

Therapeutic Assessment With a Client With Persistent Complex Bereavement Disorder: A Single-Case Time-Series Design

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Ilaria Durosini¹, Anna Tarocchi², and Filippo Aschieri¹

Abstract

This article presents the results of a study into the effectiveness of therapeutic assessment (TA), a brief form of intervention that incorporates the results of assessment findings into psychological treatment. The history of Anthony, a man who reported symptoms of persistent complex bereavement disorder (PCBD), associated with major depression disorder (MDD) and post-traumatic stress disorder (PTSD), is presented. After his parents' deaths, Anthony became detached from reality, lost all pleasure in his everyday life, and found it impossible to overcome the devastating feelings related to the loss. Following TA principles, the assessor created a supportive and empathic relationship with Anthony and helped him attain his goals for the assessment. The assessment was monitored using a single-case quasi-experimental design with time-series analysis. Results of this study revealed a specific trajectory of Anthony's self-reported symptoms and a statistically significant trend toward improvement in severity at the end of the TA. This case study highlights the utility and efficacy of TA in helping clients process traumatic losses and complicated bereavements.

Keywords

therapeutic assessment, persistent complex bereavement disorder, single-case experiment, time series

I Theoretical and Research Basis for Treatment

Normal Grief

Grief is considered a universal and expected response to the loss of someone close. As painful as it can be, normal grief allows an emotional connection with others, the possibility to be soothed by family or friends, and an overall feeling of self-worth along with the awareness that the pain will diminish, leaving positive feelings and memories beside the painful ones. People who experience loss can initially expect a shock/denial reaction. Subsequently, individuals can search for the lost one, or can experience anger and bargaining. Depression and despair often follow the

¹Università Cattolica del Sacro Cuore, Milano, Italy

²Agenzia Tutela della Salute, Milano, Italy

Corresponding Author:

Filippo Aschieri, European Center for Therapeutic Assessment, Università Cattolica del Sacro Cuore, Via Nirone 15, 20123, Milano, Italy.

Email: Filippo.aschieri@unicatt.it

realization that the loss is permanent. Finally, the bereaved tend to accept and reintegrate the lost one into their memories and their everyday life. This is a signal that the grief has been processed (Kübler-Ross & Kessler, 2005).

Persistent Complex Bereavement Disorder (PCBD)

Traumatic grief (Jacobs, 1999), complicated grief (Shear et al., 2011), or unresolved loss (Bush, Cowan, & Cowan, 2008) account for cases in which bereavement becomes a severe stressor that triggers the onset of a mental disorder. The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association [APA], 2013) includes PCBD in the third section (Emerging Measures and Models) among the conditions that may require clinical attention. PCBD features two broad clusters of symptoms, one connected to the loss, and the other connected to adjustment difficulties in everyday life (Rosner, Pfoh, & Kotouová, 2011). Six of the PCBD symptoms, if lasting in excess of 12 months, warrant the diagnosis of PCBD in adults.

Literature has shown that PCBD is a relatively diffuse condition, and its psychological, cognitive, and emotional features are connected with alterations in neurobiological functions (Gündel, O'Connor, Littrell, Fort, & Lane, 2003). Epidemiological studies have revealed the occurrence of unresolved loss in 2.4% and 4.8% of the general population (Newson, Boelen, Hek, Hofman, & Tiemeier, 2011), with predominance in female subjects. Research conducted on individuals in mourning shows that normal bereavement evolves into a PCBD in 10% to 20% of the cases (Shear et al., 2011; Zisook & Shear, 2009).

Risk Factors of PCBD

Research has indicated individual, relational, contextual, and cultural variables influencing the development of PCBD. Individuals with psychiatric illness (Ellifritt, Nelson, & Walsh, 2003) or a history of a mood disorder are more inclined to develop PCBD (Simon et al., 2007). Personality features such as low self-esteem (Boelen, Keijsers, & van den Hout, 2012), poor prospects for the future after the loss (Golden & Dalglish, 2012), a marked tendency to react negatively to unpredictable situations, and emotional distress (Boelen, 2010) also increase the risk of developing PCBD. Attachment theory also suggests that individuals with insecure early life attachments, characterized by anxious/ambivalent or disorganized/disoriented attachment patterns, show an increased risk of developing complicated grief upon the death of a significant person in adulthood (Vanderwerker, Jacobs, Parkes, & Prigerson, 2006). Among relational factors, the grief process is influenced by low perceived social support at the time of the bereavement (Ellifritt et al., 2003), and low marital supportiveness (Van Doorn, Kasl, & Beery, 1998). Contextual elements related to the circumstances of the loss such as sudden, premature, and unexpected deaths, particularly when associated with violence, suicide, murder, or protracted illness are predisposing to PCBD. Other risk factors of unresolved loss included being absent at the time of death, or the absence of comfort and care for the person who passed away (Dell'Osso, Carmassi, & Shear, 2013). Finally, religious and cultural factors play a major role in the processing of loss for particular groups of individuals (Shear et al., 2011).

Comorbidity and differential diagnosis of PCBD. Simon and colleagues (2007) showed that 75.2% of patients with complicated grief develop at least one Axis I *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM-IV-TR*; APA, 2000) disorder, in particular post-traumatic stress disorder (PTSD) and major depression disorder (MDD). PTSD and PCBD tend to co-occur when the loss is unexpected and its circumstances are traumatic, and their common feature is the presence of intrusive fantasies and thoughts connected to the death. However, in PTSD, the core aspect is the traumatic experience connected to the violent, sudden, or

unexpected death: Intrusive thoughts are anxiety-provoking hyperarousal symptoms related to negative sensory or cognitive-emotional issues derived from the trauma, and fear and avoidance behaviors are primary. On the contrary, in PCBD, the core aspect is the loss of a loved one, accompanied by sadness, and melancholy. Intrusive thoughts have a bittersweet flavor and are associated with unfulfillable wishes that the deceased could be present and with remembrances of events stored in the long-term memory. Comorbidity between PCBD and MDD prolongs the duration and increases the severity of depressive symptoms, decreases the level of functioning, and leads to an overall worse prognosis. In PCBD, despair is mainly due to the loss, while in MDD, despair is generalized and covers various areas of the subject's everyday life, including self-worth and self-image (Rosner et al., 2011).

