolan (ID: 3246279)
- **Email:** rnolan1@kent.edu
- **Institution Affiliation:** Akron General Medical Center (ID: 1772)
- **Institution Unit:** SBS
- **Phone:** 3306726500

- **Curriculum Group:** Social and Behavioral Responsible Conduct of Research
- **Course Learner Group:** Same as Curriculum Group
- **Stage:** Stage 1 - RCR
- **Description:** This course is for investigators, staff and students with an interest or focus in **Social and Behavioral** research. This course contains text, embedded case studies AND quizzes.

- **Report ID:** 17840418
- **Report Date:** 01/05/2016
- **Current Score**:** 96

REQUIRED, ELECTIVE, AND SUPPLEMENTAL MODULES	MOST RECENT	SCORE
Responsible Conduct of Research (RCR) Course Introduction (ID: 1522)	01/05/16	No Quiz
Using Animal Subjects in Research (RCR-Basic) (ID: 13301)	01/05/16	5/5 (100%)
Research Involving Human Subjects (RCR-Basic) (ID: 13566)	01/05/16	5/5 (100%)
Authorship (RCR-Basic) (ID: 16597)	01/05/16	4/5 (80%)
Introduction to the Responsible Conduct of Research Archived 1248 (ID: 1248)	12/17/12	No Quiz
Collaborative Research (RCR-Basic) (ID: 16598)	01/05/16	5/5 (100%)
Conflicts of Interest (RCR-Basic) (ID: 16599)	01/05/16	5/5 (100%)
Data Management (RCR-Basic) (ID: 16600)	01/05/16	5/5 (100%)
Mentoring (RCR-Basic) (ID: 16602)	01/05/16	5/5 (100%)
Peer Review (RCR-Basic) (ID: 16603)	01/05/16	4/5 (80%)
Research Misconduct (RCR-Basic) (ID: 16604)	01/05/16	5/5 (100%)
Responsible Conduct of Research (RCR) Course Conclusion (ID: 1043)	12/17/12	No Quiz

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COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COMPLETION REPORT - PART 1 OF 2
COURSEWORK REQUIREMENTS*

* NOTE: Scores on this Requirements Report reflect quiz completions at the time all requirements for the course were met. See list below for details. See separate Transcript Report for more recent quiz scores, including those on optional (supplemental) course elements.

- **Name:** Jeffrey Hallam (ID: 140390)
- **Email:** jhallam1@kent.edu
- **Institution Affiliation:** Kent State University (ID: 1456)
- **Institution Unit:** Social and Behavioral Sciences
- **Phone:** 330-672-0679

- **Curriculum Group:** Biomedical Research - Basic/Refresher
- **Course Learner Group:** Same as Curriculum Group
- **Stage:** Stage 1 - Basic Course
- **Description:** Choose this group to satisfy CITI training requirements for investigators and staff involved primarily in biomedical research with human subjects.

- **Report ID:** 21969879
- **Completion Date:** 17-Jan-2017
- **Expiration Date:** 17-Jan-2020
- **Minimum Passing:** 80
- **Reported Score*:** 98

REQUIRED AND ELECTIVE MODULES ONLY	DATE COMPLETED	SCORE
Avoiding Group Harms - U.S. Research Perspectives (ID: 14080)	17-Jan-2017	3/3 (100%)
Inclusion of Women and Minorities in Clinical Research (ID: 15671)	17-Jan-2017	4/4 (100%)
Belmont Report and CITI Course Introduction (ID: 1127)	10-Oct-2014	3/3 (100%)
History and Ethics of Human Subjects Research (ID: 498)	10-Oct-2014	7/7 (100%)
Basic Institutional Review Board (IRB) Regulations and Review Process (ID: 2)	10-Oct-2014	5/5 (100%)
Informed Consent (ID: 3)	10-Oct-2014	4/4 (100%)
Social and Behavioral Research (SBR) for Biomedical Researchers (ID: 4)	10-Oct-2014	4/4 (100%)
Records-Based Research (ID: 5)	10-Oct-2014	2/2 (100%)
Genetic Research in Human Populations (ID: 6)	10-Oct-2014	2/2 (100%)
Populations in Research Requiring Additional Considerations and/or Protections (ID: 16680)	17-Jan-2017	5/5 (100%)
Vulnerable Subjects - Research Involving Children (ID: 9)	10-Oct-2014	3/3 (100%)
FDA-Regulated Research (ID: 12)	10-Oct-2014	5/5 (100%)
Research and HIPAA Privacy Protections (ID: 14)	10-Oct-2014	5/5 (100%)
Conflicts of Interest in Research Involving Human Subjects (ID: 488)	10-Oct-2014	4/5 (80%)
Kent State University (ID: 13088)	17-Jan-2017	No Quiz

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COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COMPLETION REPORT - PART 2 OF 2
COURSEWORK TRANSCRIPT**

** NOTE: Scores on this Transcript Report reflect the most current quiz completions, including quizzes on optional (supplemental) elements of the course. See list below for details. See separate Requirements Report for the reported scores at the time all requirements for the course were met.

- **Name:** Jeffrey Hallam (ID: 140390)
- **Email:** jhallam1@kent.edu
- **Institution Affiliation:** Kent State University (ID: 1456)
- **Institution Unit:** Social and Behavioral Sciences
- **Phone:** 330-672-0679

- **Curriculum Group:** Biomedical Research - Basic/Refresher
- **Course Learner Group:** Same as Curriculum Group
- **Stage:** Stage 1 - Basic Course
- **Description:** Choose this group to satisfy CITI training requirements for investigators and staff involved primarily in biomedical research with human subjects.

- **Report ID:** 21969879
- **Report Date:** 17-Jan-2017
- **Current Score**:** 99

REQUIRED, ELECTIVE, AND SUPPLEMENTAL MODULES	MOST RECENT	SCORE
History and Ethics of Human Subjects Research (ID: 498)	10-Oct-2014	7/7 (100%)
Introduction (ID: 757)	04-May-2005	No Quiz
Inclusion of Women and Minorities in Clinical Research (ID: 15671)	17-Jan-2017	4/4 (100%)
Informed Consent (ID: 3)	10-Oct-2014	4/4 (100%)
Social and Behavioral Research (SBR) for Biomedical Researchers (ID: 4)	10-Oct-2014	4/4 (100%)
Belmont Report and CITI Course Introduction (ID: 1127)	10-Oct-2014	3/3 (100%)
Records-Based Research (ID: 5)	10-Oct-2014	2/2 (100%)
Genetic Research in Human Populations (ID: 6)	10-Oct-2014	2/2 (100%)
Vulnerable Subjects - Research Involving Prisoners (ID: 8)	10-Oct-2014	4/4 (100%)
Vulnerable Subjects - Research Involving Children (ID: 9)	10-Oct-2014	3/3 (100%)
Vulnerable Subjects - Research Involving Pregnant Women, Human Fetuses, and Neonates (ID: 10)	10-Oct-2014	3/3 (100%)
Group Harms: Research With Culturally or Medically Vulnerable Groups (ID: 11)	04-May-2005	3/3 (100%)
FDA-Regulated Research (ID: 12)	10-Oct-2014	5/5 (100%)
Research and HIPAA Privacy Protections (ID: 14)	10-Oct-2014	5/5 (100%)
Vulnerable Subjects - Research Involving Workers/Employees (ID: 483)	10-Oct-2014	4/4 (100%)
Conflicts of Interest in Research Involving Human Subjects (ID: 488)	10-Oct-2014	4/5 (80%)
Kent State University (ID: 13088)	17-Jan-2017	No Quiz
Avoiding Group Harms - U.S. Research Perspectives (ID: 14080)	17-Jan-2017	3/3 (100%)
Basic Institutional Review Board (IRB) Regulations and Review Process (ID: 2)	10-Oct-2014	5/5 (100%)
Populations in Research Requiring Additional Considerations and/or Protections (ID: 16680)	17-Jan-2017	5/5 (100%)

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid independent Learner.

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COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COMPLETION REPORT - PART 1 OF 2
COURSEWORK REQUIREMENTS*

* NOTE: Scores on this Requirements Report reflect quiz completions at the time all requirements for the course were met. See list below for details. See separate Transcript Report for more recent quiz scores, including those on optional (supplemental) course elements.

- **Name:** Jeffrey Hallam (ID: 140390)
- **Email:** jhallam1@kent.edu
- **Institution Affiliation:** Kent State University (ID: 1456)
- **Institution Unit:** Social and Behavioral Sciences
- **Phone:** 330-672-0679

- **Curriculum Group:** Social & Behavioral Research - Basic/Refresher
- **Course Learner Group:** Same as Curriculum Group
- **Stage:** Stage 2 - Refresher Course
- **Description:** Choose this group to satisfy CITI training requirements for investigators and staff involved primarily in Social/Behavioral Research with human subjects.

- **Report ID:** 21969880
- **Completion Date:** 17-Jan-2017
- **Expiration Date:** 17-Jan-2020
- **Minimum Passing:** 80
- **Reported Score*:** 100

REQUIRED AND ELECTIVE MODULES ONLY	DATE COMPLETED	SCORE
SBE Refresher 1 – Defining Research with Human Subjects (ID: 15029)	18-Dec-2014	2/2 (100%)
SBE Refresher 1 – Privacy and Confidentiality (ID: 15035)	18-Dec-2014	2/2 (100%)
SBE Refresher 1 – Assessing Risk (ID: 15034)	18-Dec-2014	2/2 (100%)
SBE Refresher 1 – Research with Children (ID: 15036)	18-Dec-2014	2/2 (100%)
SBE Refresher 1 – International Research (ID: 15028)	18-Dec-2014	2/2 (100%)
SBE Refresher 2 – Research with Children (ID: 15043)	17-Jan-2017	1/1 (100%)
SBE Refresher 2 – Research in the Public Schools (ID: 15042)	17-Jan-2017	1/1 (100%)
SBE Refresher 2 – International Research (ID: 15045)	17-Jan-2017	1/1 (100%)
SBE Refresher 1 – History and Ethical Principles (ID: 936)	18-Dec-2014	2/2 (100%)
SBE Refresher 1 – Federal Regulations for Protecting Research Subjects (ID: 937)	18-Dec-2014	2/2 (100%)
SBE Refresher 1 – Informed Consent (ID: 938)	18-Dec-2014	2/2 (100%)
SBE Refresher 1 – Research with Prisoners (ID: 939)	18-Dec-2014	2/2 (100%)
SBE Refresher 1 – Research in Educational Settings (ID: 940)	18-Dec-2014	2/2 (100%)
SBE Refresher 1 – Instructions (ID: 943)	18-Dec-2014	No Quiz
SBE Refresher 2 - Instructions (ID: 12629)	17-Jan-2017	No Quiz
SBE Refresher 2 – Informed Consent (ID: 12620)	17-Jan-2017	1/1 (100%)
SBE Refresher 2 – Privacy and Confidentiality (ID: 12622)	17-Jan-2017	1/1 (100%)
SBE Refresher 2 – Assessing Risk (ID: 12624)	17-Jan-2017	1/1 (100%)
Inclusion of Women and Minorities in Clinical Research (ID: 15671)	17-Jan-2017	4/4 (100%)
Completing the SBR 201 Refresher Course (ID: 12630)	17-Jan-2017	No Quiz

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid independent Learner.

