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The IADC Grief Questionnaire as a Brief Measure for Complicated Grief in Clinical Practice and Research: A Preliminary Study

Fabio D'Antoni [1,*] and Claudio Lalla [2]

[1] Maternal Infant Services Unit of Udine, Azienda Sanitaria Universitaria Friuli Centrale (ASUFC), 33100 Udine, Italy
[2] Independent Researcher, Via degli Scipioni 237, 00197 Rome, Italy; claudiolalla@gmail.com
* Correspondence: fabio.dantoni@asufc.sanita.fvg.it

Abstract: IADC (induced after-death communication) therapy is a grief treatment developed by Botkin that is increasingly being acknowledged for its effectiveness in various countries worldwide. In clinical practice, professionals trained in IADC therapy employ a brief evaluation tool called the IADC Grief Questionnaire (IADC-GQ) to determine whether mourning can be disturbed or stopped, resulting in complicated grief. This preliminary research aimed to establish the psychometric properties of the IADC-GQ. The factor structure was analyzed in a sample consisting of 113 participants undergoing psychological treatment who had endured the loss of a loved one for a minimum of six months. The findings revealed a two-dimensional framework comprising two distinct factors: the "Clinical Score", encompassing the most distressing elements of grief, and the "Continuing Bond" factor, which is associated with feelings of connection to the departed and thoughts regarding the existence of life after death. The IADC-GQ has the potential to be easily and quickly employed in both research and clinical settings. Moreover, it can qualitatively assist therapists during clinical interviews by highlighting the key areas where the grieving process may encounter obstacles.

Keywords: bereavement; mourning; grieving process; complicate grief; assessment; psychotherapy; after-death communication; continuing bonds

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1. Introduction

Complicated grief (CG), as well as prolonged grief disorder (PGD) and persistent complex bereavement disorder (PCBD), refers to a severe and prolonged form of grief that exceeds the typical mourning period and impairs the individual's ability to engage in daily activities and function normally [1]. It is a complex emotional response to the loss of a loved one that persists for an extended period, typically lasting for over six months or more. Individuals experiencing CG often have intense feelings of longing, sorrow, and pain that do not diminish over time. They may struggle to accept the loss, experience intense and intrusive thoughts or memories of the deceased, or have difficulty finding meaning or pleasure in life without the person who has died [2,3].

The Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5), does not list CG as a separate disorder [4]. However, it is recognized as a condition that may require clinical attention [5]. The DSM-5 defines grief as a natural response to the loss of a loved one. Using the diagnostic entity of persistent complex bereavement disorder, DMS-5 acknowledges that grief can be complex and that some individuals may experience prolonged and more severe symptoms than what is typically expected. The DSM-5 includes a diagnosis called "Other Specified Trauma- and Stressor-Related Disorder" that can be used to catergorize individuals experiencing prolonged grief reactions that do not meet the criteria for post-traumatic stress disorder or acute stress disorder [6]. Although the classification and diagnosis of CG are still controversial among mental health

professionals [7], the more recent DSM-5-TR includes the criteria for PGD: (1) feeling as though a part of oneself has died, (2) a marked sense of disbelief about the death, (3) avoidance of reminders that the person has died, (4) intense emotional pain (anger, bitterness, and sorrow) related to the death, (5) difficulty with reintegration into life after the death, (6) emotional numbness, (7) feeling that life is meaningless as a result of the death, and (8) intense loneliness as a result of the death [8]. The weight of these symptoms results in noticeable distress or impairment in social, work-related, or other vital aspects of life, and they must continue for at least 12 months following the loss. The length and intensity of the grief response go beyond what is considered normal or expected within the person's cultural or social background [8].

The literature is ambiguous regarding whether distinct terms such as CG, PGD, or PCBD and the proposed symptom criteria for these clinical situations denote identical or disparate diagnostic entities. Maciejewski et al. (2016) indicated that PGD and PCBD, as described by the DSM-5, were substantively the same disorder [9]. The levels of diagnostic specificity of the different brief symptom diagnostic tests used in their study were comparably high for PGD and PCBD. However, the test for CG was incongruous with those for PGD and showed poorer diagnostic specificity and no predictive validity. From a semantic standpoint, PGD emphasizes the psychopathological aspect through the prolonged duration of typical mourning symptoms over time. In contrast, CG involves the complication of the normal grief process by clinical factors such as trauma [10]. From this perspective, the current study focuses on the historical construct of CG, aiming to validate a concise assessment tool designed to assist clinicians in recognizing potential issues associated with the grieving process and to measure the efficacy of their interventions across various situations beyond pathological grief.

