# ABSTRACT


Title of Thesis: MEANING-MAKING IN PSYCHOTHERAPY AFTER TRAUMATIC LOSS: THERAPISTS' PERSPECTIVES

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We interviewed 11 experienced therapists specializing in loss/trauma about their work with one client with whom they successfully facilitated meaning-making after a traumatic loss. Interviews, analyzed using Consensual Qualitative Research (CQR), revealed that the traumatic loss had negatively impacted clients' relationships, mental health, and beliefs/religion/spirituality; therapists utilized a range of interventions to facilitate meaning-making, including interventions to help clients experience/regulate emotion and interventions to gain insight; clients made meaning in diverse ways that could be broadly categorized under meaning-as-comprehensibility and meaning-as-significance; and clients experienced positive adjustment (in mental health, relationships, etc.) through the meaning-making work. Implications for research and practice are discussed.



Keywords: meaning-making, psychotherapy, traumatic loss

# MEANING-MAKING IN PSYCHOTHERAPY AFTER TRAUMATIC LOSS: THERAPISTS' PERSPECTIVES

by

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## Introduction

When individuals experience a traumatic event, it often "shatters" many of the assumptions they hold about the world, other people, and/or God, such as, "People are generally good," "God is in control," or "I will be rewarded for being a good person" (Janoff-Bulman, 1992). Theoretical and empirical evidence suggest that in the aftermath of such trauma, human beings have an innate "will to meaning" (Frankl, 1984) and that successfully making meaning after trauma may be associated with positive outcomes such as higher well-being, less post-traumatic stress symptoms, and posttraumatic growth (Park & Ai, 2006).

Given the prevalence of trauma in the population and in those seeking mental health treatment (Gold, 2004), it is essential that clinicians be well-versed in how trauma disrupts individuals' meaning systems and prepared to help facilitate the meaning-making process. However, although theoretical perspectives on meaning-making abound, few researchers have empirically examined the process (e.g., skills, interventions) by which therapists help clients make meaning after trauma. Additionally, few researchers have looked specifically at traumatic loss, which can be particularly devastating as individuals navigate both the shock of trauma and the altered reality of life without the bereaved (Neimeyer, Botella, et al., 2002). Therefore, we sought to address this gap in the literature by investigating how therapists help facilitate meaning-making with clients who have experienced traumatic loss.

### Definition and Consequences of Traumatic Loss

Traumatic loss can be defined as loss that is "sudden, violent or unexpected" (Green, 2000, p. 2). It includes loss by homicide, suicide, or accident (Currier et al., 2006), though some consider death by natural or undetermined causes as also potentially traumatic (Deranieri et al.,

2002). Though current estimates of the prevalence of traumatic loss are lacking, reports from the 1990's and early 2000's suggest that between 20% and 53% of the population have experienced unexpected loss (Carmassi et al., 2014; Deranieri et al., 200*2*; Vries & Olff, 2009).

Traumatic loss has been associated with post-traumatic stress symptoms and complicated grief at higher rates than non-traumatic loss (Neria & Litz, 2004). Post-traumatic stress symptoms include symptoms of hyperarousal (e.g., startle reactions), re-experiencing (e.g., flashbacks), avoidance (e.g., of specific places or reminders), and negative cognition/beliefs (e.g., guilt) (Calhoun et al., 2012). Complicated grief, which is classified as Persistent Complex Bereavement Disorder (PCBD) in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), consists of symptoms of persistent yearning for the deceased, intense sorrow, preoccupation with death, and preoccupation with the circumstances of the loss (Smid et al., 2015). Thus, individuals who experience traumatic loss are at high risk for psychological distress.

**Definition of and Theories about Meaning-Making**

Although theoretical and empirical work on meaning-making after trauma and loss has accelerated within the past two decades (Matthews & Marwit, 2006; Park & Ai, 2006), meaning-making has not been consistently defined (Flesner, 2013; Landsman, 2002). Park (2010) defined meaning-making as the "restoration of meaning in the context of highly stress situations" (p. 257). Matthews and Marwit (2006) provided a constructivist definition of meaning-making as "our ability to re-evaluate, reinterpret, and restructure our life narratives . . . [involving] an integration of the loss and a reappraisal of one's own identity" (p. 90). Both definitions emphasize the effort to regain a sense of meaning after beliefs and worldviews have been violated by trauma or loss.

In her influential theory about meaning-making after trauma, Park (2010) posited that all individuals have a sense of global meaning, or broad beliefs, goals, and values (e.g., God is loving and in control). When traumatic events occur, individuals generate an appraised meaning about the event (e.g., God abandoned me); the extent of discrepancy between individuals' global and appraised meaning determines their level of distress. This distress triggers an effort to reconcile this discrepancy, which can be broadly referred to as "meaning-making."

In another influential theory, Neimeyer (2001) rejected stage models of grief for one in which meaning-reconstruction, or the process in which the bereaved find new meaning in the altered reality of life without the deceased, "is the central process in grieving" (p. 4). Though his terminology differs from Park's, Neimeyer similarly posits that bereaved individuals undergo a search for meaning when their loss is inconsistent with "pre-loss meaning structures," which can result in "new meaning structures" and reduced distress. Gillies and Neimeyer (2006) highlighted the narrative processes by which loss is integrated into reconstructed life stories.

**Forms of Meaning-Making**

Theorists and empirical researchers have also identified what have been diversely labeled as different "forms" (McAdams & Jones, 2017), "products" (Park, 2010), or "contexts" (Neimeyer & Anderson, 2002) of meaning-making. These can be divided along the lines of making meaning-as-comprehensibility vs. meaning-as-significance (Janoff-Bulman & McPherson Frantz, 1997).

Meaning-as-comprehensibility involves sense-making. This process involves a search for an explanation or "causal reasoning" for loss or trauma (Davis & Nolen-Hoeksema, 2001; McAdams & Jones, 2017, p.8).

Meaning-as-significance can involve: (a) benefit-finding or recognition of something positive resulting from the loss or trauma (Davis et al., 1998), similar to posttraumatic growth (McAdams & Jones, 2017); (b) identity reconstruction, which refers to the "re-authorship" of life stories in a world that has been fundamentally changed by loss or trauma (McAdams & Jones, 2017; Neimeyer & Anderson, 2002); and/or (c) meaning grounded in action, which refers to the "performative dimension of meaning-making" in which individuals engage in the "intense pursuit of what matters" (Armour, 2003).

**Empirical Findings on Meaning-Making**

Though meaning-making is generally theorized to be important in adjusting to loss and trauma, empirical evidence for this assertion has been mixed (Park, 2010). Researchers have found, for instance, that successfully making sense of loss or trauma is associated with better outcomes, but that both the initial search and prolonged unsuccessful searching predict worse psychological health (Davis et al., 2000; Silver & Updegraff, 2013). Additionally, whereas some researchers suggest that it is the achievement of making sense (i.e., resolution), rather than the explanation itself, that is important for positive outcomes (Silver & Updegraff, 2013), others suggest that the explanation does matter, given that individuals who had negative understandings of their loss (e.g., God is punishing me) reported poorer well-being (Stein et al., 2009) than did people with positive understanding.

Similarly, researchers have found that many people report finding benefits from trauma or loss and that these benefits are associated with positive outcomes (Davis, 2001; Stein et al., 2009; Wright et al., 2007). However, other researchers have reported potential distress associated with more negative benefits (e.g., Wright et al., 2007, found that survivors of childhood sexual

abuse who identified greater awareness of sexual abuse as a perceived benefit experienced greater isolation and worse marital satisfaction).

The empirical literature on meaning-making is fraught with limitations. In her review of the literature on meaning-making, Park (2010) wrote, "Empirical work has not matched the richness or complexity of theories regarding meaning and meaning making, perhaps partly because the abstract and complex nature of the theoretical models renders them more amenable to hypothesis generation than to hypothesis testing" (p. 262). Inconsistencies in defining and operationalizing meaning-making and the use of measures with poor psychometric properties (e.g., single-item questions) limit what we can conclude from the empirical findings regarding meaning-making.

**Meaning-Making in Psychotherapy**

Given the prevalence of trauma in the general population (Courtois & Gold, 2009; Gold, 2004), its heightened prevalence among those seeking mental health care (Gold, 2004), and the need for individuals to make meaning following trauma and loss (Gillies & Neimeyer, 2006; Park, 2010), it becomes essential to ask how psychotherapy can help facilitate such endeavors. Meaning-making is thus discussed from five theoretical approaches, although we note that empirical research on this is limited, particularly for traumatic loss.

Much of the theoretical work on meaning-making in psychotherapy has been within the narrative or constructivist approach, which integrates postmodern, feminist, empowerment, and liberation perspectives (Kamya, 2012). Narrative approaches are especially appropriate for facilitating meaning-making, as narratives "often converge on a redemptive self that allows one to understand past sufferings as functional and a precondition for future success" (Zafirides et al., 2013). In other words, narrative practices allow traumatized clients to reclaim authorship over

their own stories (Kamya, 2012). The role of the therapist is to "help the client to integrate problematic experiences more adequately within the self-narrative and to promote its ongoing revision and extension" (Neimeyer & Stewart, 1998 cited in Neimeyer, 2000, p. 212).

Psychodynamic therapists aim to foster awareness of aspects of the self that are unconscious (Corey, 2017). A psychoanalytic approach to trauma emphasizes the role of traumatic memory, defense mechanisms (e.g., avoidance), the meaning of the traumatic event, and the social context of the experience in creating distress (Young et al., 2012). Marshall et al. (2000) described the psychodynamic therapist's role throughout therapy as one of facilitating the client's processing of the traumatic event and its associated meaning through narrative retelling.

Meaning is central to existential psychotherapy. Frankl (1984), a Holocaust survivor and early existential thinker, argued that all humans have an intrinsic "will to meaning" that is the primary motivation in life. Existential theorists view psychological conflict as rooted in the dilemma of a meaning-seeking creature who is thrown into a universe that has no meaning (Yalom, 1980). Zafirides et al. (2013) described how therapists can use an existential framework to "point out different means by which truth can be ascertained" and guide clients as they engage in the process of making sense of negative events (p. 476).

Much attention has been paid to the role of meaning in treating trauma within the cognitive therapies. However, such approaches often discuss meaning implicitly, using terms such as "core beliefs" instead (Steger & Park, 2012). Indeed, much of the theory behind cognitive processing therapy (CPT), one of the standard treatments for PTSD that aims to identify and change cognitive distortions resulting from trauma, can be viewed through a meaning-making lens (Iverson et al., 2015). Similarly, Steger and Park (2012) suggested that

third-wave cognitive therapies (e.g., acceptance and commitment therapy) may be helpful in facilitating meaning-making after trauma.

Finally, meaning-making often involves religion or spirituality (e.g., "This was part of God's plan for me" as an example of sense-making) (Davis et al., 2000; Kusner & Pargament, 2012). Additionally, increasing recognition of the inherent connection between religion/spirituality and trauma points to the potential effectiveness of spiritually-oriented psychotherapies for facilitating meaning-making (Allen et al., 2017).

**Purposes of the Present Study**

The purpose of the present study was to investigate how therapists facilitate meaning-making with clients who have experienced traumatic loss. We sought to address current limitations in the literature by (a) examining meaning-making qualitatively, thus allowing for richer descriptions of meaning-making, (b) focusing on traumatic loss, which lies at the intersection of both trauma and bereavement and warrants increased attention in the field, and (c) interviewing therapists across orientations to identify the common processes by which meaning-making occurs in psychotherapy. The specific questions I sought to explore are: (a) How do therapists perceive traumatic loss as disrupting clients' meaning (i.e., beliefs about God, the world, or themselves)? (b) What are the ways that therapists perceive clients successfully make meaning (e.g., benefit-finding, sense-making, identity reconstruction, action, religion/spirituality)? (c) How do therapists perceive religion/spirituality as impacting the meaning-making process? (d) What is the process by which therapists facilitate meaning-making for clients who have experienced traumatic loss? (e) What do therapists perceive as the impact of successful meaning-making on client outcomes and the therapy process? (f) What are therapists'

own experience of facilitating meaning-making within psychotherapy after traumatic loss? (What is the impact of facilitating meaning-making after traumatic loss on the therapist?).

Given that no studies (to our knowledge) have examined therapist perspectives on meaning-making after traumatic loss, we felt a qualitative approach was best suited as the first step for exploring these research questions. We chose to use consensual qualitative research (CQR, Hill, 2012; Hill & Knox, 2021), a rigorous qualitative approach particularly suited for studying complex, subjective, phenomena. CQR is rooted in postpositivist and constructivist perspectives, which emphasize truth as a constructed reality and the subjectivity of researcher interpretation. This philosophical approach matched the nature of our topic, as the highly personal nature of "meaning" and "meaning-making" highlights the lack of an "objective" truth that can be gained. Rather, we sought to understand how meaning-making unfolds within psychotherapy from therapists' perspectives, readily acknowledging that this perspective cannot speak to how clients perceive meaning-making.

We also note that consistent with qualitative research (e.g., Hill & Knox, 2021), we initially posed research questions which served as the foundation for our interview questions. Through the data analysis, however, we bracketed our expectations/biases and research questions and focused on what emerged from the data.

## Method

### Participants

The sample consisted of 11 (10 female, 1 male; 9 White, 1 biracial Black/White, 1 "Other," 9 heterosexual, 2 bisexual; 4 Jewish, 3 Other, 2 Agnostic, 1 Buddhist/Catholic; 1 Protestant; 6 PhDs in counseling or clinical psychology, 2 masters of social work, 1 PhD in social work, 1 licensed clinical professional, 1 masters in art therapy; ranging in age from 36 to

69 years, *M* = 56.20, *SD* = 10.41; years in practice *M* = 19.60, *SD* = 13.44) psychotherapists. All participants were licensed and at least five years post-graduate school and self-identified as specializing in working with loss and/or trauma. All participants reported that they had experienced a traumatic loss in their own life. On a scale of 1 (*extremely unresolved/unfinished*) to 5 (*completely resolved*), participants indicated they had mostly worked through their loss (*M* = 4.36, *SD* = 0.51). On the Theoretical Orientation Profile Scale-Revised (TOPS-R; Worthington & Dillon, 2003), which uses a 10-point scale (10 = *high*), participants rated themselves 5.67 (*SD* = 1.80) on Humanistic/Existential, 4.73 (*SD* = 3.09) on Psychoanalytic/Psychodynamic, and 2.45 (*SD* = 1.96) on Cognitive-Behavioral.

All participants talked about one client who was either current or terminated in the past 2 years, had been in therapy at least 6 months, had experienced a traumatic loss (i.e., loss of a loved one that was sudden, unexpected, or violent) at 18 years or older, and had successfully made meaning during therapy. Therapists talked about 11 (9 female, 2 male; 10 White, 1 Black; 9 heterosexual, 2 lesbian; 3 non-religiously affiliated, 2 lapsed Catholic, 1 Catholic, 1 Episcopal, 1 Protestant, 1 Messianic Jew, 1 non-religious Jew, 1 Quaker) adult clients.

Five clients had lost siblings, four had lost children, two had lost their spouses, and one had lost a grandchild (one client had lost two loved ones). Five had lost loved ones due to suicide, four were due to sudden natural causes (e.g., cardiac arrest), one due to a motor vehicle accident, and one due to homicide. See Table 1 for information pairing therapists with clients' type of loss.