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COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COMPLETION REPORT - PART 2 OF 2
COURSEWORK TRANSCRIPT**

** NOTE: Scores on this Transcript Report reflect the most current quiz completions, including quizzes on optional (supplemental) elements of the course. See list below for details. See separate Requirements Report for the reported scores at the time all requirements for the course were met.

- **Name:** Jeffrey Hallam (ID: 140390)
- **Email:** jhallam1@kent.edu
- **Institution Affiliation:** Kent State University (ID: 1456)
- **Institution Unit:** Social and Behavioral Sciences
- **Phone:** 330-672-0679

- **Curriculum Group:** Social & Behavioral Research - Basic/Refresher
- **Course Learner Group:** Same as Curriculum Group
- **Stage:** Stage 2 - Refresher Course
- **Description:** Choose this group to satisfy CITI training requirements for investigators and staff involved primarily in Social/Behavioral Research with human subjects.

- **Report ID:** 21969880
- **Report Date:** 17-Jan-2017
- **Current Score**:** 100

REQUIRED, ELECTIVE, AND SUPPLEMENTAL MODULES	MOST RECENT	SCORE
SBE Refresher 1 – History and Ethical Principles (ID: 936)	18-Dec-2014	2/2 (100%)
SBE Refresher 2 - Instructions (ID: 12629)	17-Jan-2017	No Quiz
Inclusion of Women and Minorities in Clinical Research (ID: 15671)	17-Jan-2017	4/4 (100%)
SBE Refresher 1 – Federal Regulations for Protecting Research Subjects (ID: 937)	18-Dec-2014	2/2 (100%)
SBE Refresher 2 – Informed Consent (ID: 12620)	17-Jan-2017	1/1 (100%)
SBE Refresher 1 – Informed Consent (ID: 938)	18-Dec-2014	2/2 (100%)
SBE Refresher 1 – Research with Prisoners (ID: 939)	18-Dec-2014	2/2 (100%)
Completing the SBR 201 Refresher Course (ID: 12630)	17-Jan-2017	No Quiz
SBE Refresher 1 – Research in Educational Settings (ID: 940)	18-Dec-2014	2/2 (100%)
SBE Refresher 1 – Instructions (ID: 943)	18-Dec-2014	No Quiz
SBE Refresher 2 – Privacy and Confidentiality (ID: 12622)	17-Jan-2017	1/1 (100%)
SBE Refresher 1 – International Research (ID: 15028)	18-Dec-2014	2/2 (100%)
SBE Refresher 1 – Defining Research with Human Subjects (ID: 15029)	18-Dec-2014	2/2 (100%)
SBE Refresher 2 – Assessing Risk (ID: 12624)	17-Jan-2017	1/1 (100%)
SBE Refresher 1 – Assessing Risk (ID: 15034)	18-Dec-2014	2/2 (100%)
SBE Refresher 1 – Privacy and Confidentiality (ID: 15035)	18-Dec-2014	2/2 (100%)
SBE Refresher 1 – Research with Children (ID: 15036)	18-Dec-2014	2/2 (100%)
SBE Refresher 2 – Research in the Public Schools (ID: 15042)	17-Jan-2017	1/1 (100%)
SBE Refresher 2 – Research with Children (ID: 15043)	17-Jan-2017	1/1 (100%)
SBE Refresher 2 – International Research (ID: 15045)	17-Jan-2017	1/1 (100%)

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid independent Learner.

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Grief Recovery Questionnaire (GRQ)

Directions: Grief is a natural response to a loss of any kind that can include conflicting feelings, emotions, or patterns of behavior. This survey asks about your knowledge, attitudes, beliefs, and behaviors associated with grief. Please consider all the thoughts, emotions, feelings, and behaviors you may have experienced.

Circle the number (1-5) that best reflects your agreement with each of the items below:		**Strongly Disagree**	**Disagree**	**Neither Agree or Disagree**	**Agree**	**Strongly Agree**
1.	Grief is not a normal reaction to a loss.	1	2	3	4	5
2.	Grief comes from a lifetime accumulation of things unsaid, undone, or unfinished.	1	2	3	4	5
3.	Grief is caused by the end of or a change in a familiar pattern of behavior.	1	2	3	4	5
4.	A common source of grief is the sense of incompleteness related to loss.	1	2	3	4	5
5.	Grief recovery is a series of small and correct action choices.	1	2	3	4	5
6.	It is not possible to heal from grief.	1	2	3	4	5
7.	Grief recovery means feeling better.	1	2	3	4	5
8.	Grief is associated with conflicting feelings, such as good and bad memories.	1	2	3	4	5
9.	It is perfectly alright to feel sad about loss.	1	2	3	4	5
10.	The best way to recover from loss is to keep busy.	1	2	3	4	5
11.	When applicable, it is good to replace a loss. (For example: after a pet dies, get a new one)	1	2	3	4	5
12.	It is best to grieve alone.	1	2	3	4	5
13.	I should not feel bad about loss I experience.	1	2	3	4	5
14.	After a loss, I must be strong for others.	1	2	3	4	5
15.	Time heals all wounds.	1	2	3	4	5
16.	Loss is a natural part of life.	1	2	3	4	5
17.	Loss is something to be afraid of.	1	2	3	4	5
18.	It is wrong to speak ill of the dead.	1	2	3	4	5
19.	I am the cause of incompleteness related to loss.	1	2	3	4	5

Circle the number (1-5) that best reflects how often you perform each behavior below:		**Never** [None per week]	**Rarely** [1-2 times per week]	**Sometimes** [3-4 times per week]	**Usually** [5-6 times per week]	**Always** [Every Day]
20.	How many times during a week do you use alcohol to cope with loss?	1	2	3	4	5
21.	How many times during a week do you use food to cope with loss?	1	2	3	4	5
22.	How many times during a week do use drugs of any kind to cope with loss?	1	2	3	4	5
23.	How many times during a week do you use nicotine or tobacco products to cope with loss?	1	2	3	4	5

Grief Recovery Outcome Instrument (GROI)

Directions: Grief recovery is a process of personal growth after a loss of any kind. This survey asks about your grief recovery. Please consider all the thoughts, emotions, feelings, and behaviors you may have experienced.

Circle the number (1-5) that best reflects your agreement with each of the items below:		**Strongly Disagree**	**Disagree**	**Neither Agree or Disagree**	**Agree**	**Strongly Agree**
24.	I have communicated things unsaid related to loss. (For example: an apology or significant emotional statement)	1	2	3	4	5
25.	I have taken action to complete things undone related to loss. (For example: forgive or take responsibility)	1	2	3	4	5
26.	I have recovered things unfinished related to loss (For example: write a completion letter or postscript)	1	2	3	4	5
27.	I have let go of unmet hopes, dreams, or expectations related to loss.	1	2	3	4	5
28.	I have moved beyond loss, finding new meaning for living, to feel better.	1	2	3	4	5

KENT STATE UNIVERSITY
College of Public Health

Dear Colleague:

I am a researcher in the College of Public Health at Kent State University.

As past participants in the Grief Recovery Method® (GRM) training conducted by my colleague, Lois Hall, you have been selected as someone who might be willing/interested to review the instruments I'll be using for a future evaluative study on the GRM.

The review should take about 1 hour to complete.

The specifics of this study require the development of two instruments to measure the self-reported, targeted theoretical variables of grief recovery, as well as the single outcome of grief recovery outlined by the GRM program.

> The 18-item, Grief Recovery Questionnaire (GRQ): Measures targeted theoretical variables associated with grief that move people beyond loss identified as (*KABB*): (1) *knowledge*; (2) *attitudes*; (3) *beliefs*; and (4) *behaviors*.
>
> The 6-item, Grief Recovery Outcome Instrument (GROI): Measures dimensions associated with the single outcome of grief recovery identified as: 1) awareness; 2) responsibility; 3) recovery communication; 4) action; and 5) moving beyond loss.

To review the instruments:

- Please respond to this email with interest as a reviewer no later than **September 10, 2016**. Upon receiving your response, you will be sent the GRQ and the GROI via email.

- Please assess the instruments for face validity, content validity, and wording. For your convenience, directions for reviewing the GRQ and GROI instruments have been attached.

- Please complete the review of these instruments and submit your feedback via email to rnolan1@kent.edu no later than **September 24, 2016**.

Thank you in advance for your participation.

Ms. Rachael Nolan
Instructor and Academic Researcher
Kent State University, College of Public Health
750 Hilltop Drive, Lowry Hall
3rd Floor, Ste. #340
Kent, OH 44242

KENT STATE UNIVERSITY
College of Public Health

Directions: Please carefully read the instructions for assessing face validity, content validity, and wording of the GRQ and GROI instruments. Operational definitions have been provided.

Note: Each instrument is designed to contain core vocabulary associated with the GRM.