The prevalence of CG varies among different populations [11]. Research suggests that it affects approximately 9.8% (95% CI 6.8–14.0) of individuals who experience the loss of a loved one [12]. However, the prevalence may be higher among specific groups, such as individuals who have experienced traumatic or sudden loss [13]. CG can have a significant impact on a person's mental, emotional, and physical well-being, and may require professional intervention, such as counseling or therapy, to help them navigate the grieving process and find ways to heal [5].

The implementation of regular screenings for CG in clinical settings can enhance the knowledge and understanding of this condition, thereby expediting clients' access to necessary treatment [5]. The Inventory of Complicated Grief (ICG) is a tool developed by Prigerson et al. (1995) to assess symptoms related to CG [1]. The ICG has been widely used in research studies to assess CG in individuals who have experienced the loss of a loved one. Numerous studies have demonstrated significant associations between the scores on the ICG and other measures of grief, depression, anxiety, and post-traumatic stress disorder [1,14–18]. Furthermore, the ICG has shown good discriminant validity, as it can differentiate individuals with CG from those with other mental health conditions or non-CG, for example, the Texas Revised Inventory of Grief (TRIG), which assesses more normal grief symptoms [19]. Researchers have utilized the ICG to investigate the prevalence and risk factors associated with CG, as well as its impact on individuals' functioning and well-being. It has also been used to evaluate the effectiveness of interventions targeting CG and assess changes in symptoms over time [20].

However, a recent systematic psychometric review regarding the ICG has highlighted bad-fit indices in the confirmatory factor analysis (CFA), suggesting that the proposed theoretical conceptualization of the questionnaire may lack unidimensionality and structural validity [21]. These poor ICG-fit indices indicate that the scale might not accurately assess CG and may need revisions or adjustments to improve its ability to measure the intended construct.

For example, two ICG items that concern alleged hallucinations (item no. 15, "I hear the voice of the person who died speak to me", and item no. 16, "I see the person who died stand before me") are considered indicators of pathological grief, together with other items that refer to other aspects of CG (e.g., accepting the loss, severe social withdrawal, etc.).

However, evidence indicates that hallucinations associated with departed individuals may be an integral aspect of typical grieving and mourning in several cultures [22]. Moreover, certain instances of hallucinations could be linked to a more complex phenomenon known as after-death communication (ADC).

The sensation of perceiving the existence of the deceased individual, either during the moment of passing or subsequently thereafter, is an essential occurrence that studies indicate can impact the grieving process [23,24]. Broadly speaking, ADC is a term used to describe these reported experiences of individuals who claim to have had communication or contact with a deceased loved one. ADC events can take various forms, including dreams, visions, auditory or visual sensations, feelings, smells, or signs perceived as messages from the deceased individual [25]. In the research, the phenomenon of ADC typically refers to a spontaneous occurrence in which an individual feels or perceives a personal connection with someone who has passed away. These connections or interactions are unmediated by external agents, such as psychics or mediums, and they do not require any specific rituals or equipment designed for contacting the deceased. Furthermore, these experiences are entirely spontaneous and not sought out by the individuals involved [25,26].

ADC can be observed in various cultures, races, ages, socioeconomic statuses, education levels, genders, and religious beliefs [27]. Religious, spiritual, and cultural convictions tend to impact the substance and understanding of ADC; however, they do not impact its prevalence [24,28–30]. Research conducted on the general population suggests that approximately 30–35% of individuals have reported experiencing ADC. Furthermore, these occurrences predominantly take place within a year after the loss of a loved one [24,31]. According to a study on European values, an estimated 127 million Europeans, which accounts for 25% of the population, have indicated experiencing an ADC [32]. Additional surveys, particularly among grieving individuals, have revealed that 50–60% have encountered one or more ADC events [33–36].

These phenomena are often considered significant and meaningful to the person who experiences them, as they generally provide a sense of comfort, reassurance, or connection with their deceased loved one [37–39]. Persons who have experienced ADC events have reported a decrease in negative emotions, such as sorrow, grief, incomplete communication, regret, and remorse, as well as an increase in positive sentiments of comprehension, appreciation, gratitude, love, and forgiveness [40].