***Research Team***

The first author, a 27-year-old female, Asian American, Christian, doctoral student in counseling psychology, conducted all the interviews and led the research team. She had

participated in another CQR study and read Hill (2012). She had never experienced the loss of a loved one but had worked for two years on a research study with women who had experienced trauma. She believed that meaning-making is important for healing from loss and/or trauma and that religion/spirituality can be a helpful tool in making meaning.

Additional members of the research team included 3 (2 female, 1 male) doctoral students and 4 female undergraduate psychology majors. Before beginning data analysis, the research team wrote about their biases and expectations on meaning-making and then shared them with the team. They all believed that meaning-making was positive, could lead to hope and healing, and would differ for each person. Three people noted that meaning-making could be harmful in certain contexts; four mentioned that their experiences with loss had impacted their views of meaning-making; six acknowledged cultural/religious influences on their views of death and meaning; three mentioned that therapists should be a guide, and two believed that therapists should be careful not impose meaning-making on clients. All team members were encouraged to set aside their biases and expectations as much as possible during the data analysis process.

A licensed female counseling psychologist with extensive clinical, research and teaching experience served as the auditor and primary advisor for the study. She had not experienced any traumatic losses and was an atheist.

**Measures**

Interviewees completed a survey regarding their age, gender, race/ethnicity, sexual orientation, religious affiliation, type and year of degree, experience with trauma and/or loss, years of clinical experience, clinical training in trauma and/or loss, and theoretical orientation (See Appendix A).

A semi-structured interview (i.e., it included standardized questions with additional probes encouraged for individual interviewees, e.g., “Tell me more about that”) was developed by the first author, reviewed by her advisor and other doctoral students, and modified after conducting two pilot interviews. In the protocol, the interviewer first provided a definition of meaning-making and the criteria for traumatic loss. Then interviewees were asked to describe the process of facilitating meaning-making for one client who experienced traumatic loss; specifically, they were asked to describe the client’s demographics, traumatic loss, how the loss disrupted the client’s sense of meaning, skills/interventions used to facilitate meaning-making during psychotherapy and in a salient event, the role of religion/spirituality in the process of meaning-making, the impact of meaning-making on client outcome and psychotherapy, and what they felt made the meaning-making process successful (See Appendix B).

## Procedures

### *Data Collection*

After approval was obtained from the university Institutional Review Board, therapists were identified using a mixture of convenience and snowball sampling through searching on the Psychology Today website and personal contacts for therapists in the United States with specialties in trauma and/or loss. Potential participants were contacted via email (see Appendix C) with a description of the study procedure, eligibility requirements, the interview protocol, and a link to an eligibility and background survey (consent was obtained electronically at the start of the survey; see Appendix D). Upon completion of the survey, therapists were contacted by the first author to schedule an approximately 60- to 120-minute phone or video call interview. At the beginning of the interview, verbal consent was obtained (see Appendix E). After the interview, participants were invited to tell other therapists about the study.

Of the 16 therapists who completed the eligibility and background survey, 14 were interviewed by the first author (two did not have time availability within the data collection time period). Ten of the therapists completed the interview via phone and four completed theirs via video call. After consultation between the first author and advisor, three interviews were excluded (e.g., the loss was not sudden, unexpected, or violent for one case or lacked sufficient detail for analysis for two cases). Thus, the final sample consisted of 11 participants.

All interviews were transcribed verbatim by research team members; all identifying information was removed and code numbers were used. Transcripts were sent to participants to review for accuracy and confidentiality; all were approved with occasional minor changes to protect confidentiality. Once approval was obtained, the audio recordings were deleted.

***Data Analyses***

Research team members all read articles about CQR and then discussed biases and expectations. At all points in the research process, team members argued through to consensus on all judgments to ensure the trustworthiness of the data and limit the influence of personal bias.

Team members independently created a list of domains (i.e., broad topics) after reviewing two transcripts. They then discussed their lists and constructed a tentative list, which was reviewed by the auditor and revised upon her feedback. The team continued to revise until the list was "stable" (i.e., no more needed changes) based on reviewing three additional transcripts and feedback from the auditor.

Next, team members coded ("domained") two transcripts, assigning all data chunks ("thought units, sentences, and paragraphs that cover the same topic area;" Hill, 2012, p. 106) to one or more domains. Once all team members understood the process, they were divided into two teams (and later into pairs) to domain the rest of the transcripts, with the first author

reviewing all decisions. The domain list was continually modified via consensus and in consultation with the auditor throughout this process.

Next, the team met as a whole to construct core ideas ("summaries of the data that capture the essence of the participants statement in fewer words;" Hill, 2012, p. 111) for each data chunk for one transcript. After all team members understood the process, they were divided into pairs to construct core ideas for the remaining transcripts, with the first author reviewing all core ideas. A consensus version (i.e., table containing raw data and core ideas within each domain) was then created for each case and reviewed by the auditor, with revisions made based on the feedback.

Finally, the team conducted the cross-analysis (i.e., "identifying common themes across cases" Hill 2012, p. 117). Team members first independently identified possible themes and then met to arrive at consensus about the specific categories and subcategories for two domains. Once team members understood the process, they were divided into subgroups to code each core idea into one or more categories and subcategories within each domain. When discrepancies arose, the team members returned to the raw data to stay as close to the data as possible and minimize researcher bias. As this process was completed for each domain, the cross-analysis was given to the auditor for review and revised as needed. After the data analysis was finished, the first author and auditor worked together to review the results and make final revisions.

The final step of the cross-analysis involved calculating the frequency of themes. Categories that included core ideas from all or all but one of the participants (10 or 11) were considered to be *general.* Categories that emerged for more than half of the participants up to the cutoff for general (6 to 9) were *typical.* Categories that emerged for two participants up to half of the sample (2 to 5) were *variant*.

At the end of the data analysis process, the team reflected on our initial expectations and how our perspectives on meaning-making in therapy after traumatic loss had evolved. Additionally, the manuscript was sent to all participants to ensure that confidentiality was maintained and to solicit feedback regarding the study findings.

## Results

Table 2 presents the frequency of the categories and subcategories within each of the four domains. In this section, we describe the results within domains and provide quotations from cases to illustrate the data, removing filler words such as "uh" and "you know" to facilitate understanding and deleting sections of quotations as indicated by ellipses ( . . . ).

### Impact of the Loss on Client

#### *Negative Impact on Mental Health*

Participants generally stated that the traumatic loss had negatively impacted the client's mental health in terms of psychological symptoms. For example, Sarah described her client's depression and suicidal ideation ("If I can't keep my brother alive, why should I still be here?") and Lauren's client sought therapy because of debilitating panic attacks connected to suppressed grief about the loss of her son.

In addition, participants' clients typically struggled with a loss of identity after their loss. For instance, Brooke described, "Being his mother . . . was such a huge part of her life, and such a huge part of who she was and her identity . . . she used to be a mother and now she was the mother of a dead son." In another example, Lauren's client changed her name, cut off relationships, and began a new life after the deaths of her sister and daughter.

#### *Negative Impact on Interpersonal Relationships*

Participants generally reported that the loss negatively impacted clients' interpersonal relationships. Clients felt isolated, alone, and that they lacked social support. For example, Susan said that her client "tended to really isolate herself, didn't go out very much," and Richard's client felt isolated because of being cast into the caregiver role after the loss.

***Disruptions in Beliefs/Religion/Spirituality***

Participants typically reported that the traumatic loss disrupted clients' beliefs about the world and/or God, as well as their religious/spiritual practices. For instance, Richard described his client wrestling with existential questions after the death of her grandson,

> "What kind of universe is this? What kind of God is this, that would allow a child to die?" . . . Her faith remained very important to her, but for a time she ceased to derive much meaning from it and very little consolation that she stopped going to services for a time, and then [when she] went back, they felt very hollow.

Joanna client's beliefs about the world changed after her brother was killed, "She saw that her brother could be shot and killed by a stranger, that safety was pretty much blown out of the water - her feeling safe, safety of her, of the world in general. So, that worldview was shattered."

***Factors that Complicated Clients' Grieving Process***

Participants typically mentioned that prior loss and/or trauma histories complicated their clients' responses to the loss. Pauline described how her client's sudden loss of his brother exacerbated his negative worldview from his combat experiences. Similarly, Tessa described how her client's insecure attachment style due to being placed for adoption at birth contributed to the complicated grief she experienced at the death of her husband.

Participants variantly mentioned that cultural and societal expectations around grief influenced clients' responses to the loss. For instance, Susan described how societal stigma

around suicide made it difficult for her client to seek social support. Richard described how his client struggled to receive support in her grief over her grandson, because of societal and cultural expectations that placed her in the role of caretaker for her bereaved daughter.

Finally, participants variantly noted that a difficult or turbulent relationship with the deceased complicated client's grief process. For instance, Dawn's client's brother committed suicide after being imprisoned for a crime. Her client's knowledge of how her brother had hurt others shattered her client's respect for him and complicated her grieving process.

## Therapist Interventions Related to Meaning-Making

### *Interventions to Support Client*

Generally, participants reported using many supportive interventions, including validation, reinforcement, empowerment, and being responsive to clients' needs. In particular, participants often noted the need to progress slowly and let clients set the pace. Rebekah stated,

> He couldn't tell me the whole story of his wife's suicide immediately. That was something that he just said, "I lost my wife." And then, like the first meeting, the only thing I knew is "I lost my wife to suicide. She died by suicide." He wouldn't say, and I didn't push.

Participants also often described creating safe spaces where clients' emotions and grief were validated. For instance, Ashley stated, "It's so much about honestly, normalizing and validating their experience . . . 'no, you're not crazy, of course, that is real,' and to create that safe space."

### *Interventions to Help Client Gain Insight/Change Narratives about the Loss*

Participants generally used a wide range of interventions to help clients develop greater self-awareness, gain insight, and change their narratives about the loss. Brooke, for example, challenged her client's belief that she lost her identity when she lost her son,

> I remember just challenging her with this idea of, "Really? Are we really just one? Do we only have just one identity? Are we just a mother? Are we just a wife? Are we much more than that?" And so we sort of started exploring, I threw out a lot of different things, and together, we thought about all the things that she was: a sister and a daughter and a best friend, a hiker, all of these things, a Quaker.

Tessa used EMDR techniques to help her client develop a more positive interpretation of her husband's sudden death,

> The negative idea out of that for her was, "I wasn't worth waiting for, he just died and he didn't even tell me . . . he didn't love me that much." . . . The positive idea we introduced was, "I am worth waiting for, he did love me." . . . I'll have the client hold the chart, hold the image, focus on the body part and remember the negative cognitions and then I will process them with the tappers . . . We process three times and in the end of it, she just looked up and said, "He didn't have time. He would have waited for me, he loved me. He didn't have time, and it was out of control."

***Interventions to Help Clients Explore the Loss***

Participants typically helped clients explore their experience of the loss. They asked questions about the death and the client's relationship to the deceased and did experiential exercises to help the clients process the loss. For instance, Joanna had her client draw out her imagined death scene of her brother, asking questions to help her process her feelings about it. In subsequent sessions, she would take the picture out again and ask her client if she wanted to make any changes to the drawing. Richard described helping his client explore the collateral losses she experienced through the loss of her grandson:

> "What have you lost?" And she might pause for a moment and say, "My expectation of his future." "Thank you." "What have you lost?" "A sense that the world is fair." "Thank you." "And what have you lost?" By the time you're five minutes into that inquiry, you've got a lot of direct and indirect losses on the table.

***Interventions to Help Client Take Action***

Participants also typically helped clients figure out how to make changes in their lives. Richard described helping his client figure out how to incorporate her deceased grandson into their family's religious rituals, "So how do we memorialize this child? What happens when we have significant high holy days? And when we say kaddish what's his role in that? As we gather as a family, spontaneously, can we still speak his name?" In addition, Brooke gently challenged her client to make changes to her deceased son's room,

> She was able to just tolerate me saying, "I'm not asking you to do anything except, if there's something, like a photo or a pencil holder, could you just shift, take one item and just move it six inches? Just see what that feels like. And if it's unbearably uncomfortable, then then we'll move it back or we'll talk about it next week."

***Interventions to Help Client Express, Experience, and Regulate Emotions***

Participants typically tried to facilitate clients' emotional expression and regulation. Dawn gave her client permission to feel a range of emotions, especially stigmatized feelings,

> I wanted her to express sadness and loss . . . cynicism and anger and negative emotion . . . she was able to express appreciation that she had the opportunity to express the full range of emotions from deep sadness to "that motherfucker, I'm glad he's gone."

Similarly, Lauren stated,

> I wanted to help her reconnect to herself, to be fully present in her life, to experience her emotions, because she was terrified of her emotions . . . she really believed that she needed to be disconnected for self-preservation.

### *Interventions to Educate Client*

Participants typically educated clients about therapy and the grief process. For instance, Tessa talked to her client about what to expect during the grief process, “You have one [foot] in the biopsychosocial world and your other foot is in the world of the beloved, the lost, the bereaved. So, you’re constantly moving in between the two worlds, which is why people feel bipolar.” Tessa also taught her client about forming a continuing bond with the deceased,

> It's gonna feel bad and we are [a] very pain-averse society, but it's going to hurt. You're going to feel what you need to feel, you got to feel the hole and then you're going to learn [what] we call the hole, the tunnel that connects us to our beloved. It becomes the pain . . . The pain that you feel now becomes the continuing bond, it becomes that deep connection between you and the person that you lost.

## Factors that Facilitated Meaning-Making in Therapy

### *Therapist Factors*

**Beliefs.** Theoretical beliefs and approaches to therapy typically guided meaning-making work. Often these beliefs were about the importance of meaning-making in the grief process and the nature of meaning-making within therapy. For instance, Richard said, “I don't see meaning-making as a specialized thing we do, a kind of module that we engage, it is woven through the entire performance of therapy.” Brooke conceptualized meaning-making as,

> Just not linear . . . People don't just arrive at this point where they're like, "Oh, I've made sense in my loss" or "There's so much benefit that happened" or "My identity so changed

that I now, like this sort of fixed everything" . . . There's a continued sort of process that people, it's never really finished.

**Personality Characteristics and Experiences.** Participants variantly reported that their personal characteristics facilitated the meaning-making work. For instance, Richard spoke about his openness and willingness to be led by his client's pain, Brooke mentioned her unflappable nature as a therapist and her ability to sit with clients' raw pain, Rebekah noted her patience in working slowly with clients without getting discouraged, Susan cited her experiences as a suicide survivor, and Joanna named her religious/spiritual beliefs.

### *Client Characteristics*

**Motivation.** Participants typically reported that their clients' initiative and engagement facilitated the meaning-making work. Sarah noted that her client identified actions she wanted to take, such as participating in a walk for suicide survivors. Tessa and Rebekah both noted that their clients asked for an intervention (e.g., role-playing) that they had previously suggested.

**Grit.** Participants typically reported that their clients' bravery and resilience facilitated the meaning-making work. Susan talked about her client's willingness to not shrink away from difficult existential questions, Dawn noted her client's ability to acknowledge harsh truths, and Ashley pointed out her client's resilience from having gone through difficult past experiences.

**Religion/spirituality.** Participants variantly reported that religion/spirituality facilitated client's meaning-making work. Richard stated that his client's personal relationship with God was a healing resource for her, as she felt connected to Him because He had also lost a child in a violent and traumatic way. In addition, Joanna and Ashley both stated that their clients' spirituality helped facilitate their ongoing connection with their deceased loved ones.