Face validity
Please review each instrument and its' associated items for face validity. Please provide specific feedback, comments, or suggestions to improve the face validity of the instrument. If necessary, please provide suggestions for the addition or deletion of existing items.

Content validity
Please review each instrument and its' associated items for content validity. Please provide specific feedback, comments, or suggestions to improve the content validity of the instrument. During the review, please keep in mind the various thoughts, emotions, feelings, and behaviors a griever may experience during bereavement. If necessary, please provide suggestions for the addition or deletion of existing items.

Wording
Please review each instrument and its' associated items for the brevity and clarity of wording. Please provide specific feedback, comments, or suggestions to improve the wording of the instrument. During the review, please keep in mind that all questions should focus on a single item or concept. If necessary, please provide suggestions for the addition or deletion of existing items.

Operational definitions (**for reviewer use only**)
Face validity – a subjective assessment of whether a measure makes sense at face value
Content validity – an estimate of how much a measure represents aspects of a given construct
Wording - language used and manner in which a measure is written

KENT STATE UNIVERSITY
College of Public Health

Dear Expert Panel Review Member:

Thank you for your participation in review of The Grief Recovery Questionnaire and The Grief Recovery Outcome Instrument. The purpose of these instruments are to measure the self-reported, targeted theoretical variables of grief recovery, as well as the outcome of grief recovery defined by The Grief Recovery Method®.

> The 18-item, Grief Recovery Questionnaire (GRQ): Measures targeted theoretical variables associated with grief that move people beyond loss identified as (*KABB*): (1) *knowledge*; (2) *attitudes*; (3) *beliefs*; and (4) *behaviors*.
>
> The 6-item, Grief Recovery Outcome Instrument (GROI): Measures dimensions associated with the single outcome of grief recovery identified as: 1) awareness; 2) responsibility; 3) recovery communication; 4) action; and 5) moving beyond loss.

Before reviewing the instruments:

- Please carefully read the instructions for assessing face validity, content validity, and wording.
- Please carefully read the operational definitions for each of the terms used.
- Please complete your review of these instruments and submit feedback/comments via email to rnolan1@kent.edu no later than **September 24, 2016**.

Thank you in advance for your participation.

- **Ms. Rachael Nolan**

Instructor and Academic Researcher
Kent State University, College of Public Health
750 Hilltop Drive, Lowry Hall
3rd Floor, Ste. #340
Kent, OH 44242
Phone: (330) 672-6500 Fax: (330) 672-6505
Email: rnolan1@kent.edu Web: www.kent.edu/publichealth
LinkedIn: www.linkedin.com/pub/rachael-nolan/48/a34/39b

Grief Recovery Questionnaire (GRQ)

Directions: Grief is a common response to a loss of any kind that can include conflicting feelings, emotions, or patterns of behavior. This survey asks about your knowledge, attitudes, beliefs, and behaviors associated with grief. Please consider all the thoughts, emotions, feelings, and behaviors you may have experienced.

It should take you about 10 minutes to finish.

- Your **knowledge** – learned facts and information about grief and loss.
- Your **attitudes** – feelings about grief and loss.
- Your **beliefs** – assumptions or beliefs about grief and loss.
- Your **behaviors** – actions in response to grief and loss.

For questions 1-19:
Please circle whether you 1=Strongly Disagree, 2=Disagree, 3=Neither Agree or Disagree, 4=Agree, or 5=Strongly Agree with each statement.

For questions 20-23:
Please circle whether you 1=Never, 2=Rarely, 3=Sometimes, 4=Usually, or 5=Always engage in the described behaviors.

Grief Recovery Outcome Instrument (GROI)

Directions: Grief recovery is a process of personal growth after a loss of any kind. This survey asks about your grief recovery. Please consider all the thoughts, emotions, feelings, and behaviors you may have experienced.

It should take you about 5 minutes to finish.

- Your **awareness** – the knowledge or perception gained about grief and loss.
- Your **responsibility** – the state of being accountable for personal thoughts, feelings, or actions.
- Your **recovery communication** – what could or should have been said before the loss occurred (For example: I love you, I'm angry with you, I feel bad that…).
- Your **action** – the behavior or personal response to communicate things unsaid to a person (For example: give an apology, say good-bye, or write a letter).
- You **moving beyond loss** – the process to find or make meaning from pain caused by a loss.

For questions 24-28:
Please circle whether you 1=Never, 2=Rarely, 3=Sometimes, 4=Usually, or 5=Always engage in the described behaviors.

SURVEY ADMINISTRATION GUIDE (Pilot-Test)

Dear <name>, a *Certified Grief Recovery Specialist*® and PhD Candidate at the Kent State University, College of Public, has developed a survey that will be used in future evaluation of the Grief Recovery Method®. This survey, called The Grief Recovery Method® and Outcome Instrument (GRMOI), measures respondents' self-reported knowledge, attitudes, beliefs, and behaviors (KABB) associated with grief, as well as the outcome of grief recovery and personal growth after loss. Each survey also asks respondents (i.e. group participants) to provide demographic information and to rate their mood at the time of taking the survey.

Preparing for Survey Administration:

Please carefully read the following information before the survey is administered. You may wish to read the following information aloud to respondents. If you do not wish to read the following information aloud, please direct respondents to review the research information sheet. This information must be understood by respondents in order to gain their consent to participate in the research.

Purpose: The purpose of the research is to validate an instrument for the future evaluation of The Grief Recovery Method®, a program that aims to reduce grief in those who have experienced loss.

Participant Eligibility: Individuals who are eligible to participate in this research study are 1) ≥ 18 years of age; 2) who are not currently employed at a hospice or palliative care center; 3) who have experienced a death-associated loss 4) who are not currently receiving grief-related or bereavement counseling services; 5) who are able to read, write, and speak English; and 6) who have self-selected to receive the grief recovery program.

Procedures: You will be asked to complete a survey that should take 10-15 minutes of your time.

Benefits: You will not receive any direct benefit from participation. However, responses that you provide will help to identify the potential of The Grief Recovery Method® program to promote grief recovery in those who have experienced loss.

Risks and Discomforts: There are no anticipated risks associated with this study. However, some of the questions asked are about your personal experience with loss. These questions may be upsetting to you or may make you feel uncomfortable when answering them. If you do not wish to answer a question, you may skip it and go on to the next question, or you may stop at any time.

Compensation: No compensation is provided for participation in this study.

Voluntary Participation and Consent: By completing this survey, you voluntarily agree to participate in the study and that the information about this research has been satisfactorily explained to you. You understand you have the right to withdraw or discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled.

Notice of Privacy Practice and Confidentiality: By completing this survey, you understand that any identifying information will remain confidential. Information collected will only be used for the research purposes outlined by this research information sheet. Please be advised that only aggregated results of this research will be published and presented at scientific or professional meetings.

❖ **Contact Information**

This study has been approved by the Kent State University Institutional Review Board. If you have any questions or concerns about this research, please feel free to contact the principal investigator, Dr. Jeffrey S. Hallam at 330-672-0679 or the Institutional Review Board at 330-6722704.

For more information about the program, or to speak with someone regarding your grief, please contact the Grief Recovery Method® toll-free at 800-334-7606.

When to Administer the Survey:

The following table indicates when the survey should be administered.

Program Type	When to Administer Survey
12-wk (group format)	At the end of the last session of the program OR the end of a current program you are facilitating.

Survey Accessibility:

Currently, the survey is only available in print form.

General Administration Guidelines:

In order to ensure that valid and accurate data are collected, please be sure to follow these instructions in a consistent manner for each survey administration. You will only administer the survey once to each group that you facilitate.

1. Inform respondents that they will be asked to complete a survey as part of participating in your group. Explain that the purpose of the survey is to help make the program evidence based.

2. Assure group participants that their survey responses will be kept private. All information collected from the survey will be analyzed and reported at an aggregate level, meaning for all respondents combined.

3. Please tell respondents that this is an anonymous survey and that any sensitive information that can be used to identify them will not be collected (i.e. name, SS#, place of residence).

4. If necessary, you can read questions aloud to respondents.

5. Emphasize that this is not a test, and that we value each respondent's honesty.

6. Advise group participants to respond to the questions as best as they can. If respondents are uncomfortable with any of the questions or indicate they do not know how to respond, they may skip the question.

Survey Script:

Read the directions in the following script aloud to respondents before they begin taking the survey.

"The Grief Recovery Institute™ has partnered with the College of Public Health at Kent State University to invite you to participate in a research study on the Grief Recovery Method®. In doing so, we would like to learn about your knowledge, attitudes, beliefs, and behaviors associated with grief, grief recovery, and personal growth after loss.

There are no right or wrong answers, so please be honest. Make sure to carefully read and answer each question. You will only be allowed to take the survey once, and will not be permitted to go back in the survey once you have completed a response. If you have any questions about taking the survey, please let me know."

Survey Administration Tips:

Please DO:

- ❖ Be familiar with the survey administration guidelines.
- ❖ Please be able to answer any questions that may come from respondents.
- ❖ Direct respondents to carefully read and answer each question on the survey.
- ❖ Access to a laptop or desk computer is recommended to take the survey. However, if respondents choose to access the survey using their smartphones, please ensure privacy to the extent possible when completing the survey.
- ❖ In some instances, participants may agree to complete the survey at home or at a later time. If this is the case, you may wish to send a follow-up email or personal reminder that encourages individuals to participate.

What to do when respondents have completed the Survey:

Thank all participants for completing the survey.

Dear (study participant):

As current participants in The Grief Recovery Method® (GRM) offered at Crossroads Hospice, you are being asked to participate in a study to review a newly developed survey on the GRM.

The review should take about 10-15 minutes to complete.

To review the survey:

- Please assess the survey for clarity, readability, ease of use, and wording.
- Please provide specific feedback, comments, or suggestions to improve the survey.
- If necessary, please provide suggestions for the addition or deletion of existing items, words, or phrases used.

If you have any questions regarding this study or how to review the survey, please feel free to contact me at the email or phone number listed below. Thank you in advance for your participation.