In a historical context, ADC has been widely regarded as a manifestation of psychopathology, and numerous individuals still express concerns about being pathologized, leading them to refrain from disclosing their experiences [41]. Kamp et al. (2019) conducted a study wherein individuals who reported ADC events, known as bereavement hallucinations, exhibited higher scores on indicators of psychological distress. These findings led the researchers to propose that ADC might contribute to the diagnosis of CG [42]. However, a substantial body of evidence also indicates that ADC events are observed in healthy individuals who have neither sought nor felt the necessity for formal treatment [43]. Due to the widespread occurrence of spontaneous ADC events in individuals' lives, and the absence of agreement among scientists regarding the essence of ADC events or the sensory-perceptual phenomenology related to them, it would be overly simplistic to regard such experiences as hallucinations or a symptom of psychopathology. Consequently, it would be inaccurate to view ADC events as indications of CG.

Furthermore, ADC and "continuing bonds" [44] are two concepts in the field of grief research that challenge the traditional understanding of grief as a process of detachment and moving on, instead emphasizing the importance of maintaining connections with deceased loved ones [45]. The continuing bonds theory, derived from Bowlby's attachment theory [46], posits that individuals perceive their connection to the deceased as persisting beyond death, albeit transformed, rather than being completely severed [47]. The maintenance of ongoing connections after a loss seems to offer solace and reassurance to the grieving individual. Furthermore, it aids in incorporating the unique circumstances surrounding the death into a cohesive narrative, facilitating the process of finding new

meaning and a transformed sense of self. Based on these discoveries, it is advisable to not discourage the utilization of continuing bonds and interventions that facilitate the reconstruction of meaning and acknowledge the spiritual aspect of these bonds [48].

For example, IADC (induced after-death communication) psychotherapy is a grief therapy approach that focuses on helping people who are grieving the loss of a loved one through an experience of communication with the deceased [20,49]. In IADC therapy, the therapist guides the individual into a relaxed and open state of mind, allowing them to access an experience of interaction with loved ones who have passed away. ADC experiences, within the context of IADC therapy, exhibit distinctions from spontaneous occurrences in daily life. These differences primarily arise from the heightened phenomenological richness of the induced experiences and their prolonged duration. Throughout IADC therapy sessions, the clients communicate to the therapists the multisensory nature of their encounters, encompassing auditory perceptions, visualizations, and somatic sensations, such as hearing the words of the deceased, seeing their image, and feeling their embrace. These interactions unfold as extended dialogues, often lasting over an hour, facilitating substantial information transfers between the individual and their departed loved one [49]. IADC therapists refrain from investigating the underlying essence or inherent characteristics of this psychological experience with clients, opting instead to examine its phenomenology—the study of its appearance or manifestation—to harness its substantial therapeutic capacity. This treatment has demonstrated effectiveness in enhancing grief symptoms and coping strategies, as well as mitigating emotions associated with anger, guilt, and sadness [50].

Spontaneous ADC events were discussed by Yamamoto et al. (1969) and Rees (1971), surveyed by Kalish et al. (1973), and made famous by Moody in 1993 [24,36,51,52]. However, these studies focused primarily on interviews centered around spontaneous ADC experiences characterized by brevity, lasting a maximum of a few seconds, and typically engaging a single sensory channel. Moreover, these studies were conducted in non-clinical settings. Furthermore, empirical investigations into the potential phenomenological richness of ADC experiences induced under the guidance of expert clinicians are notably lacking. In addition, there is a paucity of literature addressing the effectiveness of IADC therapy and its role in facilitating the grieving process through the induced subjective experience of contact with the deceased [50]. The validation of the questionnaire commonly employed by IADC therapists in clinical settings may serve as a catalyst for further empirical research in this domain.

IADC therapists use the IADC Grief Questionnaire (IADC-GQ) to assess an individual's grief experience. It consists of a series of questions that aim to gather information about the client's emotions, thoughts, and behaviors related to their grief. The IADC-GQ enables IADC therapists to understand and support clients experiencing grief. It helps professionals assess an individual's level of adjustment and identify areas where they may require additional support or interventions. Nevertheless, a thorough empirical validation of the questionnaire employed generally within a clinical context has not been conducted.

Therefore, the present study aimed to explore the psychometric properties of the IADC-GQ as a brief measure for screening CG that is suitable for implementation in both clinical and research fields.