**Psychological-mindedness.** Participants variantly noted that their clients' reflectivity and intelligence were facilitating factors in the meaning-making work. Rebekah considered her client as a "great candidate" for meaning-making because he was logical and wanted to understand what had happened to him. Similarly, Dawn said that her client's psychological-mindedness and intelligence enabled her to explore difficult questions in therapy.

### *Therapeutic Relationship*

Participants typically reported that a strong therapeutic relationship facilitated the meaning-making process by providing a safe foundation for their work. Pauline stated that though at times her client pushed back during sessions, he could perceive her care for him, which enabled the meaning-making work. Similarly, although Brooke's client was initially resistant to therapy, she was able to see the therapist's commitment, which led them to trust each other and collaborate in the meaning-making process.

### *Experiences Outside of Therapy*

Variantly, external experiences were cited as facilitating the meaning-making process. Ashley's client's deceased son spoke to his grandmother in a dream telling her not to commit suicide, which helped the client come to believe that her son had a greater purpose in death than in life. When Brooke's client received a random phone call from the same number as her deceased son, she developed a friendship with the stranger and thus felt more connected to her son. Susan's client felt her son speak to her during a meditation after she asked how he could commit suicide,

> The son said, "Because I had the opportunity to do it and I did." And that changed everything . . . She never asked the question again. She came back to her sessions with me, very changed and in a substantial way, like all the guilt and the shame that she had

> carried [was gone] . . . And that began to help her to shift and open the door to actually making meaning and finding meaning in a very spiritual way.

## Outcomes of Meaning-Making Work in Therapy

### *Meanings-Made Related to Loss*

One outcome of the meaning-making process in therapy was that clients were able to successfully make meaning related to the loss. We categorize these ways of making meaning as "meaning-as-significance" and "meaning-as-comprehensibility."

**Meaning-as-Significance.** In this category, clients made meaning by creating something meaningful out of the loss. In these ways, they were able to integrate the loss into their continued lives.

In the first typical subcategory, clients made meaning by honoring the life of the loved one. Sarah's client participated in suicide survivor walks and invited her parents to join her on a walk where her brother was buried; Tessa's client held a charity run in honor of her husband and started helping others through the grief process; Ashley's client started a basketball tournament to honor her son with proceeds going toward suicide prevention.

Second, clients also typically made meaning by developing a continuing bond with the deceased. Pauline said,

> A big piece of acknowledging [the loss] was to figure out a way to internalize parts of his brother into his own life so that his brother could continue living in his memory. And to begin to make changes in his own life. So, basically, "What would your brother want you to do?" . . . So as kind of a way for him to honor his brother and honor the meaning that his brother had in his life, to begin to live his life in a more meaningful way.

Similarly, Tessa's client talked to her deceased husband about things that reminded her of him, or to ask if she was doing the right thing.

Third**,** clients variantly integrated their loss into a changed sense of self. Richard's client went from being a "frozen actor" in her life narrative to being a "narrator and author." Tessa's client went from believing that everything about her had been given to her by her husband to realizing she had skills and was capable of surviving without her husband. Lauren's client, who had changed her name and cut herself off from almost everyone who had known her before the loss, was able to get closer to her "integration place" where she could be a combination of her past self and the new identity she had forged.

**Meaning-as-Comprehensibility.** In this category, clients made meaning through finding new or revised ways to understand their loss.

In the first typical subcategory, clients revised their original interpretations of responsibility for the loss. From an empty-chair intervention, Rebekah's client developed a new understanding of his wife's suicide,

> She wanted to protect him, she didn't want him to be upset, she didn't want him to worry, so she didn't tell him about her depression . . . she loved him. That gave him peace. It's not that he missed something because he didn't care or he was not a good husband.

Tessa's client had originally interpreted her husband's sudden death as an abandonment, but came to understand, "I really feel now that that he didn't leave me. But now I really feel that he had no time and he would have called for me if he could."

Second, clients variantly came to believe there was a purpose for their loss. Susan described the shift in her client's view of the loss of her son,

> She was able to kind of let go, that this was her son's path. I mean, there was a certain acceptance on a very spiritual level. This was her son's path . . . His life was in service to an awakening for his mother.

Ashley described the belief her client came to hold about the purpose of her son's suicide,

> He is watching over people from above now and specifically people who are feeling suicidal themselves. And he helps them work through those thoughts and feelings in order to not complete suicide . . . This is why he struggled, this is why he went through what he did, because he has a bigger purpose that he could not fulfill here on Earth.

### *Positive Adjustment*

Another outcome of the meaning-making work in therapy was that clients experienced positive adjustment after the loss.

**Positive Changes in Mental Health.** First, clients generally experienced improvements in psychological symptomology (Pauline's client experienced fewer PTSD symptoms and insomnia; Lauren's client had fewer panic attacks and reduced anxiety; Joanna's client stopped ruminating over the image of the death scene; Rebekah's client's gastrointestinal problems resolved). In addition, there were increases in positive psychological outcomes (e.g., Sarah's client increased in self-esteem; Ashley's client trusted herself more).

Second, clients typically made behavioral changes and re-engaged with life. Pauline described how her client's efforts to honor his brother led him to move on in his own life by separating from his wife, moving into a new place, and thinking about career changes. Susan's client finished her MBA, which she had stopped after the loss of her son, and wrote a book about her spiritual beliefs and understanding of life.

Third, clients typically experienced greater openness to and expression of emotions. Dawn's client felt emboldened by allowing herself to feel her ambivalence toward her brother's death. Lauren described how her client went from presenting with flat affect in their sessions to being more emotionally expressive and connected to her feelings.

Fourth, clients typically engaged in greater reflectivity and gained insight. Lauren's client was able to articulate how she had used her social justice activism to cope with her loss; she made connections between her present and past, particularly her trauma history, to better understand how the deaths of her sister and daughter had affected her. Susan and Brooke both stated that their clients developed greater understanding of themselves, and Rebekah's client began to apply the meaning-making framework he learned in therapy to other areas of his life.

Fifth, clients variantly had a greater acceptance of the loss. Susan's client moved from being "victimized" to letting go and accepting that this was her son's story. Brooke's client came to accept that her son's death would never make sense to her but that she had to move forward. Rebekah's client reached a point of accepting that he would never understand the pain his wife was in, but that he could respect her wish to die.

**Positive Changes in Therapy Relationship and Process.** Participants generally reported that the meaning-making process resulted in positive changes for the overall therapy relationship and process. Dawn came to care more deeply for her client, and Lauren felt more attuned to her client. Tessa, Joanna, and Brooke reported that clients were able to talk about non-loss related concerns as a result of the meaning-making work. Rebekah summarized the impact of the meaning-making work on her relationship with her client,

> It brought us closer because as I said before, these are intimate moments that we shared. I feel like he really appreciates therapy as an important place in his life. Like he can see me as a caring person in his life.

**Positive Changes in Relationships.** Participants typically reported that clients experienced positive changes in their relationships outside of therapy because of the meaning-making work. Tessa described how her client began to establish better boundaries in her relationships with her family. Lauren's client was able to start sharing about her deceased sister and son with the people in her life, as well as reconnecting with individuals she had known before the loss. Finally, Joanna said that after her client decided she wanted to embody her deceased brother's loyalty and care for others, she became more compassionate and appreciative of her family.

**Positive Changes in Religion/Spirituality.** Participants variantly reported that clients experienced positive changes in their religious/spiritual faith practices and relationship with God as a result of the meaning-making work in therapy. For instance, Pauline's client stopped questioning the meaning of life and holding anger toward God, Richard's client became re-engaged with her religious community, and Tessa's client was able to love and connect with God again.

## Illustrative Case

Daniel, a Jewish man in his mid-60's with three adult children and no previous mental health diagnoses, sought therapy with Rebekah after his wife killed herself by taking sleeping pills while they were in bed together. Daniel was devastated by his wife's suicide and unable to understand why it had happened. He developed severe stomach pain and nausea and was unable to eat. He was tormented by questions such as, "What did I miss? How come she felt so bad?"

He lost trust in himself and doubted his own instincts, continually replaying in his head the night of his wife's death.

Rebecca normalized Daniel's emotional and physical reaction to the trauma. She educated him about how the body reacts to trauma, assured him that he was not going crazy, and taught him breathing exercises. Initially, when Daniel could not tell the whole story about his wife's death, Rebecca did not push him for details. Rather, she helped Daniel work through his memories and feelings about his wife, as well as connect his reaction to her death with previous events in their marriage and other significant relationships in his life.

A turning point occurred about a year into their therapy. Daniel was ruminating on his guilt and wondering what he had missed. Rebecca suggested that he "ask" his wife, imagining her in an empty chair in the room. He imagined her responding, "I didn't want you to know." Daniel thus realized that he had not missed signs of his wife's depression because he was a bad husband but rather his wife had protected him from knowing out of love. He realized that he would never understand the depth of his wife's pain, but he could respect her wish to die.

Daniel's guilt and anger gradually decreased and his GI problems went away. He was softer, less stiff, less perfectionistic, more forgiving of himself, and able to live more freely. Daniel found concrete ways to honor his wife's life, such as collecting money to donate to the hospital where she had worked. Daniel was able to integrate his wife's legacy into his life and continue living after his loss.

## Discussion

In this study of 11 experienced therapists with expertise in trauma and/or loss on helping clients make meaning following traumatic loss, we learned that loss had indeed impacted clients' meaning, therapists facilitated the meaning-making process through a variety of interventions,

clients made meaning in terms of both significance and comprehension, and meaning-making was perceived as being associated with positive adjustment. Results should be interpreted within the context that this was not a random sample, that we asked for successful cases, and that there were a variety of types of traumatic loss.

**Impact of the Loss on Client's Meanings**

In alignment with Janoff-Bulman's (1992, 2010) "shattered assumptions" theory conceptualizing traumatic events as violating individuals' core beliefs about themselves, the world, and/or God, therapists described traumatic loss as disrupting clients' (religious and non-religious) beliefs, triggering existential questions and identity challenges, and leading to religious/spiritual distress for some. Interestingly, for those clients who already had negative views of the world (due to prior trauma history), the loss did not "shatter" clients' beliefs as much as confirm them. These disruptions (and confirmations) of clients' beliefs contributed to their distress and triggered a search for meaning, consistent with Park's (2010) meaning-making model and Gillies & Neimeyer's (2006) meaning reconstruction model.

**Therapist Interventions Related to Meaning-Making**

Overall, therapists reported using a range of interventions to facilitate meaning-making. In descending order of frequency, therapists used interventions to support (e.g., validation), facilitate insight/awareness and change narratives (e.g., challenges, restorative retelling), explore the loss (e.g., drawing the death scene), encourage action (e.g., advice), facilitate experience/expression/regulation of emotions (e.g., exploration of stigmatized emotions), and educate (e.g., psychoeducation). Notably, all of the interventions were used at least typically and many were used generally, suggesting consistency across therapists. Many of these interventions (e.g., mindfulness, empty-chair techniques) aligned with those that Park et al. (2017) suggested

for helping clients experiencing spiritual distress following trauma. Importantly, because therapists viewed "meaning-making" as an ongoing process rather than a discrete event, we saw meaning-making as embedded within the entire context of therapy; thus we did not try to separate "meaning-making interventions" from "non-meaning-making" interventions.

When asked to describe a "salient event" in the meaning-making process, several therapists chose moments when they used experiential interventions (e.g., role-plays, empty-chair techniques, meditation). From their perspective, then, the moments that most powerfully facilitated meaning-making for clients involved an experiential aspect, as clients not just changed their cognition but experienced a new narrative around their loss. Relatedly, many therapists used elements of restorative retelling, a form of treatment that highlights retelling and recreating the narrative of the loss (Rynearson & Sollum, 2021). Although empirical studies on the efficacy of restorative retelling are limited, initial evidence suggests that it may reduce PTSD, depression, and complicated grief (Rheingold et al., 2015).

**Meanings-Made Related to Loss**

We referred to the results of the meaning-making processes as "meanings-made," which is a term used by Park (2010). Another term that has been similarly used in the literature is "new meaning structures" (Gillies & Neimeyer, 2006). These refer to "end results or changes derived from attempts to reduce discrepancies or violations between appraised [meaning of the event] and global meaning [beliefs, goals, and subjective feelings]" (Park, 2010, p. 260). Furthermore, in concert with Janoff-Bulman and McPherson Frantz (1997), we differentiated these types of meanings-made broadly as "meaning-as-comprehensibility" and "meaning-as-significance."

Some clients made meaning-as-comprehensibility through finding new or revised ways to understand the loss. For example, they revised their original attribution of being responsible for

the loss, which is consistent with previous conceptualization of meaning-making as a process of reappraisal (Park & Ai, 2006; Park et al., 2017). In addition, two clients made meaning through believing there was a purpose behind the loss (e.g., the purpose of the death was to watch over suicidal people from above), which aligns with what has been labeled "sense-making" in the literature (i.e., believing in a reason for the loss or viewing it in ways consistent with prior beliefs; Davis & Nolen-Hoeksema, 2001). It is notable, however, that only two of the clients in this study made meaning in this way. Similarly, Currier et al.'s (2006) found that sense-making may be particularly difficult for those who have experienced violent loss, as survivors navigate the "compounding effect" of trauma on top of grief. Note that we conceptualize all violent loss as traumatic, but not all traumatic loss as violent, and not all of our participants experienced violent loss.

Clients also made changes in terms of meaning-as-significance. In other words, they found ways to construct something meaningful from the loss. Consistent with the literature, clients made meaning through identity reconstruction (Neimeyer & Anderson, 2002), developing continuing bonds with the deceased (Neimeyer, Baldwin, & Gillies, 2006), and honoring the life of the loved one (a form of "meaning grounded in action;" Armour, 2003). These clients were thus able to find ways to integrate an incomprehensible loss into their lives.

**Positive Adjustment**

As would be expected given that we asked for successful cases, therapists all reported that clients experienced positive adjustment to the loss as a result of the meaning-making work in therapy. They typically listed improvements in clients' mental health, indicated positive impacts on the therapeutic relationship and process, positive changes in interpersonal relationships outside of therapy, and variantly in religion/spirituality (e.g., less anger toward God). It is

important to emphasize that although therapists attributed this positive adjustment to meaning-making, it is not possible to separate out the effects of the meaning-making from other aspects of the therapy (e.g., warm therapeutic relationship, regular space to process the loss).

**Our Model of the Meaning-Making Process**

In Figure 1, we present a visual summary of our findings. We depict how traumatic loss disrupted clients' meanings, which then led to meaning-making work within therapy. This meaning-making work included therapist interventions, as influenced by therapist and client factors, as well as experiences outside therapy. As a result of this meaning-making work, clients developed "meanings-made", which included ways of making meaning-as-comprehensibility and meaning-as-significance. Clients also experienced positive adjustment after the loss. We also note that although it is often (though not always) theorized that making meaning leads to positive adjustment (Park, 2010), we found that we could not necessarily draw this conclusion from our findings. While for some of the cases making meaning did seem to facilitate positive adjustment, for other cases, it seemed equally plausible that positive adjustment helped clients make meaning. For instance, a client's identity reconstruction might have led to less depression, but improvements in depression might also have enabled clients to reconstruct their identities. Thus we represent both "meanings-made" and "positive adjustment" as outcomes of the overall meaning-making work in therapy, with a bidirectional arrow between the two, to indicate a potentially reciprocal relationship.