Ms. Rachael Nolan
Instructor and Academic Researcher
Kent State University, College of Public Health
750 Hilltop Drive, Lowry Hall
3rd Floor, Ste. #340
Kent, OH 44242
Phone: (330) 672-6500 Fax: (330) 672-6505
Email: rnolan1@kent.edu Web: www.kent.edu/publichealth
LinkedIn: www.linkedin.com/pub/rachael-nolan/48/a34/39b

Research Information Sheet (Field Test)

This form will provide you with information on the research project, what you will need to do, and the associated risks and benefits of the research. Please read this form carefully. It is important that fully understand the research in order to make an informed decision.

Study Title: Evaluative Research of The Grief Recovery Method®

Principal Investigator: Jeffrey S. Hallam, PhD Candidate

Co-Investigator: Rachael D. Nolan, PhD

Purpose: The purpose of the research is to validate an instrument for the future evaluation of The Grief Recovery Method®, a program that aims to reduce grief in those who have experienced loss.

Participant Eligibility: Individuals who are eligible to participate in this research study are 1) ≥ 18 years of age; who are not currently employed at a hospice or palliative care center; 3) who have experienced a death-associated loss 4) who are not currently receiving grief-related or bereavement counseling services; 5) who are able to read, write, and speak English; and 6) who have self-selected to receive the grief recovery program.

Procedures and Time Involvement: You will be asked to complete a brief survey that should take 5-10 minutes to complete. You will only be asked to complete this survey once. Your participation will not require any more time from you other than the time needed to complete the survey.

Benefits: You will not receive any direct benefit from your participation. However, answers that you provide will help to show effectiveness of the grief recovery program to promote grief recovery in those who have experienced loss.

Risks and Discomforts: There are no anticipated risks associated with this study. However, some of the questions asked are about your personal experience with loss. These questions may be upsetting or make you feel uncomfortable when answering them. If you do not wish to answer a question, you may skip it and go on to the next question, or you may stop at any time.

Compensation: No compensation will be provided for participation in this study.

Voluntary Participation and Consent: By completing this survey, you voluntarily agree to participate in the research and that the information about this study has been satisfactorily explained to you. You understand you have the right to withdraw or discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled.

Notice of Privacy Practice and Confidentiality: By completing this survey, you understand that any identifying information will remain anonymous and your answers will be kept confidential. Information collected will only be used for the research purposes outlined by this research information sheet. Please be advised that only aggregated results of this research will be published and presented.

Contact Information

This study has been approved by the Kent State University Institutional Review Board. If you have any questions or concerns about this research, please feel free to contact the principal investigator, Dr. Jeffrey S. Hallam at 330-6720679 or the Institutional Review Board at 330-672-2704. For more information about the program, or to speak with someone regarding your grief, please contact The Grief Recovery Method® toll-free at 800-334-7606.

This survey is designed to evaluate the content and face validity of items intended to measure four factors of The Grief Recovery Method®, a program that aims to influence grief and promote grief recovery in those who have experienced a death-associated loss.

These factors are identified as a griever's 1) knowledge, 2) attitudes, 3) beliefs, and 4) behaviors.

Below are definitions and terms used within the program. Please read the directions carefully and rate each item based on the instruction provided.

Grief is a normal and natural response to loss of any kind that can include conflicting feelings, thoughts, emotions, or patterns of behavior.

Directions: Using the criteria of representativeness **and** clarity, please read each of the following items associated with *grief* and rate each item based on the instruction provided.

Representativeness is the extent to which an item is representative of content appropriate to grief. On a scale from 1-4, with four being the most representative, please rate the level of representativeness for each item.

Clarity is the extent to which an item is easy to read and understand. On a scale from 1-4, with four being the most clear, please indicate the level of clarity for each item.

Representativeness
1 = item is not representative
2 = item needs major revisions to be representative
3 = item needs minor revisions to be representative
4 = item is representative

Clarity
1 = item is not clear
2 = item needs major revisions to be clear
3 = item needs minor revisions to be clear
4 = item is clear

[Space is provided for you below to comment on the item(s) or to suggest revisions]

Items		Representativeness				Clarity			
1.	Grief is a normal reaction to loss.	1	2	3	4	1	2	3	4
2.	Grief comes from a lifetime accumulation of things unsaid, undone, or unfinished.	1	2	3	4	1	2	3	4
3.	Grief is caused by the end of or a change in a familiar pattern of behavior.	1	2	3	4	1	2	3	4
4.	A common source of grief is the sense of incompleteness related to loss.	1	2	3	4	1	2	3	4
5.	Grief recovery is a series of small and correct action choices.	1	2	3	4	1	2	3	4
6.	It is not possible to heal from grief.	1	2	3	4	1	2	3	4
7.	Grief recovery means feeling better.	1	2	3	4	1	2	3	4
8.	Grief is associated with conflicting feelings, such as good and bad memories.	1	2	3	4	1	2	3	4
9.	In general, it is appropriate to feel sad about a loss.	1	2	3	4	1	2	3	4
10.	The quickest way to recover from a loss is to keep busy.	1	2	3	4	1	2	3	4
11.	When applicable, it is good to replace a loss. (For example: after a pet dies, get a new one)	1	2	3	4	1	2	3	4
12.	Overall, it is best to grieve alone.	1	2	3	4	1	2	3	4
13.	When someone is experiencing a loss, it is perfectly alright to tell the person, “Don’t feel bad.”	1	2	3	4	1	2	3	4
14.	After a loss, I must be strong for others.	1	2	3	4	1	2	3	4
15.	Time heals all wounds.	1	2	3	4	1	2	3	4
16.	Loss is a natural part of life.	1	2	3	4	1	2	3	4
17.	Loss is something to be afraid of.	1	2	3	4	1	2	3	4
18.	It is wrong to speak ill of the dead.	1	2	3	4	1	2	3	4
19.	I am the cause of incompleteness related to loss.	1	2	3	4	1	2	3	4

Comment(s)/Revision(s): _____
_____
_____

Grief recovery is a series of small and correct action choices that can be described as a process of personal growth after loss of any kind.

Directions: Using the criteria of representativeness and clarity, please read each of the following items associated with *grief recovery* and rate each item based on the instruction provided.

Representativeness is the extent to which an item is representative of content appropriate to grief. On a scale from 1-4, with four being the most representative, please rate the level of representativeness for each item.

Clarity is the extent to which an item is easy to read and understand. On a scale from 1-4, with four being the most clear, please indicate the level of clarity for each item.

Representativeness
1 = item is not representative
2 = item needs major revisions to be representative
3 = item needs minor revisions to be representative
4 = item is representative

Clarity
1 = item is not clear
2 = item needs major revisions to be clear
3 = item needs minor revisions to be clear
4 = item is clear

[Space is provided for you below to comment on the item(s) or to suggest revisions]

Items		Representativeness				Clarity			
1.	I have communicated things unsaid (For example: an apology or significant emotional statement)	1	2	3	4	1	2	3	4
2.	I have taken action to complete things undone. (For example: written a Grief Recovery Completion Letter or postscript)	1	2	3	4	1	2	3	4
3.	I have recovered things unfinished. (For example: forgiven or taken some measure of responsibility	1	2	3	4	1	2	3	4
4.	I have let go of unmet hopes, dreams, or expectations. (For example: said goodbye to pain related to loss)	1	2	3	4	1	2	3	4
5.	I have found new meaning for living to feel better. (For example: enjoy fond memories without the fear of being hurt)	1	2	3	4	1	2	3	4

Comment(s)/Revision(s): _____
_____
_____

Because The Grief Recovery Method® is comprised of four different factors, you are now being asked to indicate to which factor you believe an item belongs.

Directions: Using the operational definitions provided for each of the four factors below, please read each item and indicate to which factor you believe an item belongs by circling the appropriate number that corresponds to the factor.

Knowledge – facts or information about grief, loss, and death acquired throughout life
Attitudes – an established outlook or way of thinking about grief, loss, and death
Beliefs –pertaining to grief, loss, and death, the feeling or acceptance of something as true
Behaviors – actions or reactions in response to grief, loss, and death

Items		Factors			
		Knowledge	Attitudes	Beliefs	Behaviors
1.	Grief is a normal reaction to loss.	1	2	3	4
2.	Grief comes from a lifetime accumulation of things unsaid, undone, or unfinished.	1	2	3	4
3.	Grief is caused by the end of or a change in a familiar pattern of behavior.	1	2	3	4
4.	A common source of grief is the sense of incompleteness related to loss.	1	2	3	4
5.	Grief recovery is a series of small and correct action choices.	1	2	3	4
6.	It is not possible to heal from grief.	1	2	3	4
7.	Grief recovery means feeling better.	1	2	3	4
8.	Grief is associated with conflicting feelings, such as good and bad memories.	1	2	3	4
9.	In general, it is appropriate to feel sad about a loss.	1	2	3	4
10.	The quickest way to recover from a loss is to keep busy.	1	2	3	4
11.	When applicable, it is good to replace a loss. (For example: after a pet dies, get a new one)	1	2	3	4
12.	Overall, it is best to grieve alone.	1	2	3	4
13.	When someone is experiencing a loss, it is perfectly alright to tell the person, “Don’t feel bad.”	1	2	3	4
14.	After a loss, I must be strong for others.	1	2	3	4
15.	Time heals all wounds.	1	2	3	4
16.	Loss is a natural part of life.	1	2	3	4
17.	Loss is something to be afraid of.	1	2	3	4
18.	It is wrong to speak ill of the dead.	1	2	3	4
19.	I am the cause of incompleteness related to loss.	1	2	3	4
20.	I have communicated things unsaid (For example: an apology or significant emotional statement)	1	2	3	4
21.	I have taken action to complete things undone. (For example: written a Grief Recovery Completion Letter or postscript)	1	2	3	4
22.	I have recovered things unfinished. (For example: forgiven or taken some measure of responsibility	1	2	3	4
23.	I have let go of unmet hopes, dreams, or expectations. (For example: said goodbye to pain related to loss)	1	2	3	4
24.	I have found new meaning for living to feel better. (For example: enjoy fond memories without the fear of being hurt)	1	2	3	4

SURVEY ADMINISTRATION GUIDE (CFA)

Dear <Grief Recovery Specialist>,

A fellow *Grief Recovery Specialist*® and PhD Candidate at the Kent State University, College of Public, has developed a survey that will be used in future evaluation of The Grief Recovery Method®. This survey, called The Grief Recovery Method® and Outcome Instrument (GRMOI), measures respondents' self-reported knowledge, attitudes, beliefs, and behaviors (KABB) associated with grief, as well as the outcome of grief recovery and personal growth after loss. Each survey also asks respondents (i.e. group participants) to provide demographic information and to rate their mood at the time of taking the survey.