Therapeutic assessment (TA) and the treatment of PCBD. Therapeutic assessment¹ (Finn, 2007; Frackowiak, Fantini, & Aschieri, 2015) is a semi-structured brief intervention that incorporates assessment and results in a transformative and growth-oriented process based on intersubjective and humanistic principles. TA with adult clients follows a five-step structure: (a) collection of assessment questions, (b) administration of standardized tests and an extended inquiry procedure, (c) intervention sessions, (d) summary and discussion session, and (e) follow-up.

The aim of PCBD treatment is to “identify and resolve conflicts of separation that interfere with the completion of mourning tasks in individuals whose grief is absent, delayed, excessive or prolonged” (Worden, 2002, p. 101). Treatments for PCBD with the most positive effects are complicated grief therapy (CGT; Shear, Frank, Houck, & Reynolds, 2005), family focused grief therapy (FFGT; Kissane & Bloch, 1994), interpersonal therapy (IPT; M. D. Miller et al., 1994), cognitive behavioral therapy (CBT; Boelen, De Keijser, Van den Hout, & Van den Bout, 2007), trauma focused- cognitive behavioral therapy (TF-CBT; Cohen, Mannarino, & Staron, 2006), or treatments that blend different elements from such approaches. For example, Wyman-Chick (2012) documented significant clinical improvement in a woman with depressive symptoms and complicated grief through the combined use of IPT and CBT. Stevens and Michael (2014) highlighted the significant reduction in symptoms and impairment in daily living for an adolescent with PTSD and childhood PCBD through TF-CBT. Also, Vergara-Lopez and Roberts (2015) described the effectiveness of Behavioral Activation (BA; Jacobson, Martell, & Dimidjian, 2001) for a client with MDD and PCBD. Crucial therapeutic techniques are interrupting brooding and intrusive thoughts connected with the loss, expressing and processing unelaborated affect states, re-orienting clients on the present and on the future, and re-investing in supportive and positive family relationships.

When used with clients who suffer from unresolved grief, TA is potentially suitable for clients who have unresolved losses.

In the initial session(s), the client and assessor use assessment questions to formulate the struggles and problems in life they wish to address during the process. In the context of clients who brood over intrusive memories and painful flashbacks, formulating assessment questions orients them on the here and now and helps to shift their focus from the past to the present and future. Standardized testing is selected to address the clients' questions, and with those experiencing complicated bereavement, particular attention is devoted to testing that illuminates unelaborated states of anger and sadness. Clients are helped to access such states by extended exploration of performance-based tests (such as the Rorschach or other storytelling tasks) and to process them with the assessor's support. In the assessment intervention session(s), assessors bring the problem behavior into the room, where it can be observed, explored, and addressed through various therapeutic interventions. With clients who suffer from unresolved losses, intervention sessions serve a variety of goals, including regulating emotions (e.g., teaching clients not to be overwhelmed and re-traumatized by memories), accessing dissociated states (e.g., expressing sorrow, anger, or pain to the deceased within a safe, supportive environment), sharing and

narrating traumatizing memories or images (e.g., helping clients to share and explore episodes of their life that have not been processed), or identifying behavioral changes to be implemented when clients are confronted with disturbing emotions (e.g., teaching clients self-help techniques to regulate emotions and maintain an organized behavior). In all these cases, testing materials (e.g., Rorschach cards, thematic apperception test [TAT] cards, other narrative test materials, or other techniques such as empty chair, family sculpting, or the sort) are used and linked to the client's questions. Then, in the summary/discussion session(s), individualized feedback is given, following the questions collected earlier in the process. Finally, prior to a follow-up session, the clients receive a written report summarizing the answers to the assessment questions and the recommendations for treatment.

Empirical research of TA highlights its effect for symptom reduction, increase of hope in the treatment, improvement in self-esteem, in adherence to treatment recommendations, and in alliance with the assessor and subsequent therapist (see, for a review, Aschieri, De Saeger, & Durosini, 2015; Smith, Eichler, Norman, & Smith, 2015). Recent updates concern studies about state-like and trait-like features of self-curiosity (Aschieri & Durosini, 2015; Aschieri, Durosini, Locatelli, Gennari, & Smith, 2016), the effectiveness and utility of TA on treatment engagement of clients with severe personality disorders (De Saeger et al., 2014) and substance abuse disorders (Blonigen, Timko, Jacob, & Moos, 2015), and the utility of TA as a consultation on symptom reduction and engagement in treatment with clients currently in psychotherapy (Smith et al., 2015).

2 Case Introduction

Anthony was a 51-year-old Italian cardiologist, married for 25 years to Silvia. They had two daughters, aged 16 and 13 at the time of the assessment. He did not report quarrels with his wife nor any major personal problems until the death of his mother, 6 years prior to the assessment. After she passed away, Anthony dedicated himself to caring for his widowed father, who had fallen into depression. Five years after his mother's death, his father had a fatal heart attack. This second loss made Anthony feel he was adrift, lacking purpose and prospects, to the point that a year after his bereavement, he left home, no longer able to control the flashbacks related to his grief.

Silvia initially sought support for dealing with her husband's behavior at the Counseling Center. Anthony started living alone in another house, while denying involvement in extramarital relationships or having reasons for dissatisfaction in the marriage. He made almost regular visits to his wife and children, behaving in the house as if nothing had changed. The psychologist at the Counseling Center proposed couple's counseling to try to understand the reasons for such behavior. Silvia agreed but Anthony did not. While Silvia started supportive treatment for herself, Anthony agreed to see a psychologist at the same center for an individual session only after a lot of pressure from his wife.