Moreover, we differentiated between "meanings-made" and "positive adjustment" as two outcomes of the meaning-making work, though the two were sometimes overlapping. The same positive change (e.g., improved relationships with others) could be a way of making meaning of their loss (meaning-made) for one client but simply a positive life change not associated with

one's meaning of the loss for another client. We included as "meanings-made" only those outcomes that we could clearly connect to clients' search for meaning from the loss, and categorized all other changes as positive adjustment.

Finally, though we used Park's term of "meanings-made" to capture the ways clients made meaning (as comprehensibility and significance) of the loss, it is important to highlight the inadequacies of language to convey such a nuanced concept. Though the term "meanings-made" might to some imply a resolution of the loss (or in the language of one therapist, a "You were given lemons and you made lemonade" mentality), it is important to recognize that meaning-making does not always indicate an end to distress and suffering. Instead, we see meaning-making as a continual process of integration, as individuals find ways to write their loss into their life narratives for a richer, ultimately more meaningful story.

**Fit of Findings with Initial Research Questions**

In this study, I proposed studying six questions: (a) How do therapists perceive traumatic loss as disrupting clients' meaning (i.e., beliefs about God, the world, or themselves)? (b) What are the ways that therapists perceive clients as successfully make meaning (e.g., benefit-finding, sense-making, identity reconstruction, action, religion/spirituality)? (c) How do therapists perceive religion/spirituality as impacting the meaning-making process? (d) What is the process by which therapists facilitate meaning-making for clients who have experienced traumatic loss? (e) What do therapists perceive as the impact of successful meaning-making on client outcomes and the therapy process? (f) What are therapists' own experience of facilitating meaning-making within psychotherapy after traumatic loss? (What is the impact of facilitating meaning-making after traumatic loss on the therapist?). Following guidelines for CQR, however, we bracketed those research questions and the interview questions, and focused on what emerged from the data.

Thus, our results did not completely map onto the initial research questions. In particular, we did not sufficiently answer questions c and f. Although I anticipated that religion/spirituality would impact clients' meaning-making process (question c), we found that it was more often discussed in terms of how the loss disrupted clients' faith systems rather than as a resource for facilitating meaning-making. The paucity of findings related to religion/spirituality may have been because we did not make religious/spiritual identification a criterion for eligibility for the study, and therapists and their described clients represented a broad range of religious/spiritual affiliations. In regards to the final question (f), we originally were curious about how the meaning-making impacted therapists personally. In retrospect, we realize that we did not adequately incorporate this question into our interview protocol and so we did not have sufficient data to fully answer this question.

**Limitations**

Our sample was relatively small, although most of the results were typical and general, indicating that there was some consistency within the sample. Relatedly, our therapists and clients were predominantly White American women, and so results do not necessarily apply to other groups. The therapists all self-identified as specialists in loss/trauma, which might have led to heterogeneity in their level of expertise, and many subscribed to Neimeyer's meaning-reconstruction theory (Neimeyer & Anderson, 2002).

We only interviewed therapists and thus our findings are limited to the therapist perspective. Relatedly, we relied solely on interviews, which provide a subjective snapshot of experiences at one point in time. Relatedly, because all participants were asked to describe a "successful" case of meaning-making, we are limited in our understanding of what interventions might be less helpful in facilitating clients' meaning-making. Furthermore, our results are based

only on what participants explicitly mentioned during their interviews. Thus, it is possible that the representativeness of our categories is greater than our results imply. For instance, we found that 10 of 11 participants described using interventions to help educate their client during the meaning-making process. However, it is plausible that all 11 therapists engaged in psychoeducation, even though one did not explicitly mention it in their interview.

In addition, the research team was composed of graduate and undergraduate students rather than experts in the field. Some but not all had experiences with traumatic loss. The research team discussed our biases and expectations before data analysis, and only the first author was familiar with the literature on meaning-making, out of hopes that results would emerge from the data rather than presupposed frameworks. However, it is not possible, or even desirable, to completely bracket biases and thus the data analysis process was influenced by the individual perspectives, experiences, and beliefs of the research team members.

Finally, because of the descriptive design of the study, we cannot infer causation for any of our findings. For instance, we cannot infer that the therapist's use of certain interventions resulted in the client's meaning-making outcomes, or that their meaning-making outcomes resulted in positive adjustment.

**Implications for Practice and Research**

Therapists working with clients who have experienced traumatic loss should be sensitive to the ways in which clients' beliefs about themselves, the world, and/or God may be disrupted (or confirmed, as was true for some clients in our study). Providing space in therapy for clients to name and explore their doubts, questions, and altered beliefs seems to be an important part of the meaning-making process.

Our participants also suggested that it is important to help clients process their traumatic experiences in light of their previous trauma and loss histories. For instance, one client's interpretation of her husband's sudden heart attack was that he had abandoned her, which the therapist conceptualized in light of the client's abandonment as an infant by her mother.

Another implication is that therapists should approach meaning-making slowly and carefully, following the client's pace. It is essential not to rush clients into a process of "making meaning" when clients are traumatized, but to instead engage in meaning when clients are ready (Park et al., 2017).

Many of the therapists highlighted that their approach to treatment is tailored to each client and emerges from the moment, rather than being outlined in some form of manualized treatment. Relatedly, many of the most powerful meaning-making moments seemed to emerge from spontaneous, creative, and dynamic interventions. For instance, one therapist stood up and acted out the "stuckness" she was seeing in her client; another therapist swapped roles with her client so he could play his deceased brother; and another asked her client to imagine and speak to his dead wife in their session. All of these moments emerged spontaneously from the session and led to powerful experiences that seemed to be critical to the healing process. Furthermore, they highlighted that often clients seemed to need experiences that facilitated new understandings of their loss rather than just a cognitive shift in their thinking about the loss, reflecting Fromm-Reichman's (1950) quote: "The patient needs an experience, not an explanation" (quoted in McWilliams, 2011, p.32).

Relatedly, it is important to note that for some clients, meaning-making experiences occurred outside therapy. Thus, it is important for therapists to be attuned to clients' experiences outside therapy, and then to use the therapy room to help clients explore and interpret these

experiences. In the words of Richard, “Meaning making is not just something that happens in therapy. But therapy can also scaffold clients’ own indigenous meaning-making in the space between sessions.”

Therapists can also be aware of the diverse ways in which clients might make meaning. For instance, therapists should be sensitive and responsive to clients’ needs to expand or change their sense of self to accommodate the loss (i.e., identity reconstruction), to identify greater purposes or explanations for their loss (i.e., sense-making), and/or to develop a continuing relationship with the deceased (i.e., continuing bond).

Finally, therapists need to be aware of the nuanced nature of “meaning-making.” As pointed out by several participants, meaning-making should never undermine clients’ immense pain. Our participants noted that meaning-making is not about glibly “looking on the bright side” or “taking lemons and making lemonade,” but rather is a continual process that enables clients to live meaningful lives in the midst of pain.

Future researchers could examine clients’ perspectives to obtain a more nuanced understanding of the meaning-making process. Furthermore, future researchers need to think more about what meaning-making is. As Park’s (2010) review of the meaning-making literature makes evident, there is enormous heterogeneity in the ways researchers have defined and operationalized meaning-making. This heterogeneity makes it difficult for researchers to draw conclusions about meaning-making, and we suggest that greater specification is helpful in furthering understanding of these complex processes. For instance, Park’s meaning-making model emphasizes cognitive aspects of meaning-making, while Neimeyer (2001) critiqued models of meaning-making that represent it only as a “cognitive coping strategy.” We suggest that making meaning-as-comprehensibility often is, at some level, a cognitive process, as

individuals find new ways to understand their experience; however, making meaning-as-significance extends beyond cognitive changes to encompass more comprehensive and holistic changes in one's identity and narrative. Thus, distinguishing between these two definitions of meaning may be helpful in elucidating the meaning-making literature.

Finally, future researchers could continue to examine meaning-making in psychotherapy used qualitative and mixed-method designs. For instance, a mixed-method study combining interviews on the process of meaning-making in psychotherapy with quantitative assessments of client outcomes would allow for greater understanding of the relationship between meaning-making and adjustment. Future research might also consider the use of a focus group to explore therapists' perspectives on meaning-making with clients. Finally, studies examining meaning-making using non-self-report methods (e.g., recorded psychotherapy sessions), particularly over time, would also be beneficial

# Extended Literature Review

## Definition, Prevalence, and Consequences of Traumatic Loss

Researchers have defined traumatic loss (TL) in overlapping but different ways. Green (2000) defines TL as loss that is "sudden, violent or unexpected" (p. 2) and elsewhere as "loss that occurs suddenly *and* under violent circumstance" (p.1, italics added). In their study on college students, Schnider et al., (2007) measured TL as loss that was sudden or unexpected, citing both violent (e.g., murder) and non-violent (e.g., sudden heart attack) examples. Deranieri et al., (2002) define TL as loss that occurred under "sudden, unexpected, and frequently violent circumstances" (p. 31). Currier et al., (2006) summarized that TL is typically defined in the literature as sudden and violent loss by suicide, homicide, or fatal accident, but argued that it should be labeled instead as "violent loss", while "traumatic loss" should be used instead to describe the subjective element of the experience. Finally, some (Armour, 2003; McDevitt-Murphy et al., 2012) focus on one type of TL (e.g., homicide) without offering a definition of TL as a whole, while still others (Neimeyer, 2002; Neimeyer, Prigerson, Davies, 2002) offer examples of types of TL (e.g., homicide, suicide, disfiguring accident) in lieu of an explicit definition. Thus almost all agree that TL includes elements of suddenness, unexpectedness, and/ or violence, but primary discrepancies lie in whether the loss must be violent to be considered traumatic. Accordingly, there is general consensus that death by homicide, suicide, and accident all constitute TL whereas prolonged, non-violent death (e.g., cancer) does not, but there is controversy over whether sudden, non-violent means of death (e.g., heart attacks) would be considered traumatic. To make definitions even more complicated, researchers also use a number of other terms (e.g., "violent loss", "loss/bereavement by traumatic means")

interchangeably with TL, all of which are to be differentiated from “traumatic grief,” “difficult bereavement,” and “complicated grief,” which refer to potential outcomes of TL (Neria & Litz, 2004).

Although current estimates of the prevalence of TL are lacking, a study from the 1990s on a community sample of adults in Detroit found that 60% of the population had experienced the sudden loss of a close friend or relative during their life (Breslau et al., 1998). More recent studies of nationally representative samples in Italy and the Netherlands found that 20% and 54% experienced an unexpected loss in their life, respectively (Carmassi et al., 2014; Vries & Olff, 2009). None of these studies specified that the loss had to be violent, and thus both violent and non-violent deaths were included. In contrast, Kilpatrick et al., (2013) assessed the prevalence of violent and non-violent TL separately in a national sample of adults in the U.S. and found that 51.8% experienced loss due to violence/disaster/accident, while 56.5% of the sample experienced sudden, non-violent loss. Thus, while exact prevalence rates are difficult to estimate, it seems that traumatic loss is commonly experienced across the population.

Despite the inherent overlap between the concepts of trauma and loss, it has only been recently that there is increasing study of the intersection between the fields of traumatology and thanatology (Green, 2000; Neria & Litz, 2004). Additionally, there is debate within the fields over how to conceptualize traumatic loss, with some (e.g., Green, 2000) arguing that TL should be conceptualized as a type of traumatic stressor that can lead to PTSD symptoms, and others (Neria & Litz, 2004) arguing that this “fails to sufficiently acknowledge the unique biological, psychological, and social behavior implications of bereavement” (p. 3).

The theoretical and empirical literature on the consequences of TL is similarly mixed. It has been suggested that TL is associated with worse psychological outcomes than non-TL, but

empirical findings supporting this claim are mixed. For instance, Green (2001) found that female college students who experienced violent loss had more reexperiencing and intrusive stress symptoms compared to those who experienced non-traumatic loss, but acknowledges that previous findings on this have been mixed. Further empirical study on whether TL is associated with worse outcomes than non-TL is needed to address this claim (Neria & Litz, 2004).

TL has been associated with complicated grief, which consists of persistent symptoms of separative distress (e.g., yearning, rumination) and symptoms of traumatic distress (e.g., numbness) (Neimeyer, Prigerson, & Davies, 2002). Though individuals who have experienced any type of bereavement can develop complicated grief, it has been suggested that individuals who experience TL are particularly at risk for complicated grief (Neimeyer, 2002); for instance, Currier et al. (2008) found that individuals who lost loved ones due to suicide or homicide had higher symptoms of chronic grief than those who experienced non-TL, though it is important to note they only included violent loss. Despite being recognized since the 1990's, it has only been recently that symptoms of complicated grief have been included in formal diagnostic systems (as "Persistent Complex Bereavement Disorder" (PCBD) in the DSM-5 and "Prolonged Grief Disorder" (PGD) in the proposed ICD-11; Maciejewski et al., 2016). These disorders are conceptualized to be distinct from Post-Traumatic Stress Disorder (PTSD) and Major Depressive Disorder (MDD) but share overlapping features with each other and are often diagnosed comorbidly (Smid et al., 2015). Thus while heightened attention to complicated grief and its related disorders have fostered some confusion in their overlap, (Maciejewski et al., 2016), theoretical and empirical findings seem to suggest that individuals who experience TL may be at risk for significant psychological distress.

**Shattered Assumptions Theory**

Janoff-Bulman's "shattered assumptions" theory (1992, 2010) has been foundational in creating a new approach to understanding trauma, especially as it relates to meaning. Janoff-Bulman builds off Parkes' (1988) conceptualization of bereavement as a change in individuals' "assumptive worlds" to present a theory of trauma that emphasizes its impact on survivors' internal worlds. This theory suggests that traumatic events shatter our core assumptions about God, the world, and/or ourselves. Specifically, she identified three core beliefs that are threatened in the face of trauma: (a) belief in a benevolent world (i.e., the world is a good place), (b) belief that the world is meaningful (i.e., things make sense), and (c) belief in self-worth (i.e., the self is moral and good).

**Definition of Meaning-Making**

Although theoretical and empirical work on meaning-making after trauma and loss has accelerated within the past two decades (Matthews & Marwit, 2006; Park & Ai, 2006), meaning-making has not been consistently defined (Flesner, 2013; Landsman, 2002). Park (2010) defined meaning-making as the "restoration of meaning in the context of highly stress situations" (p. 257). Others offer a constructivist approach to understanding meaning-making as "our ability to re-evaluate, reinterpret, and restructure our life narratives . . . [involving] an integration of the loss and a reappraisal of one's own identity" (Matthews & Marwit, 2006, p. 90; Neimeyer et al., 2006). Commonalities across definitions emphasize the effort to regain a sense of meaning after beliefs and worldviews have been violated by trauma or loss.

Researchers of meaning-making after trauma have generally followed Park's (2010) meaning-making model. Park proposed that (a) all individuals have a sense of global meaning, or broad beliefs, goals, and values (e.g., God is loving and in control); (b) when traumatic events occur, individuals generate an appraised meaning about what the event signifies (e.g., God

abandoned me); (c) the extent of discrepancy between individuals' global and appraised meaning determines their level of distress; (d) this distress triggers "meaning-making"; (e) this process consists of an effort to reconcile the discrepancy between global and appraised meaning to restore meaning to the world; and (f) when individuals are successful in reducing this discrepancy, they experience better adjustment to the traumatic event.