Preparing for Survey Administration:

Please carefully read the following information before the survey is administered. You may wish to read the following information aloud to respondents. If you do not wish to read the following information aloud, please direct respondents to review the research information sheet. This information must be understood by respondents in order to gain their consent to participate in the research.

Purpose: The purpose of the research is to validate an instrument for the future evaluation of The Grief Recovery Method®, a program that aims to reduce grief in those who have experienced loss.

Participant Eligibility: Individuals who are eligible to participate in this research study are 1) ≥ 18 years of age; 2) who are not currently employed at a hospice or palliative care center; 3) who have experienced a death-associated loss 4) who are not currently receiving grief-related or bereavement counseling services; 5) who are able to read, write, and speak English; and 6) who have either self-selected to receive the community-based grief recovery program **OR** have completed the community based grief recovery program within the last 25 years.

Procedures: You will be asked to complete a survey that should take 10-15 minutes of your time.

Benefits: You will not receive any direct benefit from participation. However, responses that you provide will help to identify the potential of The Grief Recovery Method® program to promote grief recovery in those who have experienced loss.

Risks and Discomforts: There are no anticipated risks associated with this study. However, some of the questions asked are about your personal experience with loss. These questions may be upsetting to you or may make you feel uncomfortable when answering them. If you do not wish to answer a question, you may skip it and go on to the next question, or you may stop at any time.

Compensation: No compensation is provided for participation in this study.

Voluntary Participation and Consent: By completing this survey, you voluntarily agree to participate in the study and that the information about this research has been satisfactorily explained to you. You understand you have the right to withdraw or discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled.

Notice of Privacy Practice and Confidentiality: By completing this survey, you understand that any identifying information will remain confidential. Information collected will only be used for the research purposes outlined by this research information sheet. Please be advised that only aggregated results of this research will be published and presented at scientific or professional meetings.

Contact Information

This study has been approved by the Kent State University Institutional Review Board. If you have any questions or concerns about this research, please feel free to contact the principal investigator, Dr. Jeffrey S. Hallam at 330-672-0679 or the Institutional Review Board at 330-672-2704. For more information about the program, or to speak with someone regarding your grief, please contact The Grief Recovery Method® toll-free at 800-334-7606.

Survey Accessibility:

Currently, the survey is available online and in print form. For the online version, it is recommended that respondents complete the survey on a personal laptop or desktop computer. However, smartphones may also be used.

General Administration Guidelines:

In order to ensure that valid and accurate data are collected, please be sure to follow these instructions in a consistent manner for each survey administration. You will only administer the survey once to each group that you facilitate.

1. Inform respondents that they will be asked to complete a survey as part of participating in your group. Explain that the purpose of the survey is to help make the program evidence-based.

2. Assure group participants that their survey responses will be kept private. All information collected from the survey will be analyzed and reported at an aggregate level, meaning for all respondents combined.

3. Please tell respondents that this is an anonymous survey and that any sensitive information that can be used to identify them will not be collected (i.e. name, SS#, and place of residence).

4. If necessary, you can read questions aloud to respondents.

5. Emphasize that this is not a test, and that we value each respondent's honesty.

6. Advise group participants to respond to the questions as best as they can. If respondents are uncomfortable with any of the questions or indicate they do not know how to respond, they may skip the question.

Survey Script:
Read the directions in the following script aloud to respondents before they begin taking the survey.

> *"The Grief Recovery Institute™ has partnered with the College of Public Health at Kent State University to invite you to participate in a research study on the Grief Recovery Method®. In doing so, we would like to learn about your knowledge, attitudes, beliefs, and behaviors associated with grief, grief recovery, and personal growth after loss.*

There are no right or wrong answers, so please be honest. Make sure to carefully read and answer each question. You will only be allowed to take the survey once, and will not be permitted to go back in the survey once you have completed a response. If you have any questions about taking the survey, please let me know."

When to Administer the Survey:
The following table indicates when the survey should be administered.

Program Type	When to Administer Survey
12-wk (group format)	At the end of the last session of the program **OR** the end of a current program you are facilitating.
10-wk (group format)	At the end of the last session of the program **OR** the end of a current program you are facilitating.
8-wk (group format)	At the end of the last session of the program **OR** the end of a current program you are facilitating.
6-wk (individual format)	At the end of the last session of the program **OR** the end of a current program you are facilitating.

Optional: For *Certified Grief Recovery Specialists*® who have maintained a personal database or email list of individuals who have previously completed the program (i.e. Alums).	In order to distribute the survey to past participants "alums" (one-onone or group), please use the **survey link** [not the paper PDF survey] and send it via email using the following verbiage that you may personalize. **PLEASE USE THE FOLLOWING VERBIAGE IN THE EMAIL:** Thank you for previously participating in The Grief Recovery Method®. As part of your participation, I invite you to take part in a research study by completing a brief survey on The Grief Recovery Method®. The survey should take about 10 minutes of your time and asks about your knowledge, attitudes, beliefs, and behaviors associated with grief, grief recovery, and personal growth after loss. There are no right or wrong answers, so please be honest and make sure to carefully read and answer each question. You will only be allowed to take the survey once, and will not be permitted to go back in the survey once you have completed a response. You may click the survey link at any time to participate: https://kent.qualtrics.com/jfe/form/SV_6z2VnQTZAcUkxSd

Survey Administration Tips:

Please DO:

- Be familiar with the survey administration guidelines.
- Please be able to answer any questions that may come from respondents.
- Direct respondents to carefully read and answer each question on the survey.
- Access to a laptop or desk computer is recommended to take the survey. However, if respondents choose to access the survey using their smartphones, please ensure privacy to the extent possible when completing the survey.
- In some instances, participants may agree to complete the survey at home or at a later time. If this is the case, you may wish to send a follow-up email or personal reminder that encourages individuals to participate.
- Offer to read or complete the survey on an individual basis for the respondent if needed (e.g., if language or reading is challenging for the respondent).

Please DON'T:

- Provide any personal opinions or comments regarding any survey items.
- Inform respondents to put any identifying information on the survey (i.e. name, SS#, and place of residence)

What to do when respondents (in-person) have completed the Survey: Thank all participants for completing the survey.

For additional information or if you have any questions with regard to how to administer the survey:

Please contact researcher:

Ms. Rachael Nolan, PhD Candidate, MPH, CPH
Kent State University, College of Public Health
750 Hilltop Drive, Lowry Hall - 3rd floor, Ste. #340 Kent, OH 44242
Phone: (330) 510-4940 Fax: (330) 929-6695
Email: rnolan1@kent.edu

Research Information Sheet (CFA)

This form will provide you with information on the research project, what you will need to do, and the associated risks and benefits of the research. Please read this form carefully. It is important that fully understand the research in order to make an informed decision.

Study Title: Evaluative Research of The Grief Recovery Method®

Principal Investigator: Jeffrey S. Hallam, PhD Candidate **Co-Investigator:** Rachael D. Nolan, PhD

Purpose: The purpose of the research is to validate an instrument for the future evaluation of The Grief Recovery Method®, a program that aims to reduce grief in those who have experienced loss.

Participant Eligibility: Individuals who are eligible to participate in this research study are 1) ≥ 18 years of age; who are not currently employed at a hospice or palliative care center; 3) who have experienced a death-associated loss 4) who are not currently receiving grief-related or bereavement counseling services; 5) who are able to read, write, and speak English; and 6) who have self-selected to receive the grief recovery program OR who have completed the grief recovery program within the last 25 years.

Procedures and Time Involvement: You will be asked to complete a brief survey that should take 5-10 minutes to complete. You will only be asked to complete this survey once. Your participation will not require any more time from you other than the time needed to complete the survey.

Benefits: You will not receive any direct benefit from your participation. However, answers that you provide will help to show effectiveness of the grief recovery program to promote grief recovery in those who have experienced loss.

Risks and Discomforts: There are no anticipated risks associated with this study. However, some of the questions asked are about your personal experience with loss. These questions may be upsetting or make you feel uncomfortable when answering them. If you do not wish to answer a question, you may skip it and go on to the next question, or you may stop at any time.

Compensation: No compensation will be provided for participation in this study.

Voluntary Participation and Consent: By completing this survey, you voluntarily agree to participate in the research and that the information about this study has been satisfactorily explained to you. You understand you have the right to withdraw or discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled.

Notice of Privacy Practice and Confidentiality: By completing this survey, you understand that any identifying information will remain anonymous and your answers will be kept confidential. Information collected will only be used for the research purposes outlined by this research information sheet. Please be advised that only aggregated results of this research will be published and presented.

Contact Information

This study has been approved by the Kent State University Institutional Review Board. If you have any questions or concerns about this research, please feel free to contact the principal investigator, Dr. Jeffrey S. Hallam at 330-6720679 or the Institutional Review Board at 330-672-2704. For more information about the program, or to speak with someone regarding your grief, please contact The Grief Recovery Method® toll-free at 800-334-7606.

You are being invited to participate in a research study presented by:

KENT STATE UNIVERSITY

College of Public Health

The Grief Recovery Method ®

by The Grief Recovery Institute®

In this study, you will be asked to complete a brief survey called The Grief Recovery Method® and Outcome Instrument. This survey measures your knowledge, attitudes, beliefs, and behaviors associated with grief and grief recovery, as well as your personal growth after loss. The survey also asks you to provide demographic information and to rate your current mood at the time of taking the survey.

Research Information Sheet

This form will provide you with information on the research project, what you will need to do, and the associated risks and benefits of the research. Please read this form carefully. It is important that fully understand the research in order to make an informed decision.