3 Presenting Complaints

In the first individual session, Anthony reported that he had no psychological issues nor particular problems prior to his parents' deaths. Both parents died from myocardial infarction. Since then, Anthony lost all pleasure and direction in life. At the time of the assessment, Anthony shifted between the desire to "disappear" and "to go away without leaving any trace of himself," and feeling obliged toward his family, for whom he still felt a sense of responsibility. He felt he lacked a point of reference since the death of his father and that he no longer had anyone "to whom he was accountable." He felt he was still able to function at work, which absorbed him and was a place where he could escape from the negative thoughts that otherwise overwhelmed him.

Otherwise, in his daily life, reminders of his parents' deaths were elicited by every stimulus related to the circumstances of discovery (e.g., an ambulance siren), to his orphan status (church bells, a film about family), or to the family itself (e.g., having dinner with his family). Living at home was particularly challenging when he had to face potential conflicts, for example, with his elder adolescent daughter when he had to scold her for leaving her room messy. The memories of his parents' deaths were terribly intrusive, and he could not stop reliving the experience, obsessively wondering if he had done everything possible, knowing well, as a medical doctor, that there was nothing different he could have done. The only refuge from his thoughts, apart from his work, was to "withdraw into his ball," curling up in the dark, wearing headphones with the volume at full blast, or dulling his senses through physical activity.

4 History

Information in this section emerged at various points during the assessment, not only during the initial interview. As an only child, Anthony described his family as traditionalist in terms of values and closed in terms of emotional exchange. During the first years of his life, since both of his parents worked full time, he was entrusted to the care of his maternal grandmother, whom he described fondly. The extended family had a history of cardiovascular disease. Anthony remembered deciding to study medicine when he was still in elementary school, and his grandmother telling him "I hope you will take care of me when you grow up"; he dreamed of finding the cure to her cardiac problems. He recalled his emotional distress at her death, when he was 8 years old, and said that in the months that followed, he got up frequently during the night to make sure his parents were still breathing. After his grandmother's death, Anthony became very self-sufficient, and his responsibilities grew, as he spent his days at home alone awaiting his parents' return.

He reported experiencing a quiet adolescence, in part, he said, because he did not want to fatigue his mother, who appeared to suffer from depression. He described himself as a diligent and studious boy; he took his degree in medicine, and specialized in heart surgery. Thanks to the energy he dedicated to his patients, he soon became very popular in the hospital unit where he was working. Since the two losses, he kept working without enthusiasm, and decided to leave home 1 year before the assessment.

5 Assessment, Case Conceptualization, and Course of Treatment

This section describes the process of the TA with Anthony. Our description starts with the first contact between Anthony and the assessor who later conducted the TA with him. In that session, the assessor screened his PCBD symptoms and once Anthony became eligible for inclusion, the assessor proposed him to participate in the research program on TA with clients with PCBD. In the subsequent paragraphs, we describe the progression of the TA and sharing the results of the psychological assessment, which is the centerpiece of the model. We then describe the single-case time-series experiment and discuss the results, which were used to empirically assess Anthony's progress and determine the effectiveness of the TA.

The First Contact With Anthony and the Definition of the Rating Scales

Anthony turned to the counseling service without optimism, just to please his wife who had asked him to do it, as she was worried about his inexplicable behavior and was troubled by his absence. During the initial interview, Anthony showed the six criteria needed for a PCBD diagnosis according to *DSM-5* (APA, 2013). Most of the symptoms had been present for 2 years, and, in the past year, the frequency of their manifestation had increased. Seven of the nine Criterion C symptoms (cognitive, emotional, and behavioral symptoms) were still present. He felt confused about his own

identity, as he was assailed by doubts about whether he was a good husband and was worried that he had not lived up to his parents' expectations as a son (C.1). He showed difficulty accepting the loss of his two parents, obsessively mulling over the circumstances of their deaths, and how and if they could have been avoided (C.2). He did not trust the people close to him; their concern bothered him, and he was quite open to the assessor about his skepticism concerning the usefulness of the psychological counseling (C.4). He had feelings of bitterness and anger with regard to his losses, alternating between turning his anger toward himself and toward what he felt was an undeserved fate (C.5). While still able to function at work, he no longer felt the motivation he had before his bereavements, and he no longer had career aspirations or plans for the future (C.6). He reported that he could not find a direction in his life, as he was no longer accountable to his father for his actions (C.8). He described finding relief for his pain by "withdrawing into his ball," a state of numbness and detachment from reality in which he took refuge and found solace (C.9).

Anthony's report suggested comorbidity of PCBD with PTSD and with symptoms of MDD (Zisook & Shear, 2009), that were later confirmed by information emerged during the TA. With regard to the PTSD, Anthony was in both cases the one to find the dying parent and had recurrent flashbacks of when his parents were rushed to the hospital. He felt intense guilt about how both parents died, blaming himself for not spending enough time with his father, thereby forestalling the possibility of his father being alone at the time of the heart attack. He became very emotionally reactive, and among the reasons behind his leaving home was his distress at seeing his daughters smile and his losing control with them over issues that in other periods in his life would not have led to such consequences. Finally, despite being a religious believer, he avoided Mass to avoid memories of his parents. With regard to MDD, Anthony felt emotionally drained and, despite being able to work at the hospital, complained of a loss of interest and pleasure in his personal activities, insomnia, low energy levels, difficulty in focusing, and a deep feeling of despair.

Given the preponderance of grief and a score of 19 in the Patient Health Questionnaire (PHQ-9; Kroenke, Spitzer, & Williams, 2001), participation in a study for the evaluation of the efficacy of TA was proposed to Anthony. After he completed the informed consent procedures, the research program required part of the first session to be devoted to defining his subjective view of the most disturbing aspects of his condition. He agreed to evaluate his psychological state using rating scales according to 5 indicators rated, on a daily basis, using a Likert-type scale ranging from 0 (*absence*) to 10 (*highest level*) for each state. The research project included three indices typical of bereavement (*sense of loneliness, level of suffering, missing of the deceased person*) for all participants, and two additional indices defined in agreement with each patient.