In contrast, research on meaning-making after bereavement often follows Neimeyer's (2001) theory of meaning-making, which he refers to as meaning reconstruction. In this theory, Neimeyer rejected what he considered as outdated theories of stage models of grief for one in which reconstructing meaning "is the central process in grieving" (Neimeyer, 2001, p. 4). Though his terminology differs from Park's, Neimeyer similarly posits that bereaved individuals undergo a search for meaning when their loss is inconsistent with "pre-loss meaning structures," which can result in "new meaning structures" and reduced distress. Neimeyer's theory contributed a constructivist lens to grief. He argued that human beings instinctively use stories to organize and make sense of their lives, particularly during difficult times, but that major loss challenges these stories as key characters in our narratives are removed. In the wake of this loss, we must "relearn the self" and "relearn the world" (Attig, 1996 as cited in Neimeyer, Prigerson, & Davies, 2002) as daily rituals, goals, and habits are changed. In this process, the bereaved strive to both adapt to an altered world while also preserving continuity in who they are. Thus, in comparison to Park's meaning-making model, Neimeyer highlighted the narrative processes by which loss is integrated in individuals' life stories (Gillies & Neimeyer, 2006; Matthews & Marwit, 2006).

Though Park and Neimeyer differed in their terminology and emphasized different aspects of meaning-making (cognitive vs. narrative aspects of meaning), they shared overlapping

points and can be broadly summed up as conceptualizing meaning-making as the process by which individuals restore meaning to a world that has been fundamentally changed by trauma or loss. Furthermore, meaning-making is widely theorized to be a critical component of adapting to trauma and loss, though empirical support for this assertion is mixed (discussed further below).

## Forms of Meaning-Making

Theorists and empirical researchers have also identified what have been diversely labeled as different "forms" (McAdams & Jones, 2017), "products" (Park, 2010), or "contexts" (Neimeyer & Anderson, 2002) of meaning-making. It is crucial to distinguish between the meaning-making process as a whole and these various forms of meaning-making to prevent an overly narrow conceptualization of meaning-making. For instance, some individuals seek meaning by searching for an explanation for why something occurred (i.e., sense-making; Davis et al., 2000), but it would be inaccurate to equate this with meaning-making as a whole. Rather, it is one form of meaning-making. Theoretical and empirical research have identified four common types of meaning-making. These can be divided along the lines of making meaning-as-comprehensibility vs. meaning-as-significance (Janoff-Bulman & McPherson Frantz, 1997).

### *Meaning-as-comprehensibility*

**Sense-making.** When conceptualizing meaning-as-comprehensibility, meaning-making can take the form of what has been labeled sense-making (Davis & Nolen-Hoeksema, 2001). This type of meaning making often involves the search for an explanation or "causal reasoning" (McAdams & Jones, 2017, p.8) for loss or trauma. However, sense-making doesn't always have to consist of a causal explanation; it can more broadly represents the ability to view the loss as consistent with prior worldviews or beliefs (Davis, 2001).

Davis et al. (2000) reviewed two studies on sense-making after loss. The first study examined 124 parents who lost an infant due to Sudden Infant Death Syndrome (SIDS). Participants in the study were mostly female and about half were African American. They were interviewed 2 to 4 weeks, 3 months, and 18 months after their loss and asked if they had searched for meaning after the loss, if they had succeeded in making sense of the loss, and about their levels of distress. Results of this study indicated that though the majority of participants indicated searching for making at some point after the loss of their baby, a significant minority (32%) were not searching for meaning by the time of the first interview (either because they never had, or because they initially had searched but since stopped). Surprisingly, these participants consistently reported lower distress at all time points than the 68% of the sample who did report searching for meaning. Additionally, the researchers found that less than half of the sample reported finding meaning in their loss and that for those who did, successfully finding meaning predicted better adjustment than those who searched and did not find meaning, but not better adjustment than those who never searched at all. Thus, these findings challenged the idea that finding meaning is important for better adjustment.

The second study similarly examined the relationship between sense-making and adjustment in a sample of 93 individuals who lost a family member in a motor vehicle accident four to seven years before the time of the study. They were interviewed at only one time point and asked questions about whether they had made sense of their loss and whether they had succeeded in finding it. Findings from this study parallel findings from the SIDS study, in that only a minority (28 participants) reported searching for and successfully finding meaning from their loss. In addition, those who never searched for meaning (30% of those who lose a spouse

and 21% of those who lost a child) again had less distress than those who did search for it, even for those who succeeded in finding it.

Together, these studies seem to challenge the idea that finding meaning is important for adjustment to loss. However, it is important to recognize these studies' significant limitations in operationalizing meaning. In the questions asked of participants, the terms "find meaning" and "make sense" of the loss were used interchangeably (e.g., "At present, can you make any sense or find any meaning in your baby's death?"). Thus although Davis et al. (2001) write that they "used the term 'finding meaning' to refer to being able to explain or make sense of the loss, in terms of the philosophical reasons for its occurrence" (p. 522), their addition of the phrase "or find any meaning" in their questions posed a problem by opening it up to much broader definitions of "sense-making". Accordingly, while some participants reported making sense of their loss in ways that were consistent with how Davis et al. conceptualized sense-making (e.g., "God wanted her"), Davis et al. reported that the most frequent category of finding meaning was finding something positive in the death (e.g., "It's brought my wife and I closer together"). This latter category represents a distinct psychological construct from sense-making, which is referred to as benefit-finding (discussed further below; Davis et al., 1998). Consequently, these studies demonstrated the problems that emerge when conflating meaning-making as a process with any one of its specific forms. As Davis et al. (2001) pointed out, "we need to be far more precise about what we mean by 'finding meaning'" (p. 522).

Another study by Davis et al. (1998) corrects for this conflated conceptualization of sense-making. They examined both sense-making and benefit-finding (discussed further below) separately in a sample of 205 caregivers who lost a loved one after prolonged illness. Sense-making was assessed with the question, "Do you feel that you have been able to make sense of

the death?" Benefit-finding was assessed in a separate question, thus helping to differentiate these two constructs. The participants were interviewed prior to their loss, as well as six, thirteen, and eighteen months after the loss. Findings differed from the earlier cited findings by Davis et al. (2001) in that most participants reported making sense of their loss by the 6-month interview. They most commonly made sense of the loss by viewing the death as predictable in some way (e.g., attribute to lifestyle habits), as consistent with the caregiver's worldviews, or by integrating religion/spirituality to find meaning. Furthermore, making sense of the loss earlier in the process (at six months) was associated with better adjustment than making sense later in the process, suggesting that sense-making may be particularly important early in the grieving process (Davis et al., 1998).

Silver and Updegraff (2013) reviewed several earlier studies from the late twentieth century on sense-making after trauma. In one study, Silver (1982) interviewed 102 spinal cord injured patients starting one week after their accident. They found that the search for an explanation was not associated with the objective severity of the accident; additionally, efforts to make sense of the event were initially correlated with worse psychological symptoms, though psychological outcomes seemed to improve when survivors were able to successfully make sense of the event. Importantly, the explanations participants reached varied and it was the general ability to make sense of the event, and not the specific explanation found, that seemed to predict positive outcomes.

Furthermore, Holland et al. (2006) examined sense-making (and other types of meaning-making) and complicated grief in 1,022 college students who reported losing a loved one in the past two years. Sense-making was assessed using the question, "How much sense would you say you have made of the loss?" while complicated grief was measured with the Inventory of

Complicated Grief (ICG). Results from this study support earlier findings that the time since loss was not significantly associated with sense-making (Holland et al., 2006). In addition, Currier et al. (2006) examined a subset of these participants (28%) who had experienced violent loss (e.g., due to homicide, suicide, or accident) and found that sense-making mediated the relationship between violent loss and complicated grief. This finding suggests the importance of sense-making in adaptation to traumatic loss.

However, it is important to note that while these studies suggest that the ability to make sense of why an event happened is associated with better outcomes, other research suggests the type of explanation found may matter. For instance, Stein et al. (2009) examined meaning-making in a sample of 111 college students who had experienced loss (death or relational loss) at some point in their life. In this study, "religious meaning-making coping" was assessed using the Religious Coping Scale (RCOPE). Their findings suggested that a more negative religious explanation for loss (e.g., this is God's punishment towards me) predicted higher depression and loneliness. Though this study differed from others in framing meaning-making in terms of religious coping, it essentially overlaps with the construct of sense-making and seems an important caveat in considering the relationship between sense-making and psychological outcomes. Thus, whereas previous researchers suggest it is the ability to make sense of the event, and not the explanation itself, that predicts functioning, this study potentially challenges such findings by suggesting the type of explanation may matter in predicting adaptation following loss/trauma.

### *Meaning-as-significance*

**Benefit-finding.** Benefit-finding refers to when individuals recognize something positive that resulted from the loss or trauma (Davis et al., 1998). Benefit-finding is closely associated

with posttraumatic growth (McAdams & Jones, 2017) and it is perhaps the most frequently studied construct in the trauma literature (McAdams & Jones, 2017; Park, 2010).

Davis et al. (1998) studied both sense-making and benefit-finding in the study on bereaved caregivers reviewed earlier. They found that the most common positive results that bereaved individuals identified were changes in character, shifts in perspective, and strengthened relationships. Additionally, benefit-finding seems to be a distinct psychological process from sense-making; indeed, evidence from the study suggested that for those who answered "yes" or "no" to both benefit-finding and sense-making, the ability to make sense of loss and the ability to find benefit in it were not associated, $x^2(1, N=168)=0.70$, *n.s,* at 6 months; $x^2(1,N=179)=0.11$, *n.s*. at 13 months (Davis et al., 1998). Moreover, whereas the association between sense-making and adjustment decreased over time, $\beta = -.17$, $p < 0.01$ at 6 months; $\beta = 0.10$, $p < 0.08$ at 13 month, the association between benefit-finding seemed to increase with time, $\beta = -.11$, $p < 0.05$ at 6 months; $\beta = -.14$, $p < 0.05$ at 13 months, providing further suggestion that the two forms of meaning-making represent distinct psychological processes (Davis et al., 1998). Davis (2001) hypothesized that perhaps benefit-finding is especially meaningful for individuals *particularly* when they are unable to make sense of loss or trauma; he speculates that being able to identify positive benefits from loss may provide some relief or compensation from the pain of not being able to understand why it occurred. He concluded by suggesting that perhaps finding benefit from loss makes people less concerned with needing to make sense of it, but that empirical research is needed to test this assertion.

More recent research on benefit-finding has yielded mixed results. The same study (Stein et al., 2009) that examined sense-making in college students who experienced loss (i.e., as bereavement and relational loss) also measured benefit-finding as well. They found that

perceived growth, as measured by the Stress-Related Growth Scales (SRGS), was associated with lower levels of loneliness. Wright et al. (2007) contributed nuance to the literature on benefit-finding in their study on 60 women who experienced childhood sexual abuse. They used quantitative and qualitative methods to assess coping, benefit-finding, and psychological adjustment. Their findings suggested that for the 87% of participants who reported finding some benefit from their trauma, only certain types of benefits were associated with adjustment. Improved relationships predicted better marital satisfaction and physical health, religious growth predicted less isolation and physical health, and improved parenting skills predicted less isolation. Interestingly, none of the perceived benefits predicted depression. Moreover, not all perceived benefits were associated with positive outcomes; for instance, having a greater awareness of sexual abuse predicted greater isolation and worse marital satisfaction. Thus, it seems that, potentially similarly to sense-making, it may be overly simplistic to label benefit-finding as adaptive; greater attention needs to be paid to the nuances of the types of benefits individuals report. It is interesting to consider these results along with findings from a meta-analysis of 87 studies on benefit-finding suggesting that benefit-finding is associated with less depression and higher well-being, but that it also predicts more intrusive and avoidant thoughts about the stressor (Helgeson et al., 2006). The authors of this meta-analysis suggested that differences in conceptualizing benefit-finding (e.g., as actual positive change vs. a cognitive coping process) may explain some of the inconsistencies in the literature. Thus, while benefit-finding has received much attention in the meaning-making literature, it is clear that further empirical research is needed to understand it.

Finally, it is important to note inconsistencies in differentiating benefit-finding and posttraumatic growth (PTG). Posttraumatic growth refers to “the experience of positive change

that occurs as a result of the struggle with highly challenging life circumstances" (Tedeschi & Calhoun, 2004, p. 1). It has been widely studied in the context of diverse adverse experiences and associated with numerous measures of positive well-being (McAdams & Jones, 2017). Similarity in the definitions of benefit-finding and PTG has led to confusion in the literature. Some researchers equate the two; in the earlier described studies by Stein et al. (2009) and Helgeson et al. (2006), self-report measures of PTG (e.g., Stress-Related Growth Scale, Posttraumatic Growth Inventory) were used to operationalize benefit-finding, essentially equating the two. Similarly, Park (2010) equated PTG with benefit-finding as a product of meaning-making.

However, other researchers have distinguished the two constructs. McAdams and Jones (2017) stated that PTG must "go beyond . . . meaning-making to involve demonstrable change in a person's social behavior and emotional experience" (p.12). They conceptualized that PTG must reflect observable growth in the life of the individual, which goes beyond the simpler definition of benefit-finding as identifying positive outcomes of adverse experience. For instance, in the Davis et al. (1998) study on bereaved caregivers, one example of a perceived benefit was learning the value of relationships. While this lesson might ideally lead to observable change in someone's life, it might also remain at the cognitive level. Thus, Davis (2001) observed that "clearly not all of these reported benefits represent 'growth' or transformation'" and that differentiating these constructs remains an important task for researchers (p. 143). Similarly, McAdams and Jones (2017) assert that "meaning and behavior are still two different things" (p. 12), which demonstrates the controversy within the literature over whether benefit-finding and posttraumatic growth represent distinct or uniform constructs, and may explain some of the mixed findings in the empirical literature on benefit-finding.

**Identity Reconstruction.** Another pathway of making meaning-as-significance is identity reconstruction. The process of grieving is shaped by our personal identities, which refers to the values, beliefs, and experiences we hold. Thus, loss requires us to reconstruct our identities as we navigate a world that has been fundamentally changed; it requires a "re-authorship" of our life stories in a world that has been fundamentally changed by loss or trauma (Neimeyer & Anderson, 2002). This narrative approach emphasizes the narrative processes by which meaning is reconstructed (McAdams & Jones, 2017; Neimeyer & Anderson, 2002).

Less empirical research has been conducted on identity reconstruction as a form of meaning-making compared to sense-making and benefit-finding (Park, 2010). Zebrack (2000) proposed a framework for understanding cancer survivorship that highlights how identity reconstruction may relate to well-being. He drew attention to the definition of cancer survivorship as the experience of life after a cancer diagnosis and the lifelong implications of having had cancer. He suggested that a successful ability to integrate the cancer experience into a survivor's self-concept may promote better well-being. In short, his framework closely aligns with Neimeyer's theory of meaning-making as a process of meaning - and particularly identity - reconstruction. However, empirical evidence is needed to test his framework.

In a qualitative study on meaning-making and identity, Haase and Johnston (2012) interviewed a sample of 110 young widows after around 18 months after the loss of their spouse. Haase and Johnston discuss how identity deconstruction and reconstruction were central for most of the women, as most navigated the loss of their identity (from a "we" to "I"), took on the new identity of widow, and began the challenging process of reconstructing their identities as separate from but also intrinsically tied to their deceased husbands. Their findings suggest the important role that identity reconstruction plays in adjusting to bereavement, particularly in the context of

young widowhood. However, they did not explicitly discuss how the process of identity reconstruction related to well-being.