2. Materials and Methods

2.1. Participants and Procedures

The research sample consisted of individuals selected from the pool of patients undergoing treatment under the guidance of nine freelance psychotherapists belonging to a professional community focused on IADC therapy situated in distinct regions of Italy. To take part in this study, participants had to meet the following inclusion criteria: (1) be at least 18 years old, (2) have experienced the loss of a loved one for a minimum period of six months, and (3) not have shown symptoms of severe mental disorders, specifically those that might impede their capability to distinguish between reality and fantasy, such

as psychotic disorders. Per the Declaration of Helsinki and the National Board of Italian Psychologists' Code of Ethics, all psychotherapists obtained the participants' specific informed consent during the clinical consultations. The psychotherapists then utilized an online survey platform to ensure the secure and anonymous transmission of the data to the first author of this paper. The survey included questions assessing participants' general information and symptoms of CG. It did not necessitate the collection of any supplementary data beyond what is typically obtained during therapy sessions by a psychotherapist. The online survey was advertised between 15 January 2020 and 14 September 2023.

A total sample of 113 participants completed the survey. Concerning primary sociodemographic attributes, 90% of the participants identified as female, with an average age of 51.02 years (*SD* = 12.15). The basic descriptive statistics are reported in Table 1. A majority of the participants expressed having attained a higher-education degree (50%) or completed secondary education (49%). Regarding the spiritual facet, a notable proportion of the participants, amounting to 54%, asserted that this had a profound significance in their lives. Additionally, a considerable subset of respondents, specifically 24%, reported having encountered at least one ADC experience before this study. A total of 21% of the participants in this study reported the utilization of psychiatric drugs, namely anxiolytics and mood stabilizers (no antipsychotics), to alleviate the distressing symptoms associated with the grieving process. Regarding bereavement characteristics, the deceased individuals were evenly distributed in terms of gender, with a collective average age of 51.49 years (*SD* = 25.92). The deceased individuals primarily consisted of parents (38%), children (22%), and partners (20%). Concerning the manner of mortality, the majority of individuals (71%) succumbed to diseases or medical conditions, while 19% experienced fatalities resulting from accidents, such as vehicular collisions. In addition, suicide accounted for 7% of deaths, while murder constituted the remaining 3%.

Table 1. Descriptive statistics.

Categories		*N*	%
Gender	Female	102	90.27%
	Male	11	9.73%
Education	Primary school	1	0.88%
	Secondary school	57	50.44%
	Bachelor's degree	55	48.67%
Ongoing treatment with various psychotropic drugs	Yes	24	21.24%
	No	89	78.76%
Previous ADC experiences	Yes	27	23.89%
	No	86	76.11%
Importance of spirituality in life	Not at all important	2	1.77%
	Slightly important	4	3.54%
	Neutral	11	9.73%
	Moderately important	35	30.97%
	Very important	61	53.98%
Gender of the deceased	Female	57	50.44%
	Male	56	49.56%
Deceased's relation to the bereaved	Child	25	22.12%
	Parent	43	38.05%
	Spouse/partner	23	20.35%
	Sibling	7	6.19%
	Other family member	11	9.73%
	Close friend	1	0.88%
	Pet	3	2.65%
Cause of death	Disease	80	70.80%
	Accident	22	19.47%
	Suicide	8	7.08%
	Murder	3	2.65%

Notes: *N* = 113 participants.

2.2. Instruments

Sociodemographic data: The survey collected data on participants' gender, age, educational level achieved, and bereavement (e.g., various relevant details encompassing the date of demise, age at the time of passing, and the relational degree to the departed individual).

The Inventory of Complicated Grief (ICG) [1]: The ICG is a self-report questionnaire consisting of 19 items that are rated on a 5-point Likert scale, ranging from 0 (never) to 4 (always). The items cover various domains of complicated grief, including emotional, cognitive, and behavioral symptoms. For example, respondents are asked to rate how often they experience feelings such as yearning, disbelief, anger, or guilt since their loss. If an individual scores more than 25 on the ICG score (ranging from 0 to 74), it indicates a high level of complicated grief symptoms [1,53]. However, researchers have often set an ICG score threshold of $\geq$30 to identify individuals with clinically significant levels of grief symptoms for inclusion in research studies on CG [54,55]. Researchers have found the ICG to have good internal consistency (Cronbach's α = 0.94). Additionally, the ICG's test–retest reliability has been shown to be high after 6 months (0.80), indicating that it provides consistent results over time. The ICG has been found to have a good construct and concurrent validity [1]. In the present study, the ICG's Cronbach's alpha and McDonald's omega coefficients were both equal to 0.90.