Anthony identified the "ball" state and the sense of failure as important aspects for him. Thanks to his "ball," Anthony managed to keep the intrusive thoughts about his grief and the destructive emotions connected with it at bay. In his "ball," for example, he went to the gym and ran on the treadmill to the point of exhaustion, closed all the blinds and curled up in the dark, put on headphones, and listened to very loud music. The sense of failure was related both to the circumstances of his parents' deaths, which he could do nothing to prevent, and to his self-reproach for not having done enough when they were alive, and for no longer being able to perform as a husband and father. Anthony also agreed to complete the Outcome Rating Scale (ORS; S. D. Miller, Duncan, Brown, Sparks, & Claud, 2003), which is a brief, self-report measure used in psychotherapy outcome research to evaluate (a) sense of well-being, (b) sense of personal well-being, (c) sense of well-being in intimate relationships, and (d) sense of well-being in social relationships, with the assessor before each of the following sessions.

Session 1 and 2: Collection of Assessment Questions (Step 1) and the Minnesota Multiphasic Personality Inventory-2 Restructured Form (MMPI-2 RF; Step 2)

The actual TA started when Anthony met with the assessor to define his assessment questions. At the onset of the first TA session, Anthony started complaining about how hard it was for him to

complete his rating scales. He expressed that capturing his emotions on paper stirred up a feeling of lacking people with whom to talk to about whether or not he was behaving well in his daily life. In line with the TA principles of investigating clients' concerns to develop the assessment questions, the assessor explored the question of whom, after his parents passed away, Anthony was able to turn to for guidance and advice about his life. He immediately disclosed how anguished he still felt since his parents' deaths and about the absence of any one able to replace them. He spoke with sadness and anger about the delay in medical care right after they were hit by their heart attacks. He felt responsible and guilty as well for his choice of the emergency room to which he took them, and said he kept on brooding on how he might have saved his parents had he chosen differently. He connected these feelings to his withdrawal from his home. On one hand, he said he did not feel worthy of his daughters' love. On the other hand, he left home because he wanted to protect them from suffering at the moment of his own death. The assessor mirrored the level of his pain and how she felt he deserved to take good care of himself after all the suffering he went through. He replied he felt guilty about taking care of himself, and he felt that if he did so, everything around him might have fallen apart. He said he was afraid that taking care of himself would have exposed his wife and daughters to suffering and that he was, instead, trying to protect them from that by withdrawing from them. So Anthony and the assessor agreed to formulate the question: "Why do I feel that taking care of myself is in contrast to taking care of others?" At the end of the session, the assessor asked him to complete the Minnesota Multiphasic Personality Inventory-2 Restructured Form (MMPI-2 RF, Tellegen & Ben-Porath, 2011) in the testing room, to be able to score it immediately and use it to better understand Anthony's subjective experience in the subsequent sessions.

Prior to the second session, the assessor interpreted his MMPI-2 RF and noted the presence of four suicidal items (e.g., Anthony answered as *true* Items 93 "I have recently considered killing myself" and 164 "Lately I have thought a lot about killing myself") and serious indicators of suicidal risk (Demoralization = 83 T; Low Positive Emotions = 81 T; Hypomanic Activation = 69 T; Suicidal/Death Ideation = 96 T; Helplessness/Hopelessness = 87). During the second session, after checking in with Anthony, the assessor decided to suspend the administration of other testing tools and, instead, raised the issue of self-harm with him. Anthony immediately started listing a number of triggers for suicidal thoughts, particularly his guilt and the memories of his parents' deaths. He connected this vulnerability to flashbacks to his "entering into a ball." When he entered in his "ball," he felt protected from contact with external stimuli. In the "ball," he could feel detached from his emotions and numb to his own thoughts. As frequently happens in TA, assessment questions can emerge in any part of the assessment, and hence, Anthony and the assessor took advantage of this information to formulate a second question: "Which thoughts am I trying to avoid when I enter in my ball?" The remaining part of the session was devoted to discussion of his MMPI-2 RF results. He said he wished he was dead, but that he was not really thinking about actively taking his own life. Despite the high Demoralization, Suicidal/Death Ideation, and Helplessness/Hopelessness scores, Anthony did not want to visit a psychiatrist and said that he was already taking antidepressants prescribed by his family doctor. He said he wanted to finish his assessment prior to deciding whether to let all his hopes drop (either abandoning his family or killing himself) or finding himself able to take on his life again. The assessor and Anthony agreed upon a contract whereby if despair took over, he would call her at any time, as well as request assistance from his wife. The other relevant aspect of his MMPI-2 RF was anger. Despite not feeling the internal signals of anger (Anger Proneness = 55 T) and not being familiar with using assertiveness for adaptive purposes (Aggressiveness = 46 T), he lamented high levels of aggression in terms of acting-out behaviors (Aggression = 81 T). When asked about this last finding, Anthony said he left home when he felt he risked losing control over his behavior toward his daughters. For example, he was close to physically assaulting his older daughter because he could no longer tolerate finding her clothing out of her room.

Session 3: Early Memories Procedures (EMP; Step 2)

The EMP (Bruhn, 1992a, 1992b) explores autobiographical memories in the form of a journaling exercise. As such, it has been found useful to elicit and process traumatic memories, in written or verbal form, with the assessor's supportive presence. The assessor introduced the EMP to Anthony by saying that, sometimes, the roots of the balance between how we take care of ourselves and how we take care of others resides in our early experiences, and to help answer his question, "Why do I feel that taking care of myself is in contrast to taking care of others?"