Meert et al. (2015) identified identity reconstruction as one form of meaning-making in bereaved parents. A sample of 53 parents met with their child's physician for a bereavement meeting in which they were offered the chance to gain more information about their child's illness and hospital experience, ask questions, and provide feedback. Meetings were recorded, transcribed, and analyzed to identify themes that emerged. Meert et al. suggested that identity reconstruction was one form of meaning-making (along with sense-making, benefit-finding, and continuing bonds) that emerged from the data. Within this category of identity reconstruction, they cited examples of parents assuring themselves they had been good parents and had fulfilled their roles and responsibilities toward their children. They also discussed life changes, such as changes in their relationships, ability to travel, and work. While these findings contribute to the literature on identity reconstruction, they also highlight the difficulty of operationalizing and differentiating these forms of meaning-making. For instance, the authors identified life changes (e.g., ability to travel) as part of identity reconstruction, but this also closely aligns with the process of benefit-finding (i.e., finding positive outcomes from adverse experiences). Similarly, Neimeyer and Anderson (2002) suggested that identity reconstruction can lead to posttraumatic growth, which others (Helgeson et al., 2006; Park, 2010; Stein et al., 2009) have equated with benefit-finding. This emphasizes how these types of meaning-making can overlap and demonstrate the challenges of examining them empirically.

Finally, Neimeyer et al. ( 2006) examined identity reconstruction, other forms of meaning-making, and complicated grief in a sample of 506 bereaved college students, all of whom had experienced the loss of a loved one within the past two years. Identity reconstruction

was measured through the question, “Do you feel that you are different, or that your sense of identity has changed, as a result of this loss?” from 1 (*no* different) to 5 (*very different*), with an additional question assessing the direction of the change as 1 (*for the better*), 2 (*mixed*), and 3 (*for the worse*). Complicated grief was measured with the Complicated Grief Inventory (CGI) and the two subscales – separation distress and traumatic distress – were examined separately. Results indicated that overall, higher levels of making meaning (assessed through multiple types) predicted better grief outcomes. Interestingly, greater identity change was associated with higher levels of both separation and traumatic distress, but positive identity change predicted lower levels of distress. However, it is worth noting the limitations of using single-item measures to operationalize identity reconstruction.

In summary, identity reconstruction has been theorized to be one form of meaning-making that can lead to adjustment after loss. However, empirical studies examining this assertion are lacking. Furthermore, existing studies highlight the difficulties of operationalizing identity reconstruction and demonstrate the challenges facing empirical study of meaning-making.

**Meaning Grounded in Action.** The third form of meaning-making (i.e., significance) consists of meaning grounded in action, which refers to the “performative dimension of meaning-making” in which individuals engage in the “intense pursuit of what matters” (Armour, 2003). Armour expanded on this definition by identifying it as a “form of coping composed of intentional acts that have symbolic meaning” (p. 525). These acts can consist of problem solving or striving toward visionary goals. Armour suggested that meaning grounded in action is particularly relevant to individuals who have experienced violent loss (e.g., loss due to homicide) for whom more traditional meaning-making endeavors (e.g., sense-making or benefit-finding)

may be difficult; she argues that the inherent meaningless-ness, societal stigma, and intrusive details of violent loss may disrupt the higher-order cognitive processing required of other meaning-making methods. Meaning-making grounded in action thus allows these individuals an alternative way to actively restore meaning to a violated world. Furthermore, Armour suggested that meaning-making grounded in action might be one mechanism for facilitating identity reconstruction.

Armour's conceptualization of meaning-making grounded in action stems from her (2002) qualitative study of families of homicide victims. She conducted open-ended interviews with 48 participants from 14 families who had lost a relative to homicide from 18 months to 23 years previously. Armour identified three methods of pursuing meaning grounded in action: first, she found that the family members in her study made meaning through declarations of truth, which consisted of (a) declarations that expose hypocrisy (e.g., one father exposed the government's negligence in releasing the criminal who murdered his daughter) and declarations of self-determination (e.g., one mother's decision to refuse to watch the news about her son's death, choosing her own sources of knowledge). Through declarations of truth, family members constructed their own narratives around their loved one's death, refusing to let society shape these stories for them.

Secondly, Armour found that many family members pursed meaning by fighting for what was right, which consisted of (a) fighting for what was theirs (e.g., two sisters refused to be put on medication, claiming their right to intense and non-pathologized reactions to their father's murder) and (b) fighting to correct what was wrong (e.g., one mother's plea at her son's funeral for the young attendees to end their violence against each other). Through fighting for what is right, family members strove to restore moral order to their worlds.

Finally, Amour identified actions that give purpose to the live of the deceased as the final method of making meaning through action. Thus, they (a) used their experiences to help others (e.g., one mother attended a support group to help others through their loss) and (b) lived their lives deliberately to attribute positive value to their loss (e.g., a father's decision to publicly depict his loss through displaying a "Parents of Murdered Children" bumper sticker). In this way, family members converted their own lives into testimonies of how their loved ones mattered.

Thus, while "prosocial action," which Janoff-Bulman (2013) recognized as a particularly common activity for survivors of trauma, is one category of meaning-making grounded in action, Armour's concept of meaning-as-action expands this to include actions that do not necessarily benefit others. These active forms of meaning-making might be especially powerful in providing a sense of "mastery and control" to individuals whose assumptions of agency in a meaningful world have been shattered by traumatic loss (Armour, 2003, p. 535).

Meaning-making grounded in action has received less attention compared to other forms of meaning-making (e.g., sense-making, benefit-finding). However, some researchers have found results that contribute to Armour's work. Grossman et al. (2006) examined meaning-making in a qualitative study of 16 male survivors of childhood sexual abuse. One of the categories they identified was meaning making through action, which consisted of (a) meaning making through altruism (e.g., looking out for the vulnerable, becoming mental health professionals) and (b) meaning making through creative expression (e.g., becoming musicians, writers, or painters). They pointed out that few of their participants explicitly tied their actions to their traumatic pasts, but that their activities still seemed to represent ways to make meaning out of their experiences.

As in the case with identity reconstruction, meaning-making grounded in action can similarly overlap with other forms of meaning-making. For instance, in the earlier described

study by Meert et al. (2015) that examined bereavement meetings between parents and their children's physicians, they identified benefit-finding as one form of meaning-making. Within this category, they cited examples of parents using their experience to help others; for instance, some parents volunteered at organizations or provided feedback to hospital professionals. Though they coded this as benefit-finding, it seems that these examples could also be cited as forms of meaning-making through action, which again demonstrates the inconsistencies and overlap in differentiating forms of meaning-making.

## Meaning-Making in Psychotherapy

Given the prevalence of trauma in the general population (Courtois & Gold, 2009; Gold, 2004), its heightened prevalence among those seeking mental health care (Gold, 2004), and the well-documented need for individuals to make meaning following trauma and loss (Gillies & Neimeyer, 2006; Park, 2010), we can ask how psychotherapy facilitates such endeavors. Indeed, Janoff-Bulman (1992), in her theory of shattered assumptions, described the "extremely important role" therapists can play in the healing process. However, much of the work examining the clinical implications of meaning-making remains largely theoretical, whereas empirical research on specific meaning-making interventions has been slow to develop (Steger & Park, 2012). In the following sections, theoretical and empirical work on meaning-making is discussed from four theoretical approaches.

### *Narrative Approach*

Much of the theoretical work on meaning-making in psychotherapy has been within the narrative or constructivist approach, which integrates postmodern, feminist, empowerment, and liberation perspectives (Kamya, 2012). Narrative approaches have been suggested as especially appropriate for facilitating meaning-making, as narratives "often converge on a redemptive self

that allows one to understand past sufferings as functional and a precondition for future success" (McAdams, 2013 as cited in Zafirides et al., 2013). In other words, narrative practices allow traumatized clients to reclaim authorship over their own stories (Kamya, 2012). Narrative techniques for creating meaning (see Kamya, 2012) can be broadly categorized as external, internal, and reflexive (see Neimeyer & Anderson, 2002). Importantly, Neimeyer (2000) emphasized that the power of storytelling lies in practicing it as a social dialogue (rather than monologue) concluding that "this is nowhere clearer than in the interpersonal context of psychotherapy" (p. 233). Within this view, the role of the therapist is to "help the client to integrate problematic experiences more adequately within the self-narrative and to promote its ongoing revision and extension" (Neimeyer & Stewart, 1998 as cited in Neimeyer, 2000, p. 212).

Despite the extensive amount of theoretical work linking narrative practice and meaning, empirical studies testing the effectiveness of different narrative interventions within psychotherapy for facilitating meaning-making after loss or trauma are lacking. However, potentially related work on expressive writing (EW) interventions, which generally involve having participants write about difficult life experiences with a focus on thoughts and affect, suggest that it may be an effective tool for facilitating meaning-making, though further research is needed to explore this (Park, 2010).

### *Psychodynamic Approach*

Psychodynamic therapy refers to treatments founded in psychoanalytic theory that are briefer and simpler than classical psychoanalysis (Corey, 2017). Shedler (2010) summarized the key features of contemporary psychodynamic therapy as those with a focus on (a) affect and expression of emotion, (b) avoidance of distressing thoughts and feelings, (c) recurring themes and patterns, (d) past experiences, (e) interpersonal relationships, (f) the therapeutic relationship,

and (g) wishes and fantasies. Psychodynamic therapy aims to foster awareness of aspects of the self that are unconscious.

Although meaning-making after loss and trauma has not been as discussed within psychodynamic therapy (at least not using these terms) as it has been within some others (e.g., cognitive therapy), researchers have started to recognize how psychodynamic theory can contribute to treatment for trauma. In their study on trauma in South African police, Young et al. (2012) included a psychodynamic definition of trauma as an event that "overwhelms existing defences against anxiety in a form which also provides confirmation of those deepest universal anxieties" (Garland, 1998, as cited in Young et al., 2012, p. 3). They highlighted the role that meaning plays in psychological trauma by citing Krystal's (1978) suggestion that it is not the experience itself, but the meaning that an individual attributes to the experience, that generates a traumatic response (Young et al., 2012). Furthermore, a psychoanalytic approach to trauma emphasizes the role of traumatic memory, defense mechanisms (e.g., avoidance), the meaning of the traumatic event, and the social context of the experience in creating distress (Young et al., 2012).

Schottenbauer et al. (2008) discussed the contribution of psychodynamic theory to treatments for PTSD, highlighting how its emphasis on interpersonal relationships (particularly between the therapist and client), defense mechanisms, and self-concept can provide a helpful framework for understanding and treating PTSD. For instance, they discussed how the concept of defense mechanisms can help make sense of PTSD symptoms such as disassociation and avoidance. Marshall et al. (2000) called for more empirical research on trauma-focused psychodynamic psychotherapy, acknowledging that "psychodynamic therapy is the least well-researched treatment for PTSD, despite the fact that psychodynamic principles are widely used in

clinical practice" (Shalev et al., 1996 as cited in Marshall et al., 2000, p. 350). As an example of how psychodynamic perspective can be used to treat trauma, Marshall et al. (2000) similarly related the idea of self-concept to trauma by discussing how traumatic events often alter individuals' perceptions of themselves as "weak, defective and vulnerable," which then reinforces distress (p. 356). Notably, this aligns with Janoff-Bulman's (1992) identification of "the self as worthy" as one of our three fundamental assumptions that can be shattered by traumatic events. Marshall et al. (2000) described the psychodynamic therapist's role throughout therapy as one of facilitating the client's processing of the traumatic event and its associated meaning through narrative retelling.

Thus, while meaning-making has not been as explicitly studied in psychodynamic therapy (at least using this terminology), recent psychodynamic frameworks for understanding trauma implicitly highlight the key role that meaning can play in treatment. It remains for empirical research to test these theories.

### *Existential Approach*

Meaning is central to existential psychotherapy. Early founders of the existential orientation developed their ideas as a response to Freudian psychoanalysis, which they felt were overly deterministic and reductionistic (Zafirides et al., 2013). Frankl (1984) developed logotherapy, a meaning-centered therapy, in response to his experiences in the Holocaust concentration camps. Frankl argued that all humans have an intrinsic "will to meaning" that is the primary motivation in life. Accordingly, the aim of logotherapy is to help individuals find meaning in their lives. Yalom (1980) built upon early existential thinkers to suggest four "ultimate concerns" of existence: (a) death, (b) freedom, (c) existential isolation, and (d) meaninglessness. Existential theorists view psychological conflict as rooted in the dilemma of a

meaning-seeking creature who is thrown into a universe that has no meaning (Yalom, 1980). Zafirides et al., (2013) described how therapists can use an existential framework to help clients address of "What does it all mean?" and "Why should I go on?" They depicted the therapist as an objective figure who can "point out different means by which truth can be ascertained" and guide clients as they engage in the process of making sense of negative events (p. 476).

Wong (2010) discussed the importance of meaning-making within meaning therapy, a type of existential therapy. He wrote that meaning therapy "assumes that humans are meaning seekers and meaning making creatures" and within it, therapists guide clients as they navigate their "existential quest[s]" (p. 87). Meaning therapy is founded on meaning-management theory, which posits that meaning-reconstruction and tragic optimism (i.e., "hope that can weather the worst storms and disasters", p. 88) can promote healing from negative life events that individuals cannot make sense of (Wong, 2010). Wong (2015) presented several interventions to promote meaning: Socratic dialogue, dereflection (i.e., directing attention from challenges to something positive), and fast-forwarding techniques.

In addition, Hill (2018) built off the work of Yalom and Frankl to present a model for therapists working with clients on meaning-in-life (MIL). Though MIL is a more global construct than meaning-making, many implications of the model may be clinically relevant for therapists working with meaning-making. Hill's model consists of three stages: exploration (therapists help clients narrate and experience meaning), insight (therapists help clients understand and revise their narratives around MIL), and action (therapists help facilitate any desired change). Hill also emphasizes the need for therapists to be self-aware of their own MIL, particularly in understanding their own "hot buttons" to avoid imposing their own values onto clients. Given that meaning-making (like MIL) often invokes highly personal values such as

religion/spirituality, in addition to the emotionally difficult work of discussing trauma and loss, it seems self-awareness would also be especially important for therapists working with clients on meaning-making. Finally, Hill notes that for therapists working on MIL specifically with clients who have experienced trauma, it is important for therapists to help clients revisit their assumptions about the world. She cautions against therapists being overly directive in changing clients' worldviews, instead advocating for empathetic questions that allow clients to safely explore and revise their views as needed. Though this model needs to be empirically tested, it provides suggestions that may be relevant for therapists working with meaning-making. Relatedly, Hill et al. (2015) conducted a qualitative study of experience therapists on working on MIL. They distinguished between clients who had explicit vs. implicit meaning concerns (a distinction that may be relevant to meaning-making as well) and found that therapists used insight-oriented interventions, support, action-oriented interventions (e.g., suggestions for new directions), and exploratory interventions (e.g., reflections of feelings, open questions) to discuss MIL.

Though meaning is a central tenet of existential therapy, few studies have empirically examined how existential therapy can promote meaning-making specifically (rather than more global measures of meaning, such as meaning in life), particularly in contexts of loss or trauma. Lee et al. (2006) examined the effectiveness of a meaning-making intervention (MMi) designed to address existential concerns in a sample of 74 cancer patients. The MMi consisted of a narrative exercise and tasks that focused on emotional and cognitive responses to their diagnosis, exploration of past life events, and discussion of life priorities given their recognized mortality. They found that participants in their MMi had higher levels of self-esteem, optimism, and self-efficacy compared to participants who had received routine care.