The Inventory of Complicated Grief (ICG) remains a prevalent instrument in the literature. It could be adapted to clinical research by potentially reducing the number of items, particularly when time constraints are a concern [21]. In our study, the original version of the ICG, consisting of a greater number of items (15) than its revised counterparts, was employed. This decision was informed by the fact that only the first version has been validated in Italian, as established by Carmassi et al. (2014) [56]. Likewise, a direct comparison with the IADC-GQ was not feasible in this study due to the recent validation of both the PG-13-R scale [57] and the Traumatic Grief Inventory-Self-Report Plus (TGI-SR+) 4 [58] in their original languages, as well as a lack of validation in Italian.

The IADC Grief Questionnaire (IADC-GQ): The IADC-GQ questionnaire was developed by Botkin in 2005 for clinical use. It consists of 9 items answered using a 5-point Likert scale from 1 (not at all) to 5 (completely or maximally). The questionnaire used in this survey was translated into Italian for Italian practitioners by Dr. Claudio Lalla, a certified trainer for IADC therapy. The IADC-GQ assesses both the emotional aspects of grief related to bereavement and the experience of connection/disconnection with the deceased person (the English version of the IADC-GQ can be found in Appendix A).

2.3. Data Analysis

The dimensionality of the IADC Grief Questionnaire was evaluated with CFA utilizing several indices, namely the comparative fit index (CFI), the Tucker–Lewis index (TLI), the root mean square error of approximation (RMSEA), and the standardized root mean square residual (SRMR). The construct reliability included an examination of several internal and external reliability coefficients (i.e., Cronbach's alpha, the omega coefficient, and temporal stability).

3. Results

3.1. Dimensionality

To explore the factorial structure of the IADC-GQ in the Italian sample, all nine items of the instrument were subjected to exploratory factor analyses with oblique rotation (promax). The Kaiser–Meyer–Olkin measure verified the sampling adequacy for the analysis (KMO = 0.80). Bartlett's test of sphericity (χ^2 (36) = 271.894; $p < 0.001$) indicated that the correlation structure was adequate for factor analyses. The maximum likelihood factor analysis had a cut-off point of 0.40. The results of this factor analysis are presented in Table 2. The analysis showed a two-dimensional structure that explained a total of 41.6% of the variance among the items in this study. Factor 1 ("Clinical Score") included items

1-3-4-5-6-7, which represented the negative impacts of loss. Factor 2 ("Continuing Bond") gathered items 2-8-9, which represented feelings of connection with the deceased one.

Table 2. Exploratory Factor Analysis of the Items of the IADC Grief Questionnaire.

	Items	Factor	
		1	2
1.	My loss is having an overall negative impact on my life	0.789	
2.	I believe in an afterlife		0.503
Rank the intensity of each feeling you have associated with your loss:			
3.	Anger	0.620	
4.	Guilt	0.440	
5.	Sadness	0.671	
6.	I have unwanted and distressing thoughts or images associated with my loss	0.579	
7.	I believe I can get on with life in spite of my loss	−0.610	
8.	I feel disconnected from the person I lost		−0.653
9.	I believe the person I lost is still with me in an important way		0.657

Notes: Extraction method; maximum likelihood; rotation method; promax with Kaiser normalization.

To investigate the dimensional structure of the IADC-GQ, a CFA was conducted on the nine items. The obtained results provided support for a two-factor solution (χ^2 (26) = 58.551; CFI = 0.87; TLI = 0.82; RMSEA = 0.056 (90% CI: 0.027–0.081), $p < 0.263$; and SRMR = 0.072). As shown in Figure 1, all factor-standardized factor loadings of the IADC-GQ were considered high and statistically significant ($\lambda > 0.50$; $p < 0.001$). The bidimensional model is represented in Figure 1. The results indicate a fair-fit of the two-factor model to the data.