Anthony started taking the test but the assessor noticed his distress after completing the first of the six episodes required and interrupted the procedure. He said he got overwhelmed recalling an episode in which, aged 4, his grandmother stumbled on him. He said he still felt terrible for having hurt her, as she was his primary caregiver. He felt bad also because a part of himself saw that episode as funny. He said she was the first person he disappointed in his life: She used to tell him, "You will take care of me when I am old." Instead, she died few years later and since then, he started to be concerned by death, for example, he visited his parents' bedroom at night to make sure they were breathing. The assessor mirrored the deepness of his bond with his grandmother and noticed he did not get a lot of support from his family after her death. He said he became a sort of "lone soldier," task oriented, not used to being taken care of or cared for emotionally.

Session 4: Extended EMP Inquiry (Step 2)

The assessor's goal was to complete the extended EMP inquiry with Anthony. Instead, Anthony came into the session commenting on how he had felt overwhelmed during the whole week by all the memories of the different losses he had witnessed. Not just in his own family, but also in his early years of work, when he assisted dozens of families who lost young children to heart problems. Anthony vividly described some of the episodes in which he witnessed and interacted with families who lost their children. The assessor asked him if he had received support for this series of losses, and Anthony said that its absence fit with his skills of being a "lone soldier of grief." The assessor disclosed how hard it was even for her to contain all the grieving he was harboring and that she was amazed by how he did such a job alone. He said he never saw any other options than to be a "lone soldier of grief," and asked the assessor what her alternative was in her job when she had to contain the emotions connected to her clients' pain. She replied that she could rely on a group of colleagues and one supervisor to share and contain the pain she encountered both in her work and in her private life.

Anthony and the assessor started to think about the implications of him sharing his feelings of grief with her as well as with others. The assessor decided to use a portrayal technique with Anthony. In TA, assessors often base portrayals with clients on their responses to testing, bringing the examples to life and allowing clients to reprocess therapeutically emotionally charged images and memories. The assessor asked Anthony to think back to the episode he reported at the EMP, and to consider what might have happened differently in other families after the loss of a beloved grandmother. Together, they explored the possibility that parents in other families might have checked in on their child at night instead of leaving the child overwhelmed by his fears and anxiety. Considering this possibility, Anthony expressed mixed feelings of relief ("this makes me feel less guilty for having disappointed my grandma") and sadness (for the lack of support he experienced).

Session 5: Assessment Intervention Session (Step 3)

The assessor planned the Assessment Intervention Session with the aim of addressing Anthony's question about how to balance taking care of himself while attending to others' needs. To do so,

following the principles that guide the planning of the intervention session in TA (see, for specific techniques, Aschieri et al., 2016; Tharinger et al., 2008), the assessor planned to show him a number of pictures selected from the Internet depicting people interacting with each other, and asked him to tell stories about them. The assessor expected Anthony to avoid the “individual needs-based” negotiation among participants, and hoped to work with him on integrating assertiveness in his representation of relationships.

The first picture showed a couple depicted from behind, looking at a landscape. His first story was about a father and a daughter, the father did not realize that his daughter was bored spending time with him (instead of seeing her friends); the daughter was thinking of killing her father and going away. The assessor mirrored and validated the daughter’s frustration and asked Anthony what the daughter could have done to signal her needs to her father. He said that the father in the picture probably knew she was suffering, but that he was “lost in time,” full of his own memories from the past, and had lost contact with his daughter. The assessor asked Anthony if this story paralleled to some extent his own experiences. He said that as a child, he remembered his mother taking the lead on the family’s activities. The only exception he recalled was when he was a teenager and he told his parents that he wanted to give up spending holidays with them at their house on the seaside. He remembered his grief when his parents sold that house right after he expressed his need. Anthony confessed that he was surprised to hear that the assessor “was on the adolescent’s side” in the story, and the assessor repeated that she felt that his anger was a normal and adaptive emotion in such a situation. She asked Anthony if his difficulty in taking care of himself while attending to others’ needs had emerged when he learned that expressing his own needs led to others’ sacrificing themselves (in this case, his parents selling their house). Anthony and the assessor then discussed for the remainder of the session his fear that his desires might have wounded or hurt others, and the assessor commented that it also depends on the others to take care of themselves. At the end of the session, Anthony expressed that his ambivalence between re-approaching his family and interrupting all his ties with them was stronger than ever.

Case Conceptualization and Brief Summary of TA Results

Anthony’s assessment showed the consequences of a number of unresolved losses (in both his personal and professional lives). Starting with the loss of his grandmother, he took on a caregiving role with his parents and did not perceive concern on their part for his feelings. In addition, he experienced his family environment as too weak to contain and contend with his needs. His MMPI-2 RF illuminated the outcomes of unprocessed loneliness and pain and of his fear of expressing anger. The EMP exemplified, in the memory of the seaside house, his belief that his needs would have hurt his family, and such memory mirrored his fear that his anger might hurt his daughters. In terms of the grieving process, Anthony seemed to be stuck around anger. He could not direct his anger against the lost ones and, instead, turned it against himself. Doing so, he maintained an idealized view of others, and avoided contact with the negative emotions he harbored against them during their life together. His lack of interpersonal support, and shame for his unacceptable feelings of anger and loneliness were getting in the way of finding the necessary help to start processing his losses and traumatic separations.

Session 6: Summary and Discussion

The assessor and the client examined Anthony’s assessment questions in the light of test results. The assessor began the summary and discussion session by acknowledging Anthony’s openness and availability during all the phases of TA. The dialog then turned to his first TA question: “Why do I feel that taking care of myself is in contrast to taking care of others?” The answer to his question included his inability to pay attention to himself, due to the fact he learned to satisfy others’

needs instead his own. Since early on in his life, he took responsibility for others' needs (e.g., his grandmother's health), and he started to set aside the sorrow for his own bereavements and, instead, took care of others' pain (e.g., checking that his parents were sleeping well). In his words, he became a kind of "soldier of grief." Also, later on in his life, by working as a medical doctor, Anthony had ample exposure to mourning. After his own parents' deaths, Anthony felt the need to shield his loved ones from suffering, and he left home to accustom his family to his own future inevitable passing away. While delivering him this answer, the assessor frequently checked his emotional reaction to such a new narrative about himself. Anthony alternated between moments of careful listening, and moments in which he let his emotions of sadness and grief emerge when asked how he was doing by the assessor.

Anthony's second question ("Which thoughts am I avoiding when I enter in my ball state?") was related to the tendency to isolate himself from surrounding stimuli. Over the years, Anthony used the "ball" state as a shield to separate himself from an intolerable life experience and to recharge his energies. The contact with death led Anthony to feel detached from his emotions and numbed to his own thoughts. Anthony received protection through the "ball" state, as a dissociative experience. The emotional support from the assessor gave Anthony the possibility to drop his "soldier of grief" armor and to express his dangerous feelings. Anthony verbalized for the first time a slight critique to his parents ("I wonder if they knew that I was so alone with my pain for the death of my granny"), and the assessor supported his expression of this feeling wholeheartedly. The session concluded with a reflection on the importance of sharing feelings and emotions. Despite Anthony stating that he felt "strange" that his emotional expressions were supported by the assessor, he also acknowledged this made him also feel understood and less guilty and inappropriate. He and the assessor decided that after the summer break, they would have a follow-up session to discuss how to move on in his grieving process.

6 Assessment of Progress: Single-Case Time-Series Design

To assess the client's response to the TA, daily measurements were recorded within the context of a time-series analysis. Systematic collection of individualized data can reveal the course (trajectory) and level of change over time (Borckardt et al., 2008; Smith, 2012). This study design includes three phases: baseline, intervention, and follow-up (Figure 1). Prior to the onset of the baseline phase, Anthony agreed to rate himself on three indices identified by the researchers as informative for clients suffering from PCBD (*sense of loneliness*, *level of suffering*, *longing for deceased parents*), and formulated two individualized ones (being in the *ball* state and *sense of failure*). Given the substantial cross-correlations (correlation of concurrent ratings on indices each day) among these variables (average correlation $r = .60$, range: $r = .37$ to $.74$), a mean score was computed for each day to form a daily in composite index, accounting for the general level of distress Anthony reported.

Analyses were run using Simulation Modeling Analysis, version 11.10.16 (SMA, Borckardt, 2006). SMA allows an examination of both the level of improvement (level-change analysis) and the trajectory of symptom change (slope-change analysis). Statistical significance of an observed level change is achieved through bootstrapping methods that rely on simulation of datastreams of similar length and serial dependence or autocorrelation (the non-independence of adjacent observations in a time-series datastream). For slope-change analyses, SMA determines the strength of the relationship between the observed datastream and a custom or individualized a priori model.

In this study, we compared (a) the baseline (21 days) with the intervention phase (46 days), (b) the intervention with the follow-up phase (42 days), and (c) the baseline data with the follow-up phase. In addition to these three level-change analyses, we also ran a slope-change analysis. We set alpha at .05 and applied the conservative Bonferroni (1935) correction to account for multiple analyses on the same datastream ($0.05/3 = 0.016$). Table 1 reports the means, standard deviations,

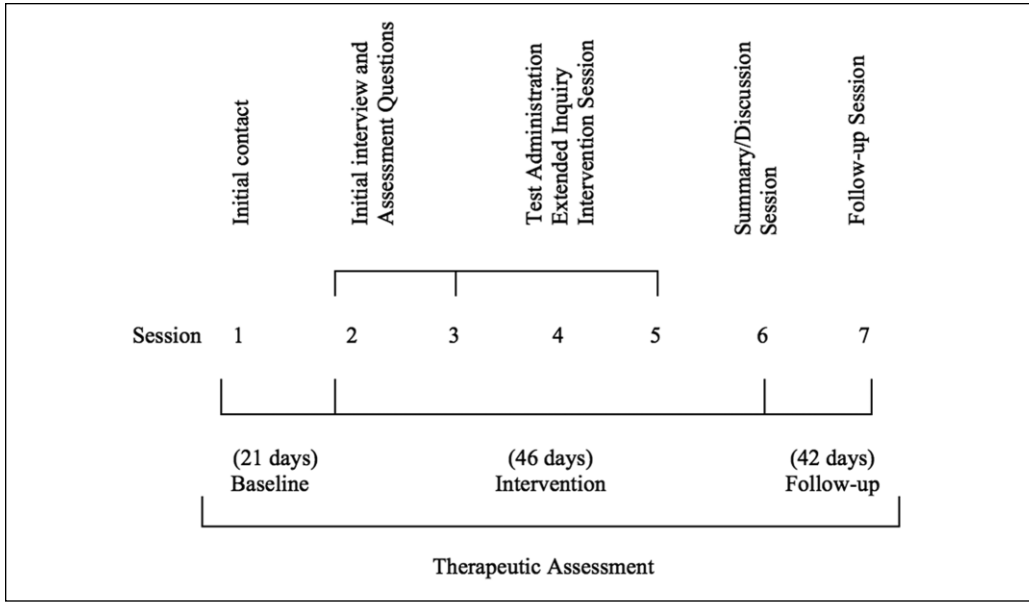


Figure 1. Timeline of the therapeutic assessment and research design.

number of observations for each phase of the analyses, and the level-change and slope-change coefficients and their statistical significance along with the autocorrelation estimates for each dependent variable.

Results showed that in comparison with the baseline, Anthony had a large and statistically significant increase of his sense of *longing for his deceased parents* during the active TA. Anthony did not report any change in his tendency to withdrawal into his *ball*, *sense of failure*, *sense of loneliness*, or *level of suffering*. Similarly, the composite variable score, reflecting the general level of distress, did not change during the TA itself.

Subsequently, we compared the intervention with the follow-up phase. Despite only trending toward statistical significance, Anthony reported moderate effects on his *ball* state and his *level of suffering* after the TA. His *sense of loneliness*, *longing for his deceased parents*, *sense of failure*, and the composite index showed a similar pattern of decrease suggesting that, despite not reaching statistical significance, Anthony’s symptom severity was beginning to show an improvement after the TA ended.