Study Title: Evaluative Research of The Grief Recovery Method®

Principal Investigator: Jeffrey S. Hallam, PhD Candidate

Co-Investigator: Rachael D. Nolan, PhD

Purpose: The purpose of the research is to validate an instrument for the future evaluation of The Grief Recovery Method®, a program that aims to reduce grief in those who have experienced loss.

Participant Eligibility: Individuals who are eligible to participate in this research study are 1) ≥ 18 years of age; 2) who are not currently employed at a hospice or palliative care center; 3) who have experienced a death-associated loss 4) who are not currently receiving grief-related or bereavement counseling services; 5) who are able to read, write, and speak English; and 6) who have either self-selected to receive the community-based grief recovery program OR have completed the community based grief recovery program within the last 25 years.

Procedures and Time Involvement: You will be asked to complete a brief survey that should take 5-10 minutes to complete. You will only be asked to complete this survey once. Your participation will not require any more time from you other than the time needed to complete the survey.

Benefits: You will not receive any direct benefit from your participation. However, answers that you provide will help to show effectiveness of The Grief Recovery Method® to promote grief recovery in those who have experienced loss.

Risks and Discomforts: There are no anticipated risks associated with this study. However, some of the questions asked are about your personal experience with loss. These questions may be upsetting or make you feel uncomfortable when answering them. If you do not wish to answer a question, you may skip it and go on to the next question, or you may stop at any time.

Compensation: No compensation will be provided for participation in this study.

Voluntary Participation and Consent: By completing this survey, you voluntarily agree to participate in the research and that the information about this study has been satisfactorily explained to you. You understand you have the right to withdraw or discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled.

Notice of Privacy Practice and Confidentiality: By completing this survey, you understand that any identifying information will remain anonymous and your answers will be kept confidential. Information collected will only be used for the research purposes outlined by this research information sheet. Please be advised that only aggregated results of this research will be published and presented.

Contact Information

This study has been approved by the Kent State University Institutional Review Board. If you have any questions or concerns about this research, please feel free to contact the principal investigator, Dr. Jeffrey S. Hallam at 330-6720679 or the Institutional Review Board at 330-672-2704. For more information about the program, or to speak with someone regarding your grief, please contact The Grief Recovery Method® toll-free at 800-334-7606.

I am ≥ 18 years of age and voluntarily agree to participate in this research.

Please circle one: **I agree** **I Do Not Agree**

Directions: Please respond below by either filling in the blank or selecting the best answer for each question.

In what year did you first participate in The Grief Recovery Method®?	(For example: 2013)
In what year did the <u>loss</u> occur for which you first participated in The Grief Recovery Method®? ……	(For example: 1991)
In what year were you born? ……	(For example: 1965)

Are you a Certified Grief Recovery Specialist®? Yes No

What is your gender?

Male Female Transgender Other

What category best describes you?

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic, Latino, or Spanish origin
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other race, ethnicity, or origin
- ☐ White

Directions: Below is a list of expressions that characterizes different levels of mood at a given moment. Please carefully read each expression from left to right and circle the number (0-6) that best reflects your current level of mood.

At this moment, I feel...

Tired	0	1	2	3	4	5	6	**Awake**
Content	0	1	2	3	4	5	6	**Discontent**
Agitated	0	1	2	3	4	5	6	**Calm**
Full of energy	0	1	2	3	4	5	6	**Without energy**
Unwell	0	1	2	3	4	5	6	**Well**
Relaxed	0	1	2	3	4	5	6	**Tense**

Grief is a normal and natural reaction to loss of any kind that can include conflicting thoughts, feelings, or emotions. The following section of the survey asks about your knowledge, attitudes, and beliefs, associated with grief.

Directions: Please consider the last time you participated in The Grief Recovery Method® and circle the number (1-5) that best reflects your agreement with each of the following statements.		**Strongly Disagree**	**Disagree**	**Neither Agree or Disagree**	**Agree**	**Strongly Agree**
1.	Grief is not a normal reaction to a loss.	1	2	3	4	5
2.	Grief comes from a lifetime accumulation of things unsaid, undone, or unfinished.	1	2	3	4	5
3.	Grief is caused by the end of or a change in a familiar pattern of behavior.	1	2	3	4	5
4.	A common source of grief is the sense of incompleteness related to loss.	1	2	3	4	5
5.	Grief recovery is a series of small and correct action choices.	1	2	3	4	5
6.	It is not possible to heal from grief.	1	2	3	4	5
7.	Grief recovery means feeling better.	1	2	3	4	5
8.	Grief is associated with conflicting feelings, such as good and bad memories.	1	2	3	4	5
9.	In general, it is appropriate to feel sad about a loss.	1	2	3	4	5
10.	The quickest way to recover from a loss is to keep busy.	1	2	3	4	5
11.	When applicable, it is a good idea to replace a loss. (For example: after a pet dies, get a new pet)	1	2	3	4	5

12.	Overall, it is best to grieve alone.	1	2	3	4	5
13.	When someone is experiencing a loss, it is perfectly alright to tell the person “Don’t feel bad.”	1	2	3	4	5
14.	After a loss, I need to be strong for others.	1	2	3	4	5
15.	Time heals all wounds.	1	2	3	4	5
16.	Loss is a natural part of life.	1	2	3	4	5
17.	Loss is something to be afraid of.	1	2	3	4	5
18.	It is wrong to speak ill of the dead.	1	2	3	4	5
19.	I am the cause of incompleteness related to loss.	1	2	3	4	5

Similar to conflicting thoughts, feelings, or emotions, grief can also include conflicting patterns of behavior when coping with loss. The next section of the survey asks about your behaviors associated with grief.

Directions: Please consider the last time you participated in The Grief Recovery Method®. When compared to your normal routine, please circle the number (1-5) that best reflects the likelihood that you ***more often*** engaged in each of the following behaviors to cope with loss.		**Extremely Unlikely**	**Unlikely**	**I don't know**	**Likely**	**Extremely Likely**
20.	Nicotine use [e-cigarettes, vapes, or chewing tobacco]	1	2	3	4	5
21.	Alcohol use [wine, beer, or spirits]	1	2	3	4	5
22.	Exercise [running, biking, or walking]	1	2	3	4	5
23.	Eating [consume foods high in fat, sugar, or salt]	1	2	3	4	5
24.	Smoking [cigarettes, cigars, or pipe tobacco]	1	2	3	4	5
25.	Sleeping [excessive sleep, fatigue, or insomnia]	1	2	3	4	5
26.	Illicit drug use [Marijuana, Cocaine, or Heroin]	1	2	3	4	5
27.	Gambling [internet, slots, or Keno]	1	2	3	4	5
28.	Meditation [prayer, Kundalini, or mindfulness]	1	2	3	4	5
29.	Shopping [online, in-stores, or on TV]	1	2	3	4	5

30.	Misuse of prescription drugs [pain relievers, stimulants, or sedatives]	1	2	3	4	5

Please identify any additional behaviors, not listed, that you ***more often*** engaged in to cope with loss:

Grief recovery is a series of small and correct action choices that can be described as a process of personal growth after loss. The final section of this survey asks about your grief recovery process from the loss you have experienced.

Directions: Please consider the last time you participated in The Grief Recovery Method® and circle the number (1-5) that best reflects your agreement with each of the following statements.		**Strongly Disagree**	**Disagree**	**Neither Agree or Disagree**	**Agree**	**Strongly Agree**
31.	I have communicated things unsaid. (For example: an apology or significant emotional statement)	1	2	3	4	5
32.	I have taken action to complete things undone. (For example: written a Grief Recovery Completion Letter® or postscript)	1	2	3	4	5
33.	I have recovered things unfinished. (For example: forgiven or taken some measure of responsibility)	1	2	3	4	5
34.	I have let go of unmet hopes, dreams, or expectations. (For example: said goodbye to pain related to loss)	1	2	3	4	5

35.	I have found new meaning for living to feel better. (For example: enjoy fond memories without the fear of being hurt)	1	2	3	4	5
36.	I am more self-reflective.	1	2	3	4	5
37.	I am a stronger person.	1	2	3	4	5
38.	I have changed my lifestyle for the better.	1	2	3	4	5
39.	I make more effort to help others.	1	2	3	4	5
40.	I value friendship and social support more.	1	2	3	4	5
41.	I am a more responsible person.	1	2	3	4	5
42	I have pursued new avenues of knowledge and learning.	1	2	3	4	5

Thank you for completing the survey on The Grief Recovery Method®.

GRM Trainer Email to Past GRM Recipients

Dear (previous GRM recipient):

As a past recipient of The Grief Recovery Method® program, you are being asked to participate in a research study on grief recovery.

In the study, each participant will be asked to complete an online survey about his or her personal experience with grief, death, and loss.

The survey should take about 10 minutes to complete.

To complete the survey:

- Please access the survey via the link www.----------
- Review the research information sheet and statement of consent.
- Please follow the directions and complete the survey
  You may complete the survey only once.

If you have any questions regarding this study or how to complete the survey, please feel free to contact me or the lead researcher on this study.

Rachael Nolan, Lead Researcher
Email: rnolan1@kent.edu

Thank you in advance for your participation.

FName LName
Certified Grief Recovery Specialist® - Trainer www.griefrecoverymethod.com

Toll-free 1-800-334-7606

Have you ever experienced the death of a loved one, family member, friend, pet, or colleague?

If so, you are being asked to participate in a research study on The Grief Recovery Method® by completing an online survey that asks about your personal experience with grief, death, and loss. The survey should take about 10 minutes to complete.

If you would like to participate by completing the online survey, please click the following link: www.----------. If you have any questions or would like more information about this study, please feel free to contact the researcher at the email listed below.

Email: rnolan1@kent.edu

Thank you in advance for your participation.