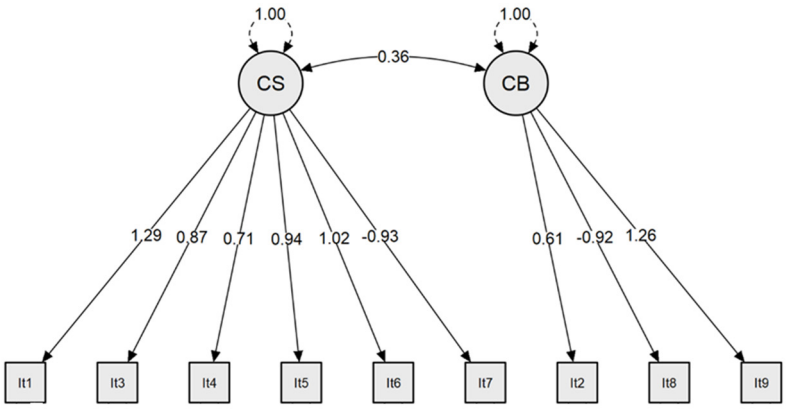

Figure 1. Path diagram with summary of the confirmatory factor analysis (CFA) obtained from the seven items of the IADC Grief Questionnaire: CS = "Clinical Score", CB = "Continuing Bond".

3.2. Reliability and Validity

Regarding the internal validity of the IADC-GQ, the "Clinical Score" dimension showed a good Cronbach's alpha coefficient of $\alpha = 0.83$, as did the "Continuing Bond" dimension ($\alpha = 0.73$). The omega reliability coefficient was also good for both dimensions ("Clinical Score" $\omega = 0.84$; "Continuing Bond" $\omega = 0.74$). Regarding external reliability, the Pearson correlation between test and retest scores was $r = 0.85$. These findings suggest that the IADC-GQ demonstrates satisfactory levels of construct validity, reliability, and temporal stability.

On average, participants had a "Clinical Score" of $M = 16.78$ ($SD = 6.63$) and a "Continuing Bond" score of $M = 10.62$ ($SD = 3.54$). Furthermore, self-reported complicated grief

symptoms (ICG) had an average score of $M = 35.47$ ($SD = 14.61$). The descriptive statistics related to grief are shown in Table 3.

Table 3. Descriptive statistics related to grief.

	Age of Participants	Age of the Deceased	ICG Total Score	IADC-GQ Clinical Score	IADC-GQ Continuing Bond
M	51.02	51.49	35.47	16.78	10.62
SD	12.15	25.92	14.61	6.63	3.54
Min.	21.69	0.30	2.00	0.00	1.00
Max	80.64	99.32	62.00	30.00	15.00

Notes: ICG = Inventory of Complicated Grief, IADC-GQ = Induced After-Death Communication Grief Questionnaire; time is measured in years.

A Pearson correlation coefficient was computed to assess the linear relationship between ICG and IADC-GQ factors. The ICG total score positively correlated with the IADC-GQ clinical score (r (113) = 0.88; $p < 0.001$). A scatterplot summarizes the results in Figure 2.

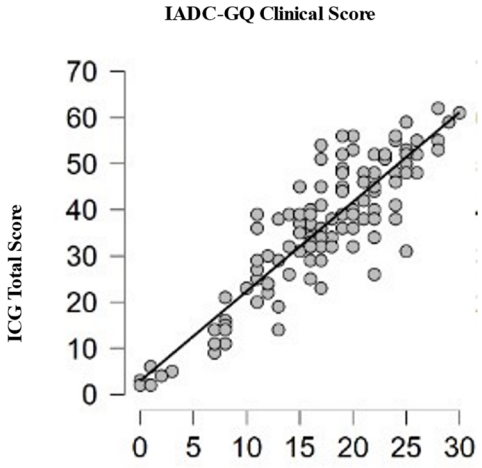

Figure 2. Scatter plot: Overall, there was a strong, positive correlation between IADC-GQ Clinical Score and ICG Total Score; IADC-GQ = Induced After-Death Communication Grief Questionnaire; ICG = Inventory of Complicated Grief.

Meanwhile, there was no correlation between the ICG "Total Score" and the IADC-GQ "Continuing Bond" score ($p = 0.190$). The correlations between the ICG total score and the IADC-GQ factors are reported in Table 4.

Table 4. Pearson's correlations.

Variable	ICG Total Score	IADC-GQ Clinical Score	IADC-GQ Continuing Bond
ICG Total Score	-		
IADC-GQ Clinical Score	0.880 ***	-	
IADC-GQ Continuing Bond	0.124	0.162	-

Notes: IADC-GQ = Induced After-Death Communication Grief Questionnaire; ICG = Inventory of Complicated Grief; *** $p < 0.001$.