Finally, the comparison between baseline and follow-up phases revealed moderate decreases in Anthony’s sense of *ball* state, *level of suffering*, *longing for his deceased parents*, and small decreases in his *sense of failure*, *sense of loneliness*, and in the general level of distress. However, none of these decreases achieved statistical significance after Bonferroni correction.

These results, considered alongside the decrease of the PHQ-9 from the initial 19 (*moderately severe depression*) to 12 (*moderate depression*) at the follow-up session suggested a reverse “U” shaped trajectory, in which the assessment did not produce a linear decrease in the symptoms, but rather a transient period of worsening during the intervention followed by moderate improvement. To test the fit of our data with this pattern, we compared Anthony’s ratings with a hypothesized model in which, after a stable baseline period, symptoms linearly worsened until mid-assessment (Session 4, devoted to the extended inquiry of the EMP), and started to improve linearly through the rest of the assessment and the follow-up phase. As reported in Table 1, the slope-change analysis showed a strong and statistical significant relationship between the hypothesized model and Anthony’s sense of *ball* state, and the general level of distress. Also, the

Table 1. Descriptive Statistics, Phase-Effect, and Slope-Change Analyses.

DV	Individual phases						Level change						Slope change <i>p</i> AR (Lag 1)		
	B (n = 21)		I (n = 46)		F (n = 42)		B vs. I		I vs. F		B vs. F				
	M	SD	M	SD	M	SD	r	p	r	p	r	p		r	p
"Ball" state	8.81	1.75	8.76	1.23	7.10	1.83	-0.016	.918	-0.478	.024	-0.414	.086	.522	.003	.599
Sense of failure	7.90	1.81	8.13	1.42	6.93	1.39	.068	.752	-0.397	.066	-0.291	.235	.437	.013	.611
Sense of loneliness	7.24	2.12	7.67	1.68	6.50	1.33	.111	.645	-0.362	.056	-0.212	.420	.330	.075	.604
Level of suffering	7.38	1.63	7.80	1.65	6.26	1.15	.120	.554	-0.477	.018	-0.375	.078	.492	.007	.611
Missing of deceased ones	3.29	3.87	7.83	1.66	6.24	1.67	.642	.007	-0.434	.062	.477	.047	.346	.116	.698
Composite Score (average)	34.62	8.82	40.20	6.55	33.02	6.50	.337	.147	-0.485	.037	-0.104	.713	.511	.011	.689

Note. DV = dependent variable; B = baseline; I = intervention; F = follow-up. Dependent variables were measured on a 0-10 scale. Decrease in mean scores indicates improvement. Composite score = mean score of five dependent variables with same valence. *p*AR(Lag 1) = autocorrelation of sequential observations.

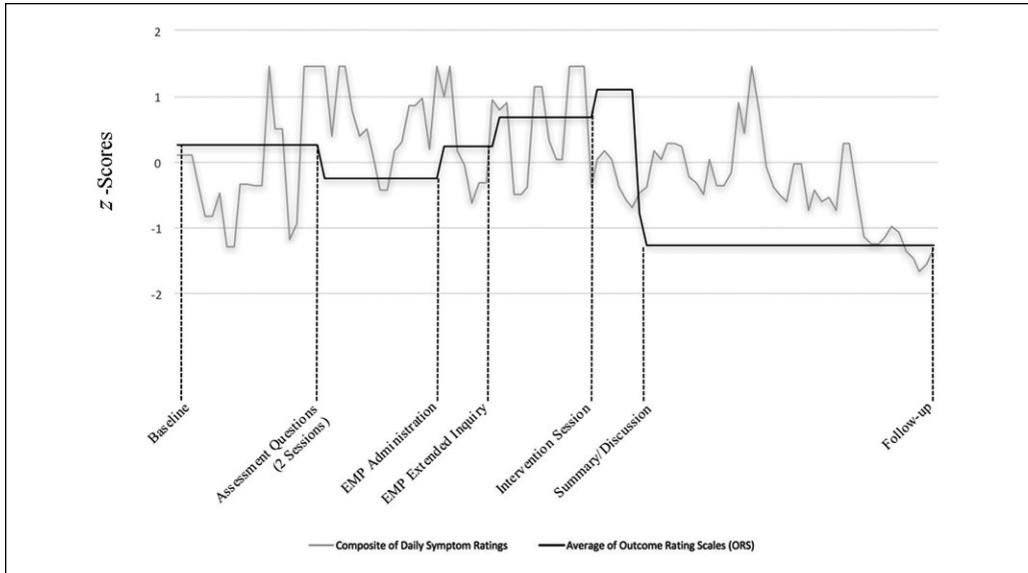


Figure 2. Baseline, intervention, and follow-up composite variable and Outcome Rating Scale scores. Note. EMP = Early Memories Procedure; TA = therapeutic assessment. Scores on both measures were converted to z scores to be on same scale of measurement. Dashed vertical lines indicate the pretreatment baseline, the TA Steps, and the Follow-up session. Outcome Rating Scale (ORS) scores are reversed.

analysis showed a moderate and statistical significant relationship between the hypothesized model and the *sense of failure* and the *level of suffering*. Finally, data showed a moderately strong but not statistically significant relationship between the hypothesized model, and his *sense of loneliness*, and *longing for his deceased parents*.

Figure 2 reports the ORS results and the Composite score transformed into z scores to allow direct comparison. ORS results were reverse-coded. Again, the data point to a trajectory in which an initial worsening of well-being and symptoms was followed by a sizable improvement, beginning in the last part of the TA, that further increased during the follow-up.

These results—framed in the context of what was happening in the assessment—are consistent with a theoretically meaningful process of change that has been demonstrated previously in TA (Tharinger et al., 2009). During the TA, Anthony was gradually exposed to evocative stimulation arising from psychological testing that produced a transient increase of missing his parents and more painful feelings by challenging his characteristic emotional defenses. This might have been particularly challenging for Anthony, who relied on his “ball” to avoid overwhelming feelings connected to the grief and the well-defended loss for his deceased parents. It could be speculated that if emotional detachment served the important function of protecting him from being emotionally overwhelmed, it also hindered him from moving through the grieving process. On this basis, the subjective worsening of self-reported symptoms may be interpreted as a weakening of the defenses against contact with painful memories and representations. Luckily, as painful as it was, the end of the follow-up saw Anthony less depressed and trending steadily toward improvement.