Ms. Rachael Nolan, Certified Grief Recovery Specialist®
Kent State University, College of Public Health
750 Hilltop Drive, Lowry Hall, 3rd Floor, Ste. #340
Kent, OH 44242

RACHAEL D. NOLAN, PhD, MPH, CPH

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EDUCATION

PhD in Prevention Science, College of Public Health, Kent State University, Kent, OH. Cognate Area: End of Life, Hand Hygiene, Minority Health, LGBT, Prognosis Communication, and Gerontology. Dissertation: *The Grief Recovery Method® Instrument (GMRI): Development and validation of the psychometric properties for construct validation of the treatment.* December, 2017.

Master of Public Health, College of Public Health, Kent State University, Kent, OH. Concentration in Social Behavioral Science. Professional specialization: Gerontology, Minority Health Marketing, Counseling, and Promotion. Practicum: *Minority Issues in Healthcare: Reaching disenfranchised populations*. December, 2015.

Bachelor of Science in Public Health, College of Public Health, Kent State University, Kent, OH. Major: Health Promotion, Education, Counseling, and Marketing. Minor: LGBT Studies. August 2013.

Graduate Gerontology Certification, College of Health and Human Sciences, Kent State University, Kent, OH. December, 2016.

Certified Grief Recovery Specialist®, The Grief Recovery Institute ™, Bend, OR.
Active: 1-1 Work, Group Programs, Helping Children Grieve Program, Pet Loss Program. January 2017.

Certified HIV Tester and Counselor, Testing No. #5438. Ohio Department of Health, Columbus, OH. August 2014.

Certified Public Health Educator, College of Public Health, Kent State University, Kent, OH. March 2013.

PRESENTATIONS

Nolan, R. *The Grief Recovery Method® Instrument (GMRI).* Oral presentation and poster presented to the American Death Education & Counseling Conference through Kent State University, Pittsburgh, PA. (April, 2018).

Nolan, R. *LGBT* after Loss.* Poster presented to the American Death Education & Counseling Conference through Kent State University, Pittsburgh, PA. (April, 2018).

Nolan, R. *The Salience of Death and Dying into a Public Health Discourse.* Oral presentation provided to the American Death Education & Counseling Conference through Kent State University, Pittsburgh, PA. (April, 2018).

Hallam, J., **Nolan, R.**, Chatfield, S., Boehm, G. Crawford, H., et al. *Process Evaluation of a Community-Based Participatory Research Approach to Hand Hygiene Research in A Healthcare Facility*. Poster presented to the American Public Health Association Conference through Kent State University, Atlanta, GA. (November, 2017).

PRESENTATIONS (continued)

Nolan, R. *LGBT Partner Bereavement.* CEU symposium sponsored by Akron/Canton Area Agency on Aging and presented to clinical counselors, Hartville, OH. (November, 2017).

Nolan, R. *Older Adult Sexuality.* CEU symposium sponsored by Akron/Canton Area Agency on Aging and presented to clinical counselors, Hartville, OH. (November, 2017).

Nolan, R. *Getting to Evidence-Based: A research update on The Grief Recovery Method®*. Oral presentation sponsored by The Grief Recovery Method® and presented to the 2nd Midwest Regional Grief Recovery Conference at the First Unitarian Universalist Church, Columbus, OH. (October, 2017).

Nolan, R. *A Qualitative Analysis on 'Coming Out' Experiences and Perceived Level of Community Supports of LGBT Persons.* Poster presented to the Ohio Public Health Association Combined Conference through Kent State University, Columbus, OH. (May, 2017).

Nolan, R. *A Qualitative Analysis on 'Coming Out' Experiences and Perceived Level of Community Supports of LGBT Persons.* Poster presented to the Graduate Student Symposium through Kent State University, Kent, OH. (April, 2017).

Nolan R, Umstattd Meyer MR, Spicer P, Hallam J**.** *Psychometric Properties of the Rural Active Living Perceived Environmental Support Scale (RALPESS): A confirmatory factor analyses.* Poster presented at the annual conference of the American Academy of Health Behavior Tucson, Arizona. (March, 2017).

Nolan, R. *Acute Care Nurses' Responses and Recommendation for Improvement of Hand Hygiene Compliance: A cross-sectional factorial survey research study.* Poster presented to the American Public Health Association Conference through Kent State University, Denver, CO. (October, 2016).

Nolan, R. *The Salience of Death and Dying into a Public Health Discourse.* Poster presented to the Ohio Public Health Association Combined Conference through Kent State University, Columbus, OH. (May, 2016).

Nolan, R. *Mental Health Disparity among the LGBTQ and Implications for Clinical Practice.* CEU symposium sponsored by Child Guidance and Family Solutions and presented to clinical counselors at Kent State University, Akron, OH. (April, 2016).

Nolan, R. *Considerations for the LGBTQ Approaching End of Life*. CEU symposium sponsored by Crossroads Charitable Foundation and presented to medical professionals at Crossroads Hospice, Cleveland, OH. (April, 2016).

Nolan, R. *Health and Sexuality among the Aging LGBTQ*. CEU symposium sponsored by the Alzheimer's Association, Greater East Ohio Chapter, and presented to Alzheimer research and care giving professionals, Hartville, OH. (June, 2015).

Nolan, R. *Diversity in the Workplace*. CEU diversity workshop sponsored by Crossroads Charitable Foundation and presented to medical professionals at Rose's Run Country Club, Stow, OH. (May, 2015).

Nolan, R. *Diversity in Aging*. CEU diversity workshop sponsored Veterans Administration (VA) and presented to medical professionals at Wade Park VAMC, Cleveland, OH. (March, 2015).

PRESENTATIONS (continued)

Nolan, R. *Caregiving of Older Adults*. CEU workshop sponsored by the United States Department of Agriculture (USDA), and presented to agricultural research service employees at the Ohio Research and Agricultural Development Center, Wooster, OH. (January, 2015).

Nolan, R. *Intimate Relationships among Aging Adults*. CEU diversity workshop sponsored by Crossroads Hospice and presented to healthcare professionals at Rose's Run Country Club, Stow, OH. (November, 2014).

Nolan, R. Guest Lecturer on "*Facing our Nation's Health Disparity Crisis*," CEU workshop at John Carroll University, Cleveland, OH. (September, 2014).

Nolan, R. *Same-Sex Partner Violence*. CEU diversity workshop sponsored by Direction Home Akron/Canton Area Agency on Aging and presented to the Area Agency Council, Hartville, OH. (August, 2014).

Nolan, R. Game Change Conference. CEU diversity workshop on prevalence of HIV/AIDS and health disparity within the LGBT older adult population, sponsored by the University of Akron and CANAPI, Akron, OH. (August, 2014).

Nolan, R. *Aging LGBT*. CEU diversity workshop sponsored by the Diversity Center of Northeast Ohio and presented to Metro Health Clinic, Cleveland, OH. (July, 2014).

Nolan, R. *Diversity over the Lifespan & Risk for HIV*. CEU diversity workshop presented to Mature Services, Akron, OH. (July, 2014).

Nolan, R. *Diversity in Aging*. CEU diversity workshop sponsored by Crossroads Hospice and presented to the Summit Senior Services Network (SSSN) at Kucko, Anthony Kertesz Funeral Home, Akron, OH. (June, 2014).

Nolan, R. *Working with LGBT Older Adults*. CEU diversity workshop sponsored by Info Line of Summit County and presented to healthcare professionals at Rose's Run Country Club, Stow, OH. (May, 2014).

Nolan, R. *Intimate Relationships and the Older Adult: Effective strategies to mitigate challenging behaviors*. Informal workshop presented to Catholic Charities and St. Joseph Care Center, Louisville, OH. (March, 2014).

Nolan, R. *Minority Health*. CEU diversity workshop presented to the Ohio's Aging Service Network, Uniontown, OH. (June, 2013).

Nolan, R. *Health Disparities*. CEU diversity workshop presented to the Ohio's Aging Service Network, Uniontown, OH. (June, 2013).

Nolan, R. *Mental Health Disparity of Gay Men in Two Counties*. Paper presented at the College of Health Sciences, Kent State University, Kent, OH. (May, 2012).

Nolan, R. *Working with the Elderly Gay Population.* Invited panel presented to the Ohio's Aging Service Network held during the meeting of the Area Agency on Aging 10b, Uniontown, OH. (January, 2010)

COLLEGIATE TEACHING EXPERIENCE

Capstone Experience, Health Disparities, Public Health Research Methods, Strategies for Prevention in Public Health

RESEARCH EXPERIENCE

2017-Present Construct Validation of the Theory of The Grief Recovery Method® in Those Who Have Experienced Loss, Kent State University (Dr. J. Hallam, PI). Original study.

2017-Present LGBT* after Loss: A qualitative analysis on the effect of bereavement on interpersonal relationships and subsequent partnerships (Dr. S. Chatfield, PI). Original study.

2017-Present The Grief Recovery Method® Instrument (GMRI): Development and validation of the psychometric properties for construct validation of the treatment, Kent State University (Dr. J. Hallam, PI). Dissertation study.

2016-2017 Prognosis Communication and the Terminally Ill Patient: A Case Study, Kent State University (Dr. M. Step, PI). Composition of published qualitative review for book chapter.

2015-Present Meta Summary and Quality Assessment of Hand Hygiene, Kent State University (Dr. S. Chatfield, PI). Composition of published qualitative review, intervention design, intervention implementation, community-based participatory research engagement, and presentation of findings.

2015-2016 Interpretative Phenomenological Exploration of the Experience of Hand Hygiene Described by Acute Care Nurses, Kent State University (Dr. J. Hallam, PI). Composition of published qualitative review for presentation of findings.

2014-2015 Disenfranchised Population Outreach, Direction Home Akron/Canton Area Agency on Aging, Kent State University (Dr. J. Hallam & Dr. D. Kerr PIs). Research facilitation, program development of an LGBT returning citizen and LGBT older adult outreach intervention, qualitative review, needs assessment, structured and unstructured interviews, professional development, community-based participatory research engagement, and initiation of the Health Inequalities and Disparities Effort (HIDE) community partnership.

2012-2013 Psychological Distress and Coping Mechanisms of White Gay Men, aged 21-49 of Northeastern Ohio, College of Health Sciences, Kent State University, (Dr. L. Wagner, PI). Qualitative assessment of the psychological effect of LGBT community separation and disillusionment from the former Akron Pride Center. Facilitation of research, survey design, administration, data analysis, and presentation of findings.