3.3. Previous Experience of After-Death Communication (ADC) and Complicated Grief (CG)

An independent-sample t-test was conducted to compare ICG and IADC-GQ scores in participants with previous ADC experiences and participants who had never experienced an ADC event. There was only a significant difference in the IADC-GQ "Continuing Bond" scores for participants with previous ADC experiences ($M = 11.89$; $SD = 2.69$) and

participants without ADC experiences (M = 10.22; SD = 3.69) (conditions: $t(111) = 2.168$; $p = 0.032$). The group descriptive statistics are reported in Table 5. While there was no significant association between previous ADC experiences and complicated grief symptoms ($p > 0.05$ for the ICG total score and the IADC-GQ "Clinical Score"), the results show that participants with previous ADC experiences felt a greater connection with their deceased loved ones.

Table 5. Pearson's correlations.

	Group	Mean	SD	SE
ICG Total Score	1	32.48	13.84	2.66
	2	36.41	14.79	1.60
IADC-GQ Clinical Score	1	16.41	6.48	1.25
	2	16.90	6.70	0.72
IADC-GQ Continuing Bond	1	11.89	2.69	0.52
	2	10.22	3.70	0.40
ICG Total Score	1	32.48	13.84	2.66
	2	36.41	14.79	1.60

Notes: 1 = participants with previous ADC experience, 2 = participants without previous ADC experience; ICG = Inventory of Complicated Grief, IADC-GQ = Induced After-Death Communication Grief Questionnaire.

4. Discussion

This study aimed to assess the reliability of the IADC Grief Questionnaire (IADC-GQ) in an Italian sample. Through our validation study, we obtained initial empirical data supporting a two-factor solution consisting of nine items. Hence, the IADC-GQ is a promising and reliable instrument for measuring complicated grief (CG) symptoms and continuing bond features related to unresolved loss. Additionally, the questionnaire is easily adaptable for use in both research and clinical settings.

Drawing upon the outcomes of the exploratory factor analysis, which yielded a two-factorial solution, we proceeded to evaluate the adequacy of this solution using a confirmatory analysis. The confirmatory analysis yielded a reasonably acceptable fit. This study's findings support the validity of the IADC-GQ in terms of internal consistency and construct validity concerning the ICG scores, especially the "Clinical Score" factor. Further studies could establish a threshold "Clinical Score" that determines a clinical cut-off point for CG.

The items comprising the IADC-CG "Clinical Score" enable clinicians to pinpoint the specific emotions that hinder the progression of the grieving process. For example, guilt arising from responsibility, indebtedness, and guilt sensation intensity are significant components of guilt in complex grief [59]. Increased levels of guilt may correspond to increased levels of complex grief [14]. This notion of experiencing an overwhelming sense of guilt, and its consequential impact on individuals' psychological responses, is widely acknowledged as a fundamental concern in the context of mourning, particularly when it involves suicide [60]. Treatments aimed at addressing complicated grief should contemplate strategies for reducing maladaptive guilt [61]. Guilt can often be linked to a diverse range of concerns that are frequently experienced due to the presence of "unfinished business" with the deceased. Generally, individuals undergoing grief also experience profound anger due to the loss of someone immensely significant. Both guilt and anger can be intertwined with matters concerning blame and responsibility [61]. Conversely, the experience of ADC typically provides solace and, therefore, can alleviate feelings of guilt or anger [37].

The "Continuing Bond" factor explores the extent to which the perceived connection/disconnection with the deceased and beliefs regarding the afterlife influence the experience of grief. In this study, the "Continuing Bond" factor included three items that specifically addressed the belief in an afterlife and the feeling of connection with the deceased. The link between believing in an afterlife and the continuing bonds theory [47] can highlight the potential impact of spiritual or religious beliefs on the grieving process. While these beliefs could be linked to religious affiliation, they are not necessarily synonymous,

as individuals with afterlife beliefs may not adhere to a specific religious doctrine [62]. In general, individuals who believe in an afterlife tend to perceive the deceased as persisting in some form, contributing to the continuation of their emotional bond. This perceived connection provides solace and influences coping mechanisms during the grieving process [45]. Consequently, during the assessment phase, clinicians must identify an individual's personal spiritual or religious beliefs about the afterlife as potential resources for navigating grief and sustaining the emotional bond with the deceased.

Although the previous literature theoretically established a connection between continuing bonds and afterlife beliefs [45,62,63], the exact nature of these relationships and their interactions remain unclear. Future research, particularly within the context of IADC therapy, may contribute to elucidating these aspects by examining whether and how ADC experiences not only impact the severity of mourning symptoms but also influence afterlife beliefs and the feeling of connection with the deceased. Therefore, the IADC-GQ "Continuing Bond" score could be useful in future research on the effectiveness of IADC therapy. The previous literature showed that ADC experiences can decrease the fear of death, resulting from the potential impact of establishing a connection with the departed [30,62] and a heightened interest in spiritual growth [39]. Nevertheless, further comprehensive investigations are needed to explore this aspect in greater detail, considering its connection to the continuing bonds theory [47], as well as alternative measures within this theoretical framework (e.g., the continuing bonds scale [64]).