### *Cognitive Approach*

Given the focus on beliefs and appraisals within the meaning-making model (Park, 2010), it is perhaps not surprising that much attention has been paid to the role of meaning in treating trauma within the cognitive therapies. However, such approaches often discuss meaning implicitly, using terms such as "core beliefs" instead (Steger & Park, 2012). Indeed, much of the theory behind cognitive processing therapy (CPT), one of the standard treatments for PTSD, can be viewed through a meaning-making lens. The aim of CPT is to identify and change cognitive distortions resulting from traumatic experiences (Iverson et al., 2015). This treatment examines how individuals may respond to trauma by (a) accommodation (e.g., altering prior beliefs to account for the traumatic event), (b) assimilation (fitting the traumatic event into previous beliefs), and (c) overaccommodation (e.g., over-altering previous beliefs in an effort to integrate the trauma) (Iverson et al., 2015). Indeed, these processes of accommodation and assimilation are the same ones identified by Park (2010) in her meaning-making model. The important role of cognition in treating trauma is also reflected in recent changes in the DSM-V, which added the requirement of two or more Criterion D symptoms (which consist of negative cognition and affect) to its diagnostic criteria. Thus, cognitive theories seem to significantly align with models of meaning-making in their shared focus on the interactions between trauma, beliefs, and distress.

When operationalizing meaning-making broadly as cognitive processes, much attention has been paid to meaning-making within the cognitive approach. Park (2010) highlighted the many studies that use a form of "cognitive processing" to operationalize meaning-making. In addition, Steger and Park (2012) suggested that third-wave cognitive therapies (e.g., acceptance and commitment therapy) may also be helpful in facilitating meaning-making after trauma.

Foa and Rauch (2004) compared the effectiveness of prolonged exposure (PE) vs prolonged exposure with cognitive restructuring (PE-CR) in reducing PTSD symptoms with a sample of 54 female assault survivors with chronic PTSD. They also measured negative cognitions using the Posttraumatic Cognitions Inventory (PTCI), which measures negative cognitions about self, the world, and self-blame. The PE condition consisted of imaginal exposure, in which participants recounted the traumatic event in present tense for 45 to 60 minutes. PE-CR similarly utilized imaginal exposure, but also included a focus on identifying and changing dysfunctional cognitions. They found that participants in both the PE and PE-CR conditions decreased in negative cognitions about self, world, and self-blame, and decreases did not significantly differ between the two treatments; in other words, adding the cognitive restructuring component did not enhance decreases in negative cognition. They interpreted their findings as support for emotional processing theory, which suggest that negative cognitions mediate the development of PTSD. Although Foa and Rauch did not explicitly discuss meaning-making in their study, the overlap between their constructs of negative cognitions and theories of meaning-making (Park, 2010) suggests that clinical treatments that focus on meaning-making might be effective in reducing trauma-related distress.

Findings by Cromer and Smith (2010) seem to align with Foa and Rauch's (2004) results. They similarly examined posttraumatic cognitions (called "negative cognitions" in Foa & Rauch, 2004), trauma exposure, and post-traumatic stress symptoms (PTS) in a sample of 475 college undergraduates. Consistent with Foa and Rauch (2004), they measured negative cognitions using the Posttraumatic Cognitions Inventory (PTCI). They also measured trauma exposure as the number of traumatic events participants endorsed experiencing. Their results indicated that negative cognitions predicted PTS above and beyond trauma exposure, suggesting

that it is the meaning individuals associate with trauma, and not just the amount of trauma experienced, that predict distress.

It is important to note that although researchers have (implicitly and explicitly) examined meaning-making through versions of cognitive processing (or emotional processing, which some researchers (Gray et al., 2007; Park, 2010) note may be fundamentally the same in mechanism), definitions of cognitive processing vary. Park and Blumberg (2002) noted that the term "cognitive processing" has been used by some to refer to the process of reappraising negative situations in more positive ways, while others have used it to describe deliberately thinking about the stressful experience, and still others define it as intrusive thinking and avoidance. Accordingly, Park and Blumberg (2002) described cognitive processing both as essential for meaning-making, and also associated with higher distress (e.g., intrusive thinking and avoidance). This statement seems to present a discrepancy in whether cognitive processing is adaptive or maladaptive; however, perhaps this aligns with earlier described findings that some forms of meaning-making (e.g., sense-making) are initially associated with greater distress but later, if achieved, seem to reduce distress (Silver & Updegraff, 2013).

***Religious/Spiritual Approaches***

Meaning-making often, but not always, involves religion/spirituality (R/S). Religion refers to "organized set of beliefs or dogma shared by a defined group" (Doka, 2013, p. 50), whereas spirituality can be defined as "the search for the sacred" which refers "not only to God, the divine, or higher powers but also to other aspects of life that take on a spiritual character by virtue of their association with the divine" (Kusner & Pargament, 2012, p. 212). Clinicians have been becoming increasingly aware of the reciprocal connection between trauma and spirituality, such that traumatic events can negatively (or positively) impact religious faith, even as R/S can

also be drawn upon as a coping mechanism for healing (Allen et al., 2017). Similarly, bereavement is also closely linked to R/S, such that "people who grieve are engaged in a quest for meaning," which is a "spiritual task" (Balk & Corr, 2001 as cited in Matthews & Marwit, 2006, p. 98). In the language of Janoff-Bulman (1992), if traumatic events (including loss) shatter our fundamental assumptions about the world and ourselves, it follows that such events often challenge the religious or spiritual beliefs upon which many people's assumptions are built.

Accordingly, R/S often plays a significant role in meaning-making processes (e.g., "This was part of God's plan for me" as an example of sense-making) (Davis et al., 2000; Kusner & Pargament, 2012). The R/S outcome (or what Park labels "meaning-made") of meaning-making processes can be diverse; some individuals may find their experience to be incompatible with previous beliefs and may disengage with or leave their faith; some may undergo a transformation as they discover new ways of connecting to the sacred; and some may experience a strengthening of their initial faith (Allen et al., 2017; Kusner & Pargament, 2012; Park et al., 2017).

Recognizing the religious and spiritual elements of meaning-making points to the potential effectiveness of spiritually-oriented psychotherapies for facilitating meaning-making after loss or trauma (Allen et al., 2017). Attention to such therapies have flourished in the past few decades, often with specific minority populations (e.g., Asian Americans, African Americans, LGBTQ populations) (Allen et al., 2017). One qualitative study on traumatized African Americans found that R/S meaning-making strategies were effective in promoting coping (Jacobson et al., 2006). Similarly, another study on Asian Americans who had lost family members on 9/11 found that R/S coping helped facilitate meaning after their loss (Yeh et al., 2006). Though these researchers did not examine meaning-making specifically within psychotherapy, they suggest that incorporating R/S into psychotherapy may be effective in

facilitating meaning-making. Harris et al. (2011) contributed to this literature by testing the effectiveness of the Building Spiritual Strength (BSS) intervention, which integrated spirituality to promote religious meaning-making for military veterans. The BSS was not designed to change or convert participants' religious affiliations; instead it allowed veterans to explore religious distress through sharing experiences, prayer exercises, theodicy discussions, forgiveness discussions, and related activities. They found that 26 veterans who received 8 sessions of BSS had significant reductions in their PTSD symptoms compared to 28 participants in the wait-list control group.

**Gaps in the Literature on Meaning-Making in Psychotherapy**

Though many theoretical frameworks for incorporating meaning in psychotherapy exist, there are a number of limitations to the current literature. First, the majority of studies on treatment for trauma or loss consist of outcome research, which test the effectiveness of various interventions on reducing psychological distress (see Boritz et al., 2014; Hayes et al., 2005; Shear et al., 2005). These treatments sometimes incorporate meaning-making (diversely operationalized) into the process, thus examining meaning-making as a potential mechanism of change within therapy. While this is undoubtedly important to examine, research has yet to address the process (e.g., use of specific interventions) by which therapy facilitates meaning-making.

Secondly, psychotherapy studies on meaning-making both conceptualize and operationalize it in diverse ways (e.g., narratives, cognitive processing, insight). Such broad and contrasting conceptualizations of meaning-making raise the concern about whether these studies are examining the same process. In addition, while some theoretical orientations (e.g., existential therapy) are centered on promoted meaning, these are often focused on more global constructs of

meaning (e.g., meaning in life), rather than focusing specifically on meaning-making after loss or trauma. Few psychotherapy studies examine meaning-making in ways that explicitly align with the major identified forms of meaning-making in the trauma and bereavement literature (sense-making, benefit-finding, identity reconstruction, and meaning grounded in action).

Finally, psychotherapy researchers studying meaning-making, trauma, and/or loss tend to narrow their scope to one type of therapeutic orientation or intervention (e.g., CBT, TF-CBT, BSS). Yet, as is even evident in this review, many of the different therapeutic approaches share significant overlap in how they suggest treating trauma (e.g., the use of narrative retelling, the importance of appraised meaning of a traumatic event rather than the event itself). This overlap perhaps aligns with current understanding in psychotherapy research that differences between theoretical orientation account for less than common factors (Wampold & Imel, 2017). Such a recognition suggests the particular importance of examining these common factors (e.g., interventions, contextual factors, the therapeutic relationship) that facilitate meaning-making *across orientations*. Indeed, Courtois (2017) suggested that the answer to how individuals make meaning is "not only the processing of the symptoms of the trauma itself . . . but also the context of the treatment and the relationship with the psychotherapist" (p. 190). Although some have suggested interventions that may be useful in helping clients engage in meaning-making (e.g., empty-chair techniques, mindfulness strategies, cognitive reframing; Park et al., 2017), the effectiveness of these interventions (and other contextual factors) for facilitating meaning-making has not been studied. This critical gap in the literature provides little guidance for clinicians across therapeutic orientations who seek to help their clients make meaning from devastating experiences such as traumatic loss.

**Consensual Qualitative Research (CQR)**

### *Background and Philosophy*

CQR is a rigorous qualitative approach particularly suited for research questions regarding complex, subjective, phenomena. It is rooted in both postpositivist and constructivist perspectives. Postpositivist approaches view truth as an objective reality, but believe that it can never be fully known. Constructivist approaches believe that no single objective truth exists, and instead that multiple socially constructed truths exist. CQR incorporates a blend of these philosophies in its methodology and approach.

The key feature of CQR is its reliance on a team of judges throughout the data analysis process. Researchers strive to reach consensus at each stage of data analysis, in order to construct "a truth" that is as close to the data as possible. In addition, researchers attempt to "bracket" their biases, while acknowledging that complete objectivity cannot be attained. Researchers also note the importance of participants' contexts and the unique reality of each participant's experience. CQR also differs from other qualitative methods, such as Grounded Theory (GT), through its use of multiple judges, semi-structured interviews, and a more fixed method of data analysis. See Hill (2012) for a full description of the philosophical foundation of CQR.

### *Method of Data Analysis*

**Developing Domains.** The first step in CQR involves creating a list of domains, or discrete topics, that emerge from the data. Team members typically create an initial domain list by together reading one or two transcripts, making modifications together until a consensual domain list is agreed upon. The domain list is then reviewed by the auditor and revised upon their feedback. Team members then together code new transcripts, assigning all data chunks ("thought units, sentences, and paragraphs that cover the same topic area;" Hill, 2012, p. 106) to one or more domains. Once everyone on the team understands the process, the team can divide

into rotating pairs to code the rest of the transcripts, with the first author monitoring the process. The domain list continues to be open to modifications as all transcripts are reviewed and coded. Once all transcripts have been coded, the mostly final domain list is numbered, such that closely related domains are listed near to each other. The last domain will be "Other."

Once the domain list has been finalized, a consensus version is created for each case. This consists of a table that contains all of the raw data copied and pasted from the transcript into the specific domains. Each consensus version is created by the team pair that coded that particular case and is reviewed by the first author.

**Constructing Core Ideas.** The second step of CQR is creating core ideas. Once the domain list has been finalized and the consensus version of each case created, the team creates core ideas ("summaries of the data that capture the essence of the participants statement in fewer words;" Hill, 2012, p. 111) for each data chunk. The team begins this process together through the first couple transcripts, with each member of the team rotating reading aloud a chunk of the data and suggesting an initial core idea. The other team members provide feedback until a final core idea is agreed upon by the whole team. Each core idea is listed in the consensus version next to the raw data. After core ideas have been created for a couple transcripts and every member of the team understands the process, teams can divide into rotating pairs and create core ideas for the rest of the transcripts. For each transcript, the first author reviews the core ideas and the team revises the ideas until consensus is reached. When this is finished, the consensus version for each case is provided to the auditor for feedback. The team then meets to review the feedback and decides whether to make the recommended edits. This continues until the finalized consensus version for each case is created.

**Conducting Cross-analysis.** The next step of CQR is conducting cross-analysis (i.e., "identifying common themes across cases" Hill 2012, p. 117). To do this, the team first creates a master version of the consensus version that compiles the data from all of the cases into one file. In this master consensus version, the raw data from the transcripts is deleted (with case numbers and line numbers kept) and contains the core ideas from each case organized by domain.

The team then creates categories for each domain. First, the team typically chooses one, relatively simple domain to begin with. Then the team together reads each of the core ideas under that domain and create categories that encompass most of the data within that category (i.e., identifying common themes across cases). Subcategories that further divide the data are also created as needed for larger domains. Then the team members together categorize each of the core ideas into the categories and subcategories within the chosen domain, discussing and debating together to ensure that consensus is reached for each core idea. When the core ideas for the chosen domain have all been categorized into categories and subcategories and every member of the team feels comfortable with the process, the process continues by repeating these steps for each domain. When discrepancies arise, team members return to the raw data to stay as close to the data as possible and minimize researcher bias. As this process is completed for each domain, the cross-analysis for each domain is given to the auditor for review. As before, the team then together discusses the recommended edits and decides whether to make the changes.

The final step of the cross-analysis involves calculating the frequency of themes. To do this, the team counts the number of cases with a core idea under each category and subcategory within every domain. Categories that include core ideas from all participants, or all but one, are coded as *general.* Categories that include core ideas from more than half of participants up to the cutoff for general are coded as *typical.* Categories that include core ideas from two participants

up to half of the sample are coded as *variant*. Calculating these frequencies help allow researchers to summarize their findings and compare them with other studies.

**Summary**

Traumatic events can "shatter" many of the assumptions people hold about the world, other people, and/or God (Janoff-Bulman, 1992), which sometimes leads to an effort to restore meaning through sense-making, benefit-finding, identity reconstruction, or meaning grounded in action (Armour, 2003; Davis et al., 2000; Neiemeyer & Anderson, 2002; Park & Ai, 2006) . Despite theoretical support for the importance of meaning-making for adjustment, empirical findings for this have been mixed and are fraught with limitations (Park, 2010). Additionally, few studies have empirically examined the process (e.g., skills, interventions) by which therapists help clients facilitate meaning-making after trauma. Traumatic loss in particular warrants further attention, as individuals who experience sudden, unexpected, and/or violent loss may be at especially high risk for psychological distress (Deranieri et al., 2002; Neimeyer, Prigerson, & Davies, 2002). Findings from this study will advance understanding of how therapists facilitate meaning-making for clients who have experienced traumatic loss.