7 Complicating Factors

Many authors highlighted the importance of empathic and genuine therapeutic relationships, especially with grieving clients (Parkes, 1996; Worden, 2002). In line with the TA model, the

client and the assessor developed a collaborative and supportive relationship, and Anthony was gradually exposed to evocative stimulation arising from psychological testing instruments. This can be very useful because it encourages the disclosure of personal information connected with the client's life history but the intensity of the intervention requires constant supervision for the assessor (Finn, 2007).

Despite the availability in literature of structured interviews and self-report tests for assessing the presence of this condition (i.e., Inventory of Complicated Grief–Revised, Prigerson et al., 1995; Hogan Grief Reaction Checklist, Carmassi et al., 2014; Hogan, Greenfield, & Schmidt, 2001), at the time of the assessment, such instruments were not adapted for use in Italy, or even translated into Italian. This shortcoming, along with the inclusion of PCBD in the category of “Emerging Measures and Models” for further evaluation and discussion in *DSM-5*, suggests that a call for more research to assess the validity of such instruments in Italy is warranted at this time.

8 Access and Barriers to Care

In Italy, mental health care services are paid for by public welfare, and practitioners are often burdened by long waiting lists and are forced to conduct short-term interventions. In this framework, TA appears to be an effective means to provide clients with a transformative experience in a relatively short term.

9 Follow-Up (Session 7)

One month and a half later, Anthony and the assessor met for a follow-up session (Session 7, Figure 1), which is customary for a TA. This phase allows clients to discuss with the assessor developments or changes in their activities and in their daily life after a summary and discussion session. During the follow-up session, Anthony reported several changes in his symptoms and emotions, including feeling better able to manage everyday stressors and experiencing more satisfaction in his relationships. Living with his family no longer triggered intrusive thoughts about the losses of his own parents, and he was able to attend Mass regularly. The quality of his relationships increased as well. For example, one of Anthony's major stressors was a messy home. Before the assessment, Anthony experienced several angry outbursts against his oldest daughter who did not clean her room properly. After TA, he reports being more tolerant of her “messy” room, while developing new strategies to induce her to be more responsible (e.g., he started to help her to tidy up the shelves). He reported having stopped the angry episodes with her as well. Anthony also seemed more satisfied and able to enjoy life as an individual and as a husband, increasing the number of activities he did with his wife. Anthony and the assessor decided to start regular treatment to monitor his developments and continue working on his grieving process.

10 Treatment Implications of the Case

Allowing the reprocessing of intrusive thoughts and memories is particularly important in the context of PCBD treatment. The results of this study accumulate further evidence in favor of TA accelerating the emergence and the possibility of processing previously well-defended emotional states (e.g., Tarocchi, Aschieri, Fantini, & Smith, 2013). Similarly to what Tharinger et al. (2009) demonstrated on TA research with children, the trajectory of change for clients who face TA with dissociated memories of trauma and loss leads to a transient period of actual symptoms worsening. In these cases, repeated measures capture the clients' pain and stress the need to provide firm interpersonal emotional support during the process (Bishop & Lane, 2003).

Anthony's symptomatology initially showed comorbidity of PCBD, PTSD, and MDD. By targeting the client's more pressing needs (captured in their assessment questions), TA pointed the assessor to address the aspects of symptomatology more "accessible" to change for Anthony. In fact, Anthony's assessment questions concerned his struggles in interpersonal relationships and the avoidance of unbearable states connected with his loss through entering his "ball." Despite the fact that the assessor did not directly tackle the MDD and PTSD symptoms, Anthony's recovery from PCBD symptoms was accompanied by a reduction of the severity of depression and of intrusive and avoidant post-traumatic symptoms as well. After the follow-up period, Anthony agreed to begin long-term psychotherapy with the assessor. During therapy, his depressive symptoms almost disappeared, and Anthony eventually was able to do things with his family without intrusive or disturbing thoughts connected to his losses. One and a half years after the end of the TA, Anthony and the assessor meet monthly just to monitor Anthony's daily struggles.

II Recommendations to Clinicians and Students

The literature on TA highlighted the importance of empathic relationships with clients (Aschieri, 2016; Chudzik & Aschieri, 2013). Different studies have revealed that TA promotes personal change and enables individual enrichment. The current case study provides preliminary evidence that TA may be efficient with a client who had unresolved loss. However, the data from this study also strongly suggest that when clients use dissociative mechanisms to cope with their pain, the TA procedure must be accompanied by solid emotional support from the assessor to the client.

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Note

1. Because therapeutic assessment (TA) frames the intervention process within a semi-structured psychological assessment process, following a previous example published in *Clinical Case Studies* (Tarocchi, Aschieri, Fantini, & Smith, 2013), this manuscript contains a slightly modified format that combines Assessment, Case Conceptualization, and Course of Treatment. Similarly, given the pivotal role of psychological assessment in the TA model, we review best practices for the assessment of trauma alongside the components of evidence-based bereavement treatment.

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Author Biographies

Ilaria Durosini is a PhD student in psychology at Catholic University of the Sacred Heart of Milan, Italy.

Anna Tarocchi, MA, is a full-time psychotherapist in the Public Mental Health service in Milan, Italy. She received a specific training in collaborative/therapeutic assessment organized by the Catholic University of the Sacred Heart at the European Center for Therapeutic Assessment.

Filippo Aschieri, PhD, is an assistant professor of psychology at Catholic University of the Sacred Heart of Milan, Italy. He is certified in therapeutic assessment of adults, couples, families with children, and adolescents and works at the European Center for Therapeutic Assessment.