In our study, we found that 24% of our Italian sample had previous experiences with ADC, which is consistent with estimates in Europe [32]. Furthermore, our findings indicate that individuals who had experienced ADC events during their lives did not exhibit more symptoms of CG. However, they did display a greater openness to the concept of an afterlife and stronger connections with the deceased. It is important to note that all participants in our study were psychotherapy clients without a diagnosis of a severe mental disorder. Therefore, it is reasonable to hypothesize that ADC experiences spontaneously occur in the general population and should not be seen as indicators of mental disorders or CG [24,28]. A significant number of individuals in Western societies opt against revealing their ADC experiences to mental health professionals due to concerns regarding the clinical tendency to pathologize or minimize such experiences [24]. Alternatively, ADC experiences hold great personal significance for some individuals, prompting them to conceal these experiences out of an apprehension that clinicians may interpret them solely through a psychological lens. Consequently, there is a paucity of literature on guiding therapists on the most effective approach to broaching the subject of ADC experiences with their clients [43]. Therefore, researchers and clinicians need to acknowledge and consider this widespread human phenomenon by conducting comprehensive and empirical investigations into the subject matter and harnessing its potential within a clinical context to aid the grieving process. IADC therapy, which is spreading across various countries globally, presents an opportunity to achieve this aim [49,50].

However, this preliminary study suffers from several limitations. For example, the representative nature of our sample was compromised due to featuring an overwhelming majority of female mourners. Further research is needed with a larger sample size to study the IADC-GQ's relatability and validity, as well as to compare the "Clinical Score" and "Continuing Bond" factors with other brief measures for screening complicated grief (e.g., Prolonged Grief Disorder-13 [57]), including in non-Western countries (e.g., the Brief Grief Questionnaire [65]).

5. Conclusions

This study confirmed the reliability of the IADC-GQ scale in evaluating individuals who have encountered elevated levels of potentially unfavorable dimensions of grief, as indicated by satisfactory scores in terms of internal consistency and consistency across time. The validation of the IADC-GQ enables us to employ this brief questionnaire in

forthcoming investigations concerning factors that forecast favorable and unfavorable mental health consequences associated with grief.

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Institutional Review Board Statement: The study was conducted in accordance with the Declaration of Helsinki and the National Board of Italian Psychologists' Code of Ethics. The patients/participants provided their written informed consent to participate in this study. Ethical reviews and approval were waived for this independent research due to the study not being a clinical trial, and the research was carried out utilizing anonymized data gathered by freelance psychologists without any interference from their clinical work. Indeed, this survey did not necessitate the inclusion of any supplementary information in comparison to the typical information gathered from therapists during the treatment process. In accordance with the local legislation and institutional requirements, freelance psychologists must respect professional ethics by adhering to the Italian Psychologists' Code of Ethics.

Informed Consent Statement: In accordance with the National Board of Italian Psychologists' Code of Ethics, informed consent was obtained from all participants involved in the study.

Data Availability Statement: The data presented in this study are available upon request from the corresponding author.

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Appendix A

IADC GRIEF QUESTIONNAIRE

IADC—yes partial no

Pre-Post Follow-up

Name_____ Date_____

Name of Deceased_____ Date of Death_____

Relationship to Deceased_____

Cause/circumstances of Death_____

Please rank the following items (1–5), where. . .

0 = not at all
1 = only a little
2 = somewhat
3 = considerably

4 = to a great degree
5 = completely or maximally

(for people responding post-treatment, answer how you have felt since your treatment)

1. My loss is having an overall negative impact on my life____
2. I believe in an afterlife____

For items 3–5, rank the intensity of each feeling you have associated with your loss:

3. anger____
4. guilt____
5. sadness____

6. I have unwanted and distressing thoughts or images associated with my loss____
7. I believe I can get on with life in spite of my loss____
8. I feel disconnected from the person I lost____
9. I believe the person I lost is still with me in an important way____

For those who have completed treatment:

10. I feel satisfied with the treatment I received____
Comments (optional)—use reverse side if necessary

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