**Table 1**

*Therapist and Client Loss Information*

| Therapist | Relationship of Deceased to Client | Nature of Client's Loss |
|---|---|---|
| Sarah | Brother | Suicide |
| Pauline | Brother | Cardiac arrest |
| Richard | Grandson | Unknown; possible congenital abnormality |
| Dawn | Brother | Suicide |
| Tessa | Husband | Cardiac arrest |
| Lauren | Sister and daughter | Car accident |
| Susan | Son | Suicide |
| Joanna | Brother | Homicide |
| Ashley | Son | Suicide |
| Brooke | Son | Undetected heart defect |
| Rebekah | Wife | Suicide |

*Note.* Therapist names are pseudonyms.

**Table 2**

*Domains, Categories, Subcategories, and Frequencies of Findings for Therapists' Perspectives on Meaning-Making in Psychotherapy After Traumatic Loss*

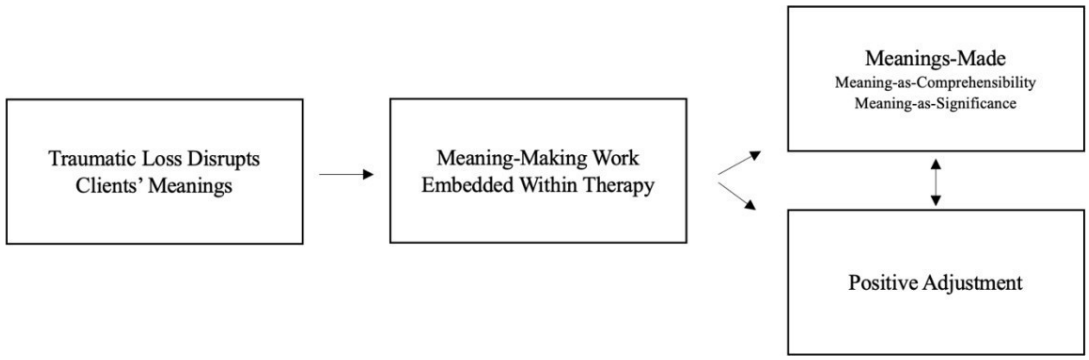
| Domain/Categories/Subcategories | Frequency |
|---|---|
| **Impact of the Loss on Client** | |
| Negative Impact on Mental Health | |
| Psychological symptomology | G (11, 100%) |
| Loss of identity | T (6, 55%) |
| Negative Impact on Interpersonal Relationships | G (10, 91%) |
| Disruptions in Beliefs/Religion/Spirituality | T (9, 82%) |
| Factors that Complicated Clients' Grieving Process | |
| Prior loss/trauma history | T (6, 55%) |
| Cultural/societal expectations around grief | V (2, 18%) |
| Complicated relationship with lost | V (2, 18%) |
| **Therapist Interventions Related to Meaning-Making** | |
| Interventions to Support Client | G (11, 100%) |
| Interventions to Help Client Gain Insight/Change Narratives about the Loss | G (11, 100%) |
| Interventions to Help Client Explore Loss | G (10, 91%) |
| Interventions to Help Client Take Action in Life | G (10, 91%) |
| Interventions to Help Client Express, Experience, and Regulate Emotions | T (9, 82%) |
| Interventions to Educate Client | T (7, 64%) |
| **Factors that Facilitated Meaning-Making in Therapy** | |
| Therapist Factors | |
| Beliefs | T (9, 82%) |
| Personal characteristics and experiences | V (5, 45%) |
| Client Characteristics | |
| Motivation | T (7, 64%) |
| Grit | T (7, 64%) |
| Religion/spirituality | V (4, 36%) |
| Psychological-Mindedness | V (4, 36%) |
| Therapeutic Relationship | T (6, 55%) |
| Experiences Outside of Therapy | V (3, 27%) |
| **Outcomes of Meaning-Making Work in Therapy** | |
| Meanings-Made Related to Loss | |
| Meaning-As-Significance | |
| Honoring the life of the loved one | T (8, 73%) |
| Developing a continuing bond | T (6, 55%) |
| Identity reconstruction | V (5, 45%) |
| Meaning-As-Comprehensibility | |
| Revised interpretation of responsibility for the loss | T (6, 55%) |
| Believing there is a purpose to the loss | V (2, 18%) |

| | |
|---|---|
| Positive Adjustment | |
| Positive Changes in Mental Health | |
| Improvement in psychological symptomology | G (11, 100%) |
| Behavioral changes/re-engagement with life | T (7, 64%) |
| Greater openness to/expression of emotions | T (7, 64%) |
| Greater reflectivity/insight | T (7, 64%) |
| Greater acceptance of the loss | V (5, 45%) |
| Positive Changes in Therapy Relationship and Process | G (10, 91%) |
| Positive Changes in Relationships | T (9, 82%) |
| Positive Changes in Religion/Spirituality | V (4, 36%) |

*Note. N*= 11. G= General (10-11 participants), T = Typical (6-9 participants), V = Variant (2–5).

**Figure 1.**

*Tentative Model of Meaning-Making in Psychotherapy after Traumatic Loss*



## Appendix A

Eligibility and Background Survey

Name: _____

Email: _____

Age: _____

Gender:

- Female
- Male
- Other

Type of Degree (PhD, PsyD, etc.): _____

Year of Degree: _____

Years in Practice Post-Graduation: _____

Do you have a self-identified specialization in working with trauma and/or loss?

- Yes
- No

Do you have a client that you can speak about a) with whom you are currently still in therapy (and have been seeing for at least 6 months) or have terminated with in the past 2 years (b) who experienced traumatic loss (i.e., loss of a loved one that was sudden, unexpected, or violent) at 18 years or older, (c) with whom you feel you successfully facilitated meaning-making?

- Yes
- No

Race (Pick all that apply):

- Asian
- American Indian or Alaska Native
- Black or African American
- Hispanic, Latino, or Spanish

- Native Hawaiian or Pacific Islander
- White
- Other _____

Sexual Orientation:

- Straight
- Bisexual
- Gay, Lesbian, Homosexual
- Other _____

Religious Affiliation:

- Buddhist
- Catholic
- Hindu
- Jewish
- Muslim
- Protestant
- Agnostic
- Atheist
- Other _____

How important is your religious/spiritual identity to you?

- Not Important
- Slightly Important,
- Moderately Important

- Important
- Very Important

How important is your religious and/or spiritual identity or views in the way you approach clinical work with grieving clients?

- Not Important
- Slightly Important,
- Moderately Important
- Important
- Very Important
- Prefer Not to Answer

Typically what percentage of your caseload are clients dealing with trauma and/or bereavement??

- 0%
- 1-5%
- 6-10%
- 11-20%
- 21-40%
- 41-70%
- 71-100%

In all of your years of doing therapy, how often have you worked with clients who have experienced trauma and/or bereavement?

- Never
- Rarely

- Fairly often
- Often
- Very often

Have you done any of the following? Please check all that apply to you:

- Taken grief counseling or death education courses in graduate program
- Received grief counseling experience/training in practica/externship/internship
- Taken continuing education courses in grief counseling or death education
- Attended professional conferences that focused on grief counseling or death education
- Read books or other educational material on grief counseling
- Received certification in grief or trauma

Have you experienced any significant deaths in your life?

- Yes
- No

To what degree do any of these losses feel unresolved or unfinished?

- Extremely unresolved/unfinished
- Very unresolved/unfinished
- Slightly unresolved/unfinished
- Mostly resolved
- Completely resolved

The phrases below describe how a therapist might follow different theoretical orientations. There are no right or wrong answers to these items. Please read each statement carefully and then fill in bubble that corresponds to where you place yourself on the scale.

I identify myself as Psychoanalytic or Psychodynamic in orientation.

O O O O O O O O O O

Not at all Completely

I conceptualize my clients from a Psychoanalytic or Psychodynamic perspective.

O O O O O O O O O O

Never Always

I utilize Psychoanalytic or Psychodynamic methods,

O O O O O O O O O O

Never Always

I identify myself as Humanistic or Existential in orientation.

O O O O O O O O O O

Not at all Completely

I conceptualize my clients from a Humanistic or Existential perspective.

O O O O O O O O O O

Never Always

I utilize Humanistic or Existential methods.

O O O O O O O O O O

Never Always

I identify myself as Cognitive or Behavioral in orientation.

O O O O O O O O O O

Not at all Completely

I conceptualize my clients from a Cognitive or Behavioral perspective.

O O O O O O O O O O

Never Always

I utilize Cognitive or Behavioral methods.

O O O O O O O O O O

Never Always

Thank you for completing this survey! You will be contacted via email if you are eligible to complete the interview portion of this research study.

## Appendix B

Interview Protocol

Meaning-Making in Psychotherapy after Traumatic Loss: Therapists' Perspectives

*When individuals experience a traumatic loss, they often experience a "shattering" of beliefs or assumptions about the world, religion/spirituality, and/or themselves. In the wake of this, many feel a need to make meaning of their experience. Individuals often try to make meaning by:*

- *making sense of the event (finding an explanation for what happened)*
- *finding benefit from the event (identifying a positive outcome from the event)*
- *engaging in action*
- *reconstructing their beliefs, identity or life narrative following the event*
- *turning to religion/spirituality*

Pick one salient case from within the past 2 years in which you were able to help the client successfully make meaning following a traumatic loss (i.e., loss of a loved one that was sudden, unexpected, or violent). Please review your notes about that case in preparation for this interview.

1. Tell me about the client
    a. Demographics (e.g., age, gender, race/ethnicity, sexual orientation, religious affiliation, diagnoses)
    b. Presenting concerns and relevant trauma/loss/mental health history
2. Tell me about the traumatic loss
    a. When it happened
    b. How it happened
    c. Client's relationship to the deceased
    d. Client's social support following the loss
3. How did the traumatic loss disrupt the client's beliefs about the world, religion/spirituality, and/or themselves?
4. Describe the overall process of working with this client on the traumatic loss
    a. How did the meaning-making process fit in with the rest of therapy?
    b. Who initiated the meaning-making process?
    c. Describe the meaning-making process over the course of therapy
5. Pick a specifically salient event within that meaning-making process (this may be within one session or across multiple sessions)
    a. When was this event during the course of therapy?
    b. What led up to the event in this moment within the session(s)?
    c. Describe the event in detail, from start to finish, including what the client said and what you said
    d. Describe the specific skills or interventions that you used
    e. Describe your thinking about why you used the intervention(s)
    f. Describe client verbal and nonverbal behaviors
    g. What was the immediate outcome of this event in the session(s)?
    h. Describe how you felt during this event

6. What (if any) was the role of religion/spirituality for this client in making meaning from the traumatic loss?
7. What was the meaning that was made for the client?
8. What was the overall impact of meaning making?
    a. on client outcomes (e.g., psychological well-being, symptomology, interpersonal relationships)
    b. on the therapeutic relationship
    c. on the therapy process
9. What do you believe made this meaning-making process successful?

## Appendix C

Recruitment Email

Subject: Meaning-Making in Psychotherapy after Traumatic Loss

Dear_____,

I am a doctoral student in the University of Maryland's Counseling Psychology program. I am currently interviewing therapists for a research study on successful meaning-making in psychotherapy for clients who have experienced traumatic loss (i.e., loss of a loved one that was sudden, unexpected, or violent). I'm reaching out in hopes that you might be willing to be interviewed. You would have the choice of completing this interview over a phone or video call and it would last between 1-2 hours.

The study eligibility requirements are that all therapists:

- are licensed and at least 5 years post-graduate school
- have a self-identified specialization in working with loss and/or trauma
- must be able to discuss one client (a) with whom you are currently still in therapy (and have been seeing for at least 6 months) or have terminated with in the past 2 years, (b) who experienced traumatic loss (i.e., loss of a loved one that was sudden, unexpected, or violent) at 18 years or older, and (c) with whom you feel you successfully facilitated meaning-making

The interview protocol is attached for you to review. If you are interested in participating in this study, please complete this eligibility and background survey. If you are eligible for the study, I will email you to schedule an interview. Verbal consent will be obtained at the start of the interview and consent can be withdrawn at any time; you may also choose to skip any question you prefer not to answer.

Unfortunately, I cannot offer any monetary compensation for participating; however, I hope the experience of being interviewed would be a meaningful one for you. I would also appreciate your consideration in forwarding this email to any therapists in your professional network who might be interested in this study; I can be contacted at katierim@umd.edu.

Thank you for considering contributing to this important area of research.

Sincerely,

Katie Rim, Doctoral student in UMD Counseling Psychology

Clara E. Hill, PhD, Advisor

## Appendix D

Qualtrics Consent

The purpose of this study is to explore therapists' perspectives on facilitating meaning-making in psychotherapy for clients who have experienced traumatic loss. I would really appreciate your help in studying this important topic.

The study involves two parts: (1) an online, eligibility and background survey and (2) a phone or video interview. The online survey will take approximately 10 minutes and the phone interview will take 1-2 hours. Completion of the survey does not guarantee that you will be interviewed. I will contact you after you complete the survey to let you know whether or not you meet the criteria for the interview.

Your participation in this study is completely voluntary. This means that you may choose not to take part at all. Additionally, even if you decide to participate in the study, you may stop participating at any time and may skip any question you prefer not to answer. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you would otherwise qualify.

You will be assigned code numbers and no names will be associated with any of the data. Only the primary investigator and research advisor have access to the assigned code numbers to be able to link the data with the individuals and this information will be password protected. Data will be uploaded to a secure computer storage system and the responses of anyone deemed ineligible will be kept for possible future data analyses.

The eligibility criteria are as follows:

- Be licensed and at least 5 years post-graduate school
- Have a self-identified specialization in working with clients who have experienced trauma and/or loss
- Be able to discuss one client
    - (a) with whom you are currently still in therapy (and have been seeing for at least 6 months) or have terminated with in the past 2 years
    - (b) who experienced traumatic loss (i.e., loss of a loved one that was sudden, unexpected, or violent) at 18 years or older
    - (c) with whom you feel you successfully facilitated meaning-making

If you have questions, concerns, or complaints, please contact Katie Rim (katierim@umd.edu or 224-234-6042) or the University of Maryland's Institutional Review Board (irb@umd.edu; 301-405-0678).

Clicking the button below indicates your consent to completing the eligibility and background survey.

## Appendix E

Verbal Consent Script

The purpose of this study is to explore therapists' perspectives on facilitating meaning-making in psychotherapy for clients who have experienced traumatic loss This [phone/video] interview will take 1-2 hours to complete. The interview will be audio-recorded and transcribed, with all identifying information removed. The recording will be immediately transferred to a secure computer storage system and the original recording will be erased. You will receive a copy of the transcript to check it for accuracy and confidentiality. Once everything is reviewed, the recording will be erased from the computer storage system.

Your participation in this research is completely voluntary. This means that you may choose not to take part at all. Additionally, even if you decide to participate in this research, you may stop participating at any time and choose to skip any question you prefer not to answer. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you would otherwise qualify.

If you have questions, concerns, or complaints, you can speak with me now or contact me separately at katierim@umd.edu or (224)-234-6042. You can also contact the University of Maryland, College Park Institutional Review Board Office at irb@umd.edu or (301) 405-0678. This study has been reviewed according to the University of Maryland, College Park IRB procedures for research involving human subjects.

Your verbal consent indicates that you are at least 18 years of age, have had the verbal consent procedures explained to you, your questions have been answered to your satisfaction, and you voluntarily agree to participate in this research study. You will receive a copy of this verbal consent script for your records.

Would you like to participate in this study?

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