HONORS and AWARDS

2018 Graduate Paper Award, Association for Death Education and Counseling

2018 Graduate Student Award, Association for Death Education and Counseling

2018 Distinguished Graduate Scholar Award, Kent State University

2010–2018 President's List, Kent State University

2016 Public Health Practitioner's Choice Award, Ohio Public Health Association

2013 Summa cum Laude Graduate, Kent State University

2013 Distinguished College of Public Health Alumni Award, Kent State University

2012 Undergraduate Academic Excellence, Kent State University Stark

2011 Kathleen Wolf Award for Math Excellence, Kent State University Stark

PROFESSIONAL DEVELOPMENT

Board Membership

2016-Present Board Member, A Place for Us Development, LLC.

2014-Present Educational Ambassador and Steering Committee, Services, and Advocacy for GLBT Elders (SAGE)

2014-2015 Board Member, Outreach and Volunteer Coordinator of the Gay Lesbian Straight Educational Network (GLSEN).

Grant Writing

2016, 2018 Robert Woods Johnson Foundation (RWJF)

2014 Mobilization for Health: National Prevention Partnership Awards (NPPA)

2013 Roy Scrivner Memorial Fund

2011-2012 Gay Community Endowment Fund

2005-2010 Summit County Health Department through Ohio Department of Health (ODH)

Journal Reviewer

Family & Community Health
Aging & Public Health
American Journal of Public Health
Aging & Physical Activity
Journal of Nursing Measurement

Continuing Education

- Complicated Grief, Kent State Stark University, Canton, OH. April, 2017. (*3 hours*)
- Grief Recovery, The Grief Recovery Method®, Columbus, OH. January, 2017. *(20 hours)*
- Conference on Current Issues in LGBTI Health Research, Baldwin Wallace University, Berea, OH. August, 2014. (*15 hours*)
- Hurricanes within Rainbows - LGBTQI Intimate Partner Violence 101, First Christian Church, Canton, OH. June, 2014. (*3 hours)*
- Bureau of Infectious Disease HIV Prevention Counseling, Ohio Department of Health, Columbus, OH. June, 2014. (*8 hours)*
- Violence and the Offender, Northeast Region Local Coalition/Partners/DRC Facility and American Physiological Association. Canton, OH. June, 2014. (*4 hours)*
- Victim Assistance Online Training from the Office for Victims of Crime (OVC). Fairfax, VA. May, 2014. *(14 hours)*
- LGBT Victim Advocacy Training: Essential Skills and Core Competencies to More Effectively Assist LGBT Victims of Crime. Victim Assistance Program of Summit County. Akron, OH. May, 2014. (*40 hours)*

- SafeZone Training: Cultivating a Safe and Respectful Atmosphere for LGBTQ Consumers, Clients, Students, Staff, and Faculty, LGBT Community Center of Greater Cleveland, Cleveland, OH. March, 2014. (*4 hours)*
- HIV/AIDS Professional Education "Making It Count," Online Module from the Ohio Department of Health, Columbus, OH. March, 2014. (*3 hours)*
- Violence and the DSM, Area Agency on Aging 10b, Uniontown, OH. January, 2014. (*3 hours)*

Software Programs

SAS, SPSS, HTML, WordPerfect, Microsoft Office Suite (Word, Access, Excel, PowerPoint).

Affiliations and Memberships

Crossroads Hospice
Case Western Reserve Center for Reducing Health Disparities
Northeast Ohio Regional Advisory Group (NEORAG)
Summit County Reentry Network (SCRN)
Stark County TASC, Inc. (Treatment Accountability for Safer Communities)
Aids Resource Center (ARC)
Dare2Care
Akron Aids Collaborative
Summit County Health Department (SCHD)
Canton City Health Department (CCHD)
National Health Task Force (NHTF)
National Gay and Lesbian Task Force (NGLTF)
Community Aids Network Akron Pride Initiative (CANAPI)
The Lesbian Gay Bisexual Transgender Community Center of Greater Cleveland
Tri-County Aids Collaborative

PROFESSIONAL EXPERIENCE

2014-Present **Kent State University: Instructor and Researcher.** Part time instructor for the College of Public Health who conducts research under the direction of Associate Dean of Research, Dr. Jeff Hallam and Dean, Dr. Sonia Alemagno.

2014-Present **Court-Appointed Guardian: Summit County Probate Court.** Under the leadership of Judge Elinore Marsh Stormer, serves as an LGBT liaison, court-appointed advocate, and surrogate decision maker for persons deemed incapable of caring for his or her own interests due to incapacity, or disability within Summit County.

2014-Present **Services & Advocacy for GLTB Elders (SAGE): Educational Ambassador**. Provide training curriculum to corporations aimed at improving the quality of services and supports offered to LGBT older adults.

2010-Present **Direction Home Akron/Canton Area Agency on Aging: Diversity Trainer & Outreach Specialist**. Supports community engagement and awareness on special interest populations relevant to advocacy, education, health equity, cultural awareness, and continuing education events.

PROFESSIONAL EXPERIENCE (continued)

2014-2015 **Victim Assistance of Summit County: Victim Advocate**. Professionally trained advocate to support LGBTQQIA victims of crime through court advocacy, crisis intervention, and community resources.

2007-2010 **United Disability Services: Job Development Coordinator**. Development, marketing, and advocacy of community employment initiatives for individuals identified disabled and/or chronically ill.

2006-2007 **United Disability Services / PCPD: Family Support Specialist**. Distribution and marketing of community supports to administrate referrals for families identified as a having a disabled child or a child at risk.

2001-2005 **Akron General Medical Center: HIV/AIDS Research Assistant**. Evaluation, administration, and support to the Institutional Review Board on approved protocols of medical research.

PUBLICATIONS

Wandell S, Mullins W, Wilson C, Chatfield S, **Nolan R**, et al. Process evaluation of a community-based participatory research approach to hand hygiene research in a healthcare facility. *Am J Infect Control*. 2017; 45:108. doi:10.1016/j.ajic.2017.04.179.

Chatfield S, **Nolan R**, Crawford H, et al. Acute care nurses' responses and recommendations for improvement of hand hygiene compliance: A cross-sectional factorial survey research study. *Am J*
Infect Control. 2017; 45:s1-s6. doi:10.1016/j.ajic.2016.

Chatfield S, DeBois K, **Nolan R**, et al. Hand hygiene among healthcare workers: A qualitative meta-summary using the GRADE-CERQual process. *J Infect Prev*. 2016; 11:1-17. doi:10.1177/1757177416680443.

Chatfield S, **Nolan R**, Crawford H, et al. Experiences of hand hygiene among acute care nurses: An interpretive phenomenological analysis. *SAGE OM*. 2016; 4:1-9. doi:10.1177/2050312116675098.

Chatfield S, **Nolan R**, Hallam J. Hand hygiene intervention design recommendation derived from a cross-sectional factorial survey given to 460 acute care nurses. *Am J Infect Control.* 2016; 44:s3-s27.

Nolan R. Step M. Prognosis communication and the terminally ill patient: A case study in Real-Life Scenarios in Health Communication, *Oxford University Press*. 2016; 1:22-27. Available through: https://global.oup.com/academic/product/real-life-scenarios-9780190623258?cc=us&lang=en&

PUBLICATIONS (in-review)

Nolan R, Hallam J. (2017). Construct Validation of the Theory of The Grief Recovery Method® in Those Who Have Experienced Loss. *Manuscript submitted for publication*.

Nolan R, Hallam J. (2017). Development and validation of a self-report instrument to measure hand hygiene compliance behavior. *Manuscript submitted for publication*.

Nolan R, Hallam J. (2017). Mediation and the role of a Social Cognitive Theory (SCT) based worksite intervention to promote exercise behavior in sedentary women. *Manuscript submitted for publication*.

Nolan R, Hallam J. (2017). Validation of the exercise self-efficacy scale: A confirmatory factor analysis, 2017. *Manuscript submitted for publication*.

Nolan R, Johnson A, Reilly O, et al. (2017). A Systematic Review of High Utilizers, Mental Illness, and Cost across the Service Sectors of Healthcare, Homelessness, and Criminal-Justice Involvement. *Manuscript submitted for publication*.

Nolan R, Umstattd MR, Spicer P, et al. (2017). Psychometric Properties of the rural active living perceived environmental support scale (RALPESS): A confirmatory factor analyses. *Manuscript submitted for publication*.

SKILLS

- Preventative Health
- Minority Health
- Hand Hygiene
- Research
- Program Planning
- Risk Reduction
- Diversity Training & Inclusion
- Leadership & Workforce Development
- Community Outreach
- Implementation & Evaluation
- Health Advocacy & Promotion
- Volunteer Management
- Public Health
- Grant Writing
- Public Speaking
- Teaching
- Cultural Competency
- Behavioral Management

BIOSKETCH

Dr. Nolan is a highly trained public health and end-of-life professional, certified in grief recovery and gerontology, who has served as an advocate for the needs of dying individuals and their families, minorities, older adults, LGBT* folk, and the differently-abled. She has worked in the fields of Prevention Science Research, Thanatology, Health Education and Health Promotion for several organizations Ds. Nolan became certified in Public Health after receiving her MPH in Social Behavioral Science from Kent State University. Prior to receiving her MPH, Dr. Nolan graduated from Kent State University with a B.S. in Public Health Education and Promotion, with a minor in LGBT* studies. Currently, Dr. Nolan is in the College of Public Health at Kent State University where she teaches and conducts research in social behavioral and prevention science, end-of-life services, gerontology, and grief recovery. Dr. Nolan's interest in the field of grief recovery and end-of-life services manifested at a young age after the death of her grandparents. She has since continued to foster this interest by pursuing and maintaining various volunteer and professional roles that specifically address hospice and palliative care, and strive to increase the quality of life for those touched by a terminal illness or life-threatening condition. It is the aim of Dr. Nolan to promote the salience of hospice and end-of-life services into the public health discourse, as well as educate and train on the death-associated needs of a diverse aging population.