

Article

Induced After-Death Communication (IADC) Therapy: An Effective and Quick Intervention to Cope with Grief

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Abstract: Background: Induced after-death communication (IADC) therapy is an emerging approach for addressing grief-related distress, particularly in individuals experiencing complicated grief (CG). Developed from eye movement desensitization and reprocessing (EMDR), IADC therapy aims to change the meanings with which loss is read and to transform acute grief into integrated grief. While spontaneous after-death communications (ADCs) have been widely reported across different cultures, IADC therapy provides a structured procedure for inducing a state of mind in which such experiences can spontaneously arise and develop. Methods: This study employed a prospective observational cohort design with a retrospective analysis, comparing the effectiveness of IADC therapy (experimental group, $n = 42$) to standard grief interventions combining talk therapy and EMDR (control group, $n = 43$). Participants completed standardized measures, including the Inventory of Complicated Grief (ICG) and the IADC Grief Questionnaire (IADC-GQ), at pre-treatment (T1), post-treatment (T2), and six-month follow-up (T3). Additional analyses explored the role of spirituality, religious affiliation, and therapist characteristics in grief processing. Results: IADC therapy led to a significantly greater reduction in grief intensity (ICG scores) immediately after the intervention and at the six-month follow-up compared to the control group. The experimental group also showed a more pronounced decrease in distress symptoms (CS scores) and higher ratings of therapeutic satisfaction. Furthermore, participants in the experimental group exhibited a significantly greater increase in their continuing bond (CB) scores, suggesting a more adaptive connection with the deceased. Additional analyses examined therapist characteristics, treatment-related factors, and the nature of ADC experiences, which are further explored in the discussion. Conclusions: These findings highlight the clinical utility of IADC therapy as a brief and cost-effective grief intervention, offering comparable or superior outcomes to traditional grief therapies. The results suggest that recognizing and integrating spontaneous ADC experiences into grief therapy may provide a valuable therapeutic pathway. Future research should further explore the long-term effects, cultural variations, and therapist characteristics to optimize the integration of IADC therapy into mainstream clinical practice.

Keywords: induced after-death communication (IADC) therapy; complicated grief; grief therapy; after-death communication (ADC); spirituality; continuing bonds



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1. Introduction

Complicated grief (CG), as defined by [Prigerson et al. \(1995\)](#), refers to a maladaptive and prolonged response to loss characterized by persistent and pervasive symptoms of yearning, emotional pain, and difficulty accepting the death of a loved one. This condition

is marked by an inability to adapt to the loss, leading to a severely impaired quality of life and significant distress (M. K. Shear et al., 2013). The prevalence of complicated grief (CG) in the general population has been estimated at 3.7%, with a conditional prevalence of 6.7% among individuals who have experienced major bereavement. The risk factors for developing CG include female gender, lower income, older age, and the loss of a child or spouse, particularly when cancer is the cause of death (Kersting et al., 2011).

While CG provided a robust framework for understanding and assessing prolonged grief, it was not formally included in diagnostic manuals, which limited its clinical application. Over time, the need for a standardized diagnostic category became increasingly evident, particularly as research highlighted the distinct nature of prolonged grief and its associated distress (M. K. Shear et al., 2011; M. K. Shear, 2012).

This shift in focus culminated in the formal inclusion of Prolonged Grief Disorder (PGD) in the DSM-5-TR (American Psychiatric Association, 2022). PGD builds on the foundational work on CG by providing a more structured and standardized diagnostic framework. It is characterized by persistent and intense yearning or preoccupation with the deceased, accompanied by profound emotional pain such as sadness, anger, guilt, or difficulty accepting the loss. These symptoms are considered pathological when they exceed what is culturally, socially, or religiously normative and lead to significant functional impairment. Unlike CG, which lacked universally agreed upon criteria, PGD introduces specific symptom thresholds and temporal criteria—requiring symptoms to persist for at least 12 months in adults and 6 months in children and adolescents (American Psychiatric Association, 2022; Falala et al., 2024).

A recent systematic review and meta-analysis identified several risk factors for developing PGD (Trembl et al., 2024). The strongest predictors were pre-loss personal factors such as depressive symptoms, showing significant effect size correlations ($ESr = 0.39$ and $ESr = 0.30$, respectively). Additional factors associated with an increased risk included unpreparedness for the death, the time elapsed since the loss, and the nature of the relationship with the deceased (e.g., loss of a child or partner). Socioeconomic and psychological factors, such as lower educational attainment, low income, female gender, and an anxious attachment style, were also identified as significant risk contributors (Buur et al., 2024).

The findings from studies on preventive grief interventions have provided inconsistent evidence supporting their effectiveness (Wittouck et al., 2011). However, evidence-based treatments for CG have been developed to address the unique emotional and psychological challenges associated with prolonged and maladaptive grief. A notable approach is Complicated Grief Therapy (CGT), a structured intervention that combines elements of Cognitive Behavioral Therapy (CBT) and Interpersonal Therapy (K. Shear et al., 2005). CGT helps individuals accept and cope with their loss while adapting to life without the deceased. It incorporates seven core themes: understanding grief, managing emotions, planning for the future, strengthening relationships, processing the story of the death, living with reminders, and maintaining a meaningful connection with memories of the deceased (Iglewicz et al., 2020). Recent research suggests that eye movement desensitization and reprocessing (EMDR) therapy is an effective approach for grief-related symptoms, showing outcomes comparable to CBT (Shapiro, 2018; Spicer, 2024).

The evolution of grief therapy has recently given rise to a novel procedure, Induced After-Death Communication (IADC) therapy, which has emerged from the modification of EMDR (Eye Movement Desensitization and Reprocessing) therapy (Botkin & Hogan, 2005). Developed by Allan Botkin, an EMDR-trained psychologist, IADC therapy originated from observations that patients spontaneously reported vivid sensory and emotional experiences of perceived communication with the deceased (Botkin, 2000). However, IADC therapy differs significantly from the standard EMDR protocol. It typically consists of only two

treatment sessions. In the initial phase, after the patient has described the personality of the loved one, the relationship with him or her, and the circumstances of the death, the psychotherapist asks the patient to identify the most distressing aspect of the grief, to rate its intensity on a scale from 1 (low) to 10 (high), and focus on it during a series of bilateral stimulations. Additionally, after each set of bilateral stimulations, patients are instructed to close their eyes for a brief period to allow the experience to unfold. Once the grief-related sadness has significantly diminished and the patient reaches a state of calm and peace, a receptive state emerges, facilitating the natural occurrence of an ADC. In this state, approximately three-quarters of patients report a multisensory experience of communication with their loved one, involving sight, sound, smell, taste, or other sensory perceptions. Just as the initial phase of IADC therapy focuses on addressing the pain of loss, once the ADC experience begins, the sequence of bilateral stimulations helps the experience develop further. After each set, the patient opens their eyes and describes the experience (Botkin & Hogan, 2005).

IADC therapy has gained recognition among clinicians worldwide (Botkin & Hannah, 2013). Training programs for IADC therapy are now available internationally, with certified trainers offering sessions in the United States and across Europe, mainly in Germany, Italy, and Switzerland. The training typically spans two days and is open to licensed mental health professionals.

After-death communications (ADCs) are defined as spontaneous experiences of encounters with the deceased (Guggenheim & Guggenheim, 1995). These occurrences are experienced as direct connections with the deceased, arising naturally without the use of rituals, devices, or intermediaries such as psychics or mediums (Houck, 2005; Woollacott et al., 2022). Individuals report that these experiences arise spontaneously and unexpectedly, without any intentional effort on their part (Beischel et al., 2014). ADC experiences have been reported across diverse cultures, age groups, socioeconomic backgrounds, education levels, genders, and religious beliefs (Houck, 2005). While spiritual, religious, and cultural perspectives may shape how individuals interpret and understand these experiences, they do not appear to influence their overall occurrence (Gariglietti & Allison, 1997).

Streit-Horn (2011) conducted a systematic review of 35 studies. This research shows that around 70–80% of bereaved people are likely to have one or more ADCs within a year of bereavement and that these experiences are positive, comforting and healing. ADC experiences are associated with reduced fear of death, enhanced spirituality, and positive emotional shifts, including decreased grief and regret and increased gratitude, love, and understanding (Penberthy et al., 2023). Although ADC experiences have historically been considered signs of psychopathology (Kamp et al., 2019) and were even incorporated into the Inventory of Complicated Grief (ICG) (Prigerson et al., 1995) as contributing items (e.g., item 15: “I hear the voice of the person who died speak to me” and item 16: “I see the person who died stand before me”), emerging evidence suggests that they may instead function as a protective factor in the natural grieving process (St. Germain-Sehr & Maxey, 2019). Indeed, research on spontaneous ADCs highlights their beneficial effects, including reduced grief intensity, increased emotional resilience, and enhanced meaning-making following a loss (Penberthy et al., 2023).

Initial findings suggest that IADC therapy can significantly reduce grief intensity, facilitate emotional resolution, and help individuals develop adaptive continuing bonds with the deceased (Valdez et al., 2022; Botkin & Hannah, 2013; Hannah et al., 2013; Holden et al., 2019). Its growing recognition within the field of grief therapy is further underscored by its inclusion among the new techniques for grief therapy in recent authoritative publications (Valdez et al., 2022). Botkin and Hannah (2013) reported the results of a survey conducted among therapists trained by Botkin in IADC therapy. The findings showed that

these therapists achieved outcomes nearly identical to those of the founder, demonstrating consistent effectiveness across different practitioners. These findings suggest that IADC is a teachable and reliable therapeutic approach. Furthermore, experienced therapists rated the outcomes of IADC therapy as significantly better compared to other therapies they have used for treating grief, reinforcing the psychotherapeutic value of IADC therapy. In a related study, [Hannah et al. \(2013\)](#) provided an updated evaluation of IADC therapy by assessing its impact on 71 clients (50 females, 21 males). Participants completed the Grief Symptom Questionnaire (GSQ) before, after, and six months following the two-session IADC protocol. Seventy-nine percent of participants reported experiencing a perceived communication with a deceased loved one. The results showed statistically significant improvements in grief symptoms, including reduced sadness and anger, along with enhanced positive coping and an increased belief in an afterlife. The changes in scores from pre- to post-treatment were compared between the two subgroups of IADC experiencers ($n = 56$) and non-experiencers ($n = 15$). The IADC experiencers scored significantly higher than the non-experiencers in terms of all three GSQ factors: depression, anger, and positive coping.

A more recent comparative study by [Holden et al. \(2019\)](#) further evaluated the effectiveness of IADC therapy in comparison to Traditional Grief Counseling (TGC) using an experimental pre/post-test design with 41 bereaved adults. The findings indicated that the IADC clients experienced a significantly greater overall improvement in grief symptoms compared to those receiving TGC. These results suggest that IADC may serve as an effective therapeutic approach for bereaved individuals, regardless of whether they meet the criteria for PGD.

1.1. Contextualizing the Study in Italy

In Italy, research on PGD and CG has gained increasing attention in recent years ([Carmassi et al., 2014](#); [Chiambretto et al., 2008](#); [De Luca et al., 2015](#)). However, the clinical recognition of PGD as a distinct disorder remains limited, and structured interventions specifically targeting PGD are not yet widely integrated into public healthcare services. Most grief-related interventions in Italy are provided within general psychotherapy settings, without standardized protocols for treating complicated or prolonged grief. The availability of IADC therapy in Italy is still relatively low, and its empirical evaluation within Italian clinical practice is scarce. While IADC therapy has been introduced through workshops and training programs for mental health professionals, it has not yet been systematically incorporated into mainstream psychological services. Furthermore, despite a rich cultural and historical tradition of spiritual beliefs regarding afterlife communication ([Cocchiara & McDaniel, 1974](#); [Schäuble, 2021](#)), ADC phenomena remain underexplored in Italian clinical research. This study represents one of the first attempts to systematically assess the effectiveness of IADC therapy in Italy, providing empirical data on its outcomes in a naturalistic clinical setting. By examining IADC therapy alongside conventional grief interventions, we contribute to the broader discourse on innovative grief therapies and their potential role in addressing PGD and CG within diverse cultural and clinical contexts.

1.2. Aims of the Study

This study aims to assess the effectiveness of IADC therapy in supporting individuals experiencing difficulties in coping with grief. As interest in IADC grows as an innovative grief intervention, this research seeks to contribute to the expanding body of evidence on its therapeutic potential. Specifically, this study evaluates the impact of IADC therapy compared to other grief interventions to determine its effectiveness in facilitating emotional healing. Additionally, it explores both the qualitative and quantitative aspects of ADC

experiences induced during the therapeutic process, examining their role in grief processing and meaning-making.

While PGD has recently been formalized as a distinct diagnostic category in the DSM-5-TR and ICD-11, this study focuses on the broader construct of CG. This decision is based on several considerations. First, CG has been extensively studied and widely used in research literature over the past few decades, providing a robust framework for examining maladaptive grief responses. The construct of CG encompasses a broader range of symptoms and has been foundational in shaping the understanding and recognition of grief-related disorders, including PGD. Second, CG remains a clinically relevant construct for exploring grief-related distress in naturalistic settings, particularly when standardized diagnostic criteria for PGD might not yet be fully integrated into clinical practice. Many assessment tools, such as the ICG, are specifically designed to measure CG and have been validated across diverse populations, making them ideal for use in studies like this one. Finally, choosing CG as the focus allows for the inclusion of participants who may not meet the strict temporal or symptom thresholds of PGD but who nonetheless experience significant functional impairment and emotional distress related to their grief. This broader focus ensures that this study captures the full spectrum of grief-related difficulties, providing insights that may have implications for both CG and PGD as distinct but overlapping constructs.

The objective of the present study is to address this research gap by means of a systematic evaluation of IADC therapy in individuals experiencing significant grief-related distress, including those meeting the PGD criteria. By comparing IADC therapy with standard grief interventions that combine talk therapy and EMDR, we aim to assess whether IADC therapy offers distinct advantages in terms of grief resolution, distress reduction, and the development of adaptive continuing bonds with the deceased. Furthermore, our study explores the long-term impact of IADC therapy by assessing the symptom reduction at a six-month follow-up, contributing valuable data on the sustainability of therapeutic effects. Finally, we examine additional psychological and demographic factors that may influence individual responses to IADC therapy.

2. Materials and Methods

2.1. Study Design

This study employed a prospective observational cohort design with a retrospective analysis of clinical outcomes. This design was chosen to evaluate the real-world effectiveness of IADC therapy in individuals experiencing CG symptoms. Unlike randomized controlled trials (RCTs), which impose strict experimental conditions, an observational cohort approach allows for the assessment of therapeutic interventions as they occur in clinical practice. This enhances the ecological validity by reflecting real-life therapeutic settings, where patients seek treatment voluntarily and clinicians tailor interventions to individual needs. Participants were assigned to two groups based on the treatment they naturally received in their therapeutic pathway: the experimental group, which underwent induced after-death communication (IADC) therapy, and the control group, which received standard talk therapy combined with eye movement desensitization and reprocessing (EMDR), which represents a commonly used therapeutic approach for grief-related distress. The treatment allocation was determined by the therapists' clinical practice rather than randomization, reflecting real-world conditions.

Data were collected between 2020 and 2024 from multiple therapists operating in different regions of Italy. In accordance with the Declaration of Helsinki and the National Board of Italian Psychologists' Code of Ethics, all the psychotherapists obtained specific informed consent from the participants during clinical consultations. Indeed, all the partic-

ipants provided written informed consent before enrollment in the study. In addition to obtaining informed consent, participants were fully informed about the confidentiality of their data, their right to withdraw from this study at any time without consequences, this study's objectives, and the procedures involved in the data collection and follow-up assessments. Subsequently, they used a secure online survey platform to ensure the anonymous transmission of data to the research team. The study design incorporated three assessment points: pre-treatment, post-treatment, and follow-up, with standardized questionnaires administered to both groups to evaluate the changes in psychological outcomes over time. Although the data collection followed a prospective approach, the analysis was conducted retrospectively, allowing for an examination of treatment effectiveness based on clinical data already gathered.

2.2. Power Analysis

A power analysis was conducted using G*Power 3.1 to determine the sample size required for adequate statistical power. For a repeated measures ANOVA with a within-between interaction, the parameters were set to detect a medium effect size ($f = 0.25$) with an alpha level of $\alpha = 0.05$ and power of $1 - \beta = 0.80$. The analysis indicated that a minimum of 28 participants was required. The actual sample size ($N = 85$) exceeded this requirement, ensuring sufficient power for detecting effects.

2.3. Participants

This study included 85 participants, with 42 assigned to the experimental group (IADC therapy) and 43 to the control group (alternative therapies). Based on the power analysis conducted prior to this study, this sample size was deemed sufficient to detect medium effect sizes in between-group comparisons with a statistical power of 0.80 ($\alpha = 0.05$). While a larger sample would enhance the generalizability of the findings, our sample size aligns with previous research on IADC therapy and other grief interventions. Furthermore, the inclusion of a six-month follow-up assessment provides valuable longitudinal data, strengthening this study's ability to evaluate the sustained effects of the interventions despite the moderate sample size.

The mean age of the participants was 52.30 years ($SD = 12.54$). A detailed overview of the demographic, clinical, and bereavement-related characteristics of the participants is presented in Table 1. Most participants identified as female (86%). Regarding their education levels, 34% had secondary education, and 49% had higher education (bachelor's or advanced degrees), while 16% had lower education levels. Their employment status was distributed as follows: 77% were employed, 15% retired, and 8% unemployed.

Variables related to spirituality and mental health were also collected. Most participants rated spirituality as very important or extremely important (84%), and the majority identified as belonging to a Christian faith (64%). Previous experiences with after-death communication (ADC) were reported by 29% of participants. Regarding mental health, 74% reported using psychotropic medication, primarily antidepressants and anxiolytics.

The bereavement-related data included the relationship to the deceased, the cause of death, and the age of the deceased. The deceased were primarily parents (39%), spouses/partners (24%), or children (21%). The most common causes of death were illness (66%) and accidents (21%), with other causes including suicide (11%) and murder (2%). The mean age of the deceased was 52.76 years ($SD = 25.21$).

Table 1. Demographic, clinical, and bereavement-related characteristics of the participants.

Characteristic	Experimental Group (N = 42)	Control Group (N = 43)	Total (N = 85)
Age (years)	Mean 50.27 (<i>SD</i> = 13.36)	Mean 54.29 (<i>SD</i> = 11.49)	Mean 52.30 (<i>SD</i> = 12.54)
Gender			
Male (%)	6 (14%)	6 (14%)	12 (14%)
Female (%)	36 (86%)	37 (86%)	73 (86%)
Education			
Lower (primary/middle school) (%)	6 (14%)	8 (19%)	29 (16%)
Secondary (high school) (%)	13 (31%)	16 (37%)	42 (34%)
Higher (bachelor's and above) (%)	23 (55%)	19 (44%)	85 (49%)
Employment Status			
Employed (%)	34 (80%)	31 (72%)	65 (77%)
Retired (%)	4 (10%)	9 (21%)	13 (15%)
Unemployed (%)	4 (10%)	3 (7%)	7 (8%)
Importance of Spirituality			
Low importance (%)	9 (21%)	5 (12%)	14 (16%)
High importance (%)	33 (79%)	38 (88%)	71 (84%)
Low importance (%)	9 (21%)	5 (12%)	14 (16%)
Faith			
No faith (%)	5 (12%)	8 (19%)	13 (15%)
Christian (%)	25 (59%)	29 (67%)	54 (64%)
Other religion (%)	12 (29%)	6 (14%)	18 (21%)
Previous ADC experiences			
Yes (%)	16 (38%)	9 (21%)	25 (29%)
No (%)	26 (32%)	34 (79%)	60 (71%)
Psychotropic medication use			
Yes (%)	10 (24%)	12 (28%)	22 (26%)
No (%)	32 (76%)	31 (72%)	63 (74%)
Age (years) of the deceased	Mean 52.61 (<i>SD</i> = 27.26)	Mean 54.90 (<i>SD</i> = 22.95)	Mean 52.76 (<i>SD</i> = 25.21)
Gender of the deceased			
Male (%)	20 (48%)	22 (51%)	42 (49%)
Female (%)	22 (52%)	21 (49%)	43 (51%)
Male (%)	20 (48%)	22 (51%)	42 (49%)
Relation to the deceased			
Child (%)	8 (19%)	13 (24%)	18 (21%)
Spouse/partner (%)	7 (17%)	13 (30%)	20 (24%)
Parent (%)	21 (50%)	12 (28%)	33 (39%)
Close friend (%)	0 (0%)	1 (2%)	1 (1%)
Other family member (%)	6 (14%)	6 (14%)	12 (14%)
Pet (%)	0 (0%)	1 (2%)	1 (1%)
Cause of death			
Disease (%)	32 (76%)	24 (56%)	56 (66%)
Accident (%)	7 (17%)	11 (25%)	18 (21%)
Suicide (%)	3 (7%)	6 (14%)	9 (11%)
Murder (%)	0 (0%)	2 (5%)	2 (2%)

Table 1 presents the demographic, clinical, and bereavement-related characteristics of the study participants. The sample consisted of 85 individuals, with 42 in the experimental group (IADC therapy) and 43 in the control group (alternative therapies). The key variables include age, gender, education, employment status, and religious/spiritual beliefs. Additionally, the table provides details on participants' prior after-death communication (ADC) experiences, psychotropic medication use, and the characteristics of the deceased, including their age, gender, relationship to the participant, and cause of death. These variables provide a comprehensive overview of the sample, highlighting potential factors that may influence grief processing and treatment outcomes.

Participants were included in this study if they met the following criteria: (1) age ≥ 18 years, (2) experience of significant grief-related distress persisting for at least

six months, (3) self-reported willingness to engage in grief therapy, and (4) no previous experience with IADC therapy. The exclusion criteria included the following: (1) diagnosis of a severe psychiatric disorder (e.g., schizophrenia, bipolar disorder with active psychotic symptoms) that could interfere with the therapy process, (2) current substance abuse or dependence, and (3) ongoing participation in another structured grief intervention program (only for the experimental group).

2.4. Measures

The **Inventory of Complicated Grief (ICG)** is a 19-item self-report questionnaire designed to assess the symptoms of complicated grief (Prigerson et al., 1995; Carmassi et al., 2014). Participants rate the frequency of symptoms on a 5-point Likert scale ranging from 0 (not at all) to 4 (always). Higher scores (above 25) indicate greater severity of grief-related symptoms (Prigerson et al., 1995). A total score of 30 or higher is typically used as a cut-off to identify individuals with clinically significant levels of complicated grief (K. Shear et al., 2005; Zisook et al., 2018).

The **IADC Grief Questionnaire (IADC-GQ)**, originally developed by Botkin in 2005 for clinical use, measures the changes in grief-related symptoms associated with IADC therapy (D'Antoni & Lalla, 2024). It includes 9 items rated on a 6-point Likert scale (0 = not at all, 5 = completely or maximally). A tenth item evaluates participants' satisfaction with the therapy (i.e., "I feel satisfied with the treatment I received."). The Clinical Score (CS) subscale, consisting of 6 items, measures the most distressing aspects of grief, such as intense sorrow, longing, and preoccupation with the deceased, with higher scores indicating greater levels of complicated grief. The Continuing Bond (CB) subscale, comprising 3 items, assesses feelings of connection to the deceased and beliefs regarding the existence of life after death.

General participant characteristics and bereavement data were collected to describe the sample and identify potential confounding variables. These included demographic information (e.g., age, gender, education, and employment status), the importance of spirituality, religious faith, and mental health variables such as psychotropic medication use and involvement in ongoing psychotherapy. The bereavement-related data included the relationship to the deceased, the cause of death, and the age of the deceased.

A **Therapist Questionnaire (TQ)** was administered to collect demographic and professional information about the therapists involved in this study. This questionnaire included items on gender, clinical approach, EMDR training, years of clinical experience, perceived importance of spirituality (rated on a Likert scale from 0 = not at all to 4 = very much), religious affiliation (if any), and previous personal experiences of after-death communication (ADC).

Additionally, the therapists were invited to document specific details of the **ADC experiences** reported by patients during IADC therapy. These included the duration of the ADC experience, the therapist's perception of the patient's conviction of experiencing an objective event (rated on a Likert scale from 0 = not at all to 10 = absolutely convinced), and the emotional intensity observed in the patient during the IADC session (rated on a Likert scale from 0 = no emotional response to 10 = extremely intense emotional response).

2.5. Procedure

Data were collected at three time points: pre-treatment (T1), post-treatment (T2), and follow-up (T3, six months after the intervention). The T2 assessments were conducted after four hours of grief-focused psychotherapy, which consisted of IADC therapy for the experimental group and talk therapy combined with EMDR for the control group. At the post-treatment (T2) and follow-up (T3) time points, participants in the experimental group

were also asked to rate their satisfaction with the IADC therapy using the 10th item of the IADC-GQ. Additionally, at T2, the therapists in the experimental group completed the Therapist Questionnaire (TQ), which included demographic and professional information, as well as details on the ADC experiences reported by patients during the sessions.

Before the intervention (T1), participants were informed about the purpose of this study and provided written informed consent. The psychotherapists facilitated the data collection by distributing the questionnaires to their clients and returning the completed forms to the research team for analysis. At T2 (post-treatment) and T3 (follow-up), data were collected following the same procedure to assess both the short-term and long-term effects of the therapies.

2.6. Intervention

In the control group, the therapists applied the therapeutic approach they deemed most appropriate for each specific case they were already treating for grief issues. This generally involved a combination of talk therapy and EMDR. However, due to the naturalistic character of this study, it was not possible to reconstruct the exact treatment combination used for each participant. The therapists provided a minimum of four hours of therapy, delivered in consecutive sessions on a weekly or biweekly basis, specifically focused on the client's grief processing.

In contrast, the IADC therapy in the experimental group followed a more structured format, consisting of two sessions of approximately two hours each, typically scheduled within one week of each other (see Table 2 for the intervention protocol). In most cases, these sessions were conducted on consecutive days, allowing the intervention to be completed within a short time frame of no more than one week. The IADC intervention was provided either to clients who were not undergoing any other form of treatment or to those already engaged in an ongoing psychotherapy process, to which they returned after completing the two IADC sessions. Notably, 50% of the clients in the experimental group were already in therapy with another clinician and resumed their ongoing therapeutic work after the IADC intervention.

Table 2. Phases of the induced after-death communication (IADC) protocol.

Phase	Description
1. Screening and history	The first phase involves an assessment of the patient's representation of his/her loved one's personality, his/her relationship with him/her, the circumstances of the death and unresolved issues, and identification of the most painful aspects of the loss.
2. Abreaction	In this phase, the therapist helps the patient to address his/her most painful sadness while receiving the bilateral stimulations. As a rule, pain gradually rises to the highest levels and then goes down until it is replaced by a momentary sense of relaxation and peace.
3. Induction and IADC experiences	It is thanks to this state of mind that the patient enters the receptive mode. At this point, the therapist instructs the patient to have the mind empty of thoughts and to let the experience come to him/her. This phase is crucial as it allows for the emergence of an IADC experience. The therapist acts as a facilitator, guiding the patient through the process and helping him/her remain open to the experience without imposing expectations.

Table 2. Cont.

Phase	Description
4. Debriefing	The final phase involves a debriefing time in which the therapist and patient explore the meaning the experience has for the patient.

Table 2 summarizes the key phases of the induced after-death communication (IADC) therapy protocol, outlining its structured therapeutic process. The protocol begins with an assessment phase, in which the therapist explores the patient's relationship with the deceased and the most distressing aspects of the loss. This is followed by the abreaction phase, in which bilateral stimulation helps the patient to process grief-related distress, often leading to momentary emotional relief. The induction phase then facilitates the emergence of an IADC experience, with the therapist guiding the patient into a receptive state. Finally, the debriefing phase allows the patient to reflect on the experience and integrate its meaning into his/her grief process.

3. Results

3.1. Effectiveness of IADC Therapy: Comparison of Grief-Related Outcomes

The descriptive statistics for the ICG and IADC-GQ subscales (Clinical Score and Continuing Bond) at each time point are presented in Table 3. Given the distribution characteristics of our dataset, we conducted preliminary normality tests (Shapiro–Wilk) to assess whether parametric assumptions were met. The results indicated significant deviations from normality in the control group ($p < 0.05$) across all the grief-related outcome measures. Consequently, we employed nonparametric statistical tests to ensure robust and reliable comparisons. To compare the baseline scores between groups, we performed Mann–Whitney U tests, as Levene's test for the equality of variances was not significant ($p > 0.5$), supporting the appropriateness of this approach. The Mann–Whitney U tests confirmed that there were no significant differences between the experimental and control groups at baseline for the ICG ($U = 758.000$, $p = 0.20$), the IADC-GQ Clinical Score (CS) ($U = 728.500$, $p = 0.12$), and the IADC-GQ Continuing Bond (CB) subscale ($U = 801.500$, $p = 0.37$). At baseline (T1), participants in both groups exhibited comparable levels of grief-related symptoms.

Table 3. Descriptive statistics for the grief-related outcomes at baseline (T1), post-treatment (T2), and follow-up (T3).

Measure	Time Point	Experimental Group (n = 42)				Control Group (n = 43)			
		Mean	SD	Min	Max	Mean	SD	Min	Max
ICG ¹ Total score	T1	32.93	13.32	9	59	36.49	13.85	3	56
	T2	22.71	15.54	0	51	31.49	13.66	3	55
	T3	21.45	14.32	0	49	28.35	12.70	2	51
IADC-GQ ² Clinical Score (CS)	T1	2.58	0.87	1.17	4.17	2.80	1.07	0	4.67
	T2	1.76	1.31	0	4.33	2.27	1.00	0.17	4.67
	T3	1.59	1.21	0	4.17	2.11	0.78	0.33	3.67
IADC-GQ ² Continuing Bond (CB)	T1	3.41	1.18	0.33	5	3.64	1.13	0.67	5
	T2	3.86	1.04	1.33	5	3.48	1.01	0.67	5.00
	T3	3.88	1.12	1	5	3.09	0.94	1	4.67

¹ ICG = Inventory of Complicated Grief; ² IADC-GQ = Induced After-Death Communication Grief Questionnaire.

3.1.1. Inventory of Complicated Grief (ICG)

A repeated measures ANOVA was conducted to evaluate the changes in the Inventory of Complicated Grief (ICG) scores across time (T1, T2, T3) and between groups (experimental vs. control). Mauchly's test of sphericity indicated a violation of the sphericity assumption, $\chi^2(2) = 35.353$, $p < 0.001$. Therefore, the Greenhouse–Geisser correction ($\epsilon = 0.741$) was

applied to adjust the degrees of freedom. Levene's test confirmed that the assumption of the equality of variances between groups was met ($p > 0.05$).

The corrected ANOVA results showed a significant main effect of time, $F(1.481, 122.942) = 106.816$, $p < 0.001$, $\eta_p^2 = 0.563$. A significant main effect of the group was also observed, $F(1, 83) = 4.859$, $p = 0.03$, $\eta_p^2 = 0.055$. Additionally, a significant time $\times$ group interaction was found, $F(1.481, 122.942) = 7.032$, $p = 0.003$, $\eta_p^2 = 0.078$.

To further explore the significant time $\times$ group interaction effect found in the repeated measures ANOVA, post hoc pairwise comparisons were conducted using the Bonferroni correction. These analyses examined the changes in the ICG scores over time within each group (T1, T2, T3) and the differences between the experimental and control groups at each time point.

In the experimental group, the ICG scores decreased significantly from T1 (pre-treatment) to T2 (post-treatment), $t(83) = 8.442$, $p < 0.001$, and from T1 to T3 (follow-up), $t(83) = 10.952$, $p < 0.001$. No significant changes were observed between T2 and T3, $t(83) = 1.884$, $p = 0.945$, indicating that the improvements achieved at T2 were maintained at follow-up.

In the control group, the ICG scores also decreased significantly from T1 to T2, $t(83) = 4.181$, $p = 0.001$, and from T1 to T3, $t(83) = 7.860$, $p < 0.001$. Additionally, a smaller but significant reduction was observed between T2 and T3, $t(83) = 4.744$, $p < 0.001$.

At T1 (pre-treatment), there was no significant difference between the experimental and control groups, $t(83) = -1.207$, $p = 1.000$, confirming the comparable baseline scores.

At T2 (post-treatment), the experimental group exhibited significantly lower ICG scores compared to the control group, $t(83) = -8.774$, $p < 0.001$.

At T3 (follow-up), the experimental group continued to have lower ICG scores than the control group, even though half of the IADC patients did not continue to be followed in psychotherapy, in contrast to the control group. However, this difference was not statistically significant, $t(83) = -2.351$, $p = 0.317$.

The results showed that the experimental group (IADC therapy) experienced rapid and significant improvements in the ICG scores after the intervention, which were sustained over time. The control group showed gradual improvements but did not reach the same level of symptom reduction as the experimental group. Significant differences between the groups were observed at post-treatment (T2), $p < 0.001$, but not at follow-up (T3), $p = 0.317$. The trends in the ICG total scores across time points for the experimental and control groups are presented in Figure 1.

3.1.2. IADC Grief Questionnaire (IADC-GQ)

Due to the significant violations of the assumptions of the homogeneity of variances, as indicated by Levene's test at the post-treatment and follow-up time points ($p < 0.05$), and sphericity, as indicated by Mauchly's test ($p < 0.001$), Welch's ANOVA was employed to compare the Clinical Score (CS) values across groups and time points. The analysis revealed a significant difference in the CS values across time, $F(3, 174.18) = 33.82$, $p < 0.001$.

To further investigate the observed differences, post hoc analyses were conducted to compare the Clinical Score (CS) values between the experimental and control groups at each time point (pre-treatment, post-treatment, and follow-up). Given the violation of normality assumptions for the control group, nonparametric Mann–Whitney U tests were employed to ensure robust comparisons. The Mann–Whitney U test indicated no significant difference between the experimental and control groups at baseline, $U = 728.5$, $p = 0.125$. At post-treatment, the Mann–Whitney U test revealed a marginally significant difference between the experimental and control groups, $U = 681.5$, $p = 0.052$. The rank-biserial correlation was $r = -0.245$, suggesting a small to medium effect size. At follow-up,

the Mann–Whitney U test showed a significant difference between the groups, $U = 637$, $p = 0.019$. The rank-biserial correlation was $r = -0.295$, indicating a medium effect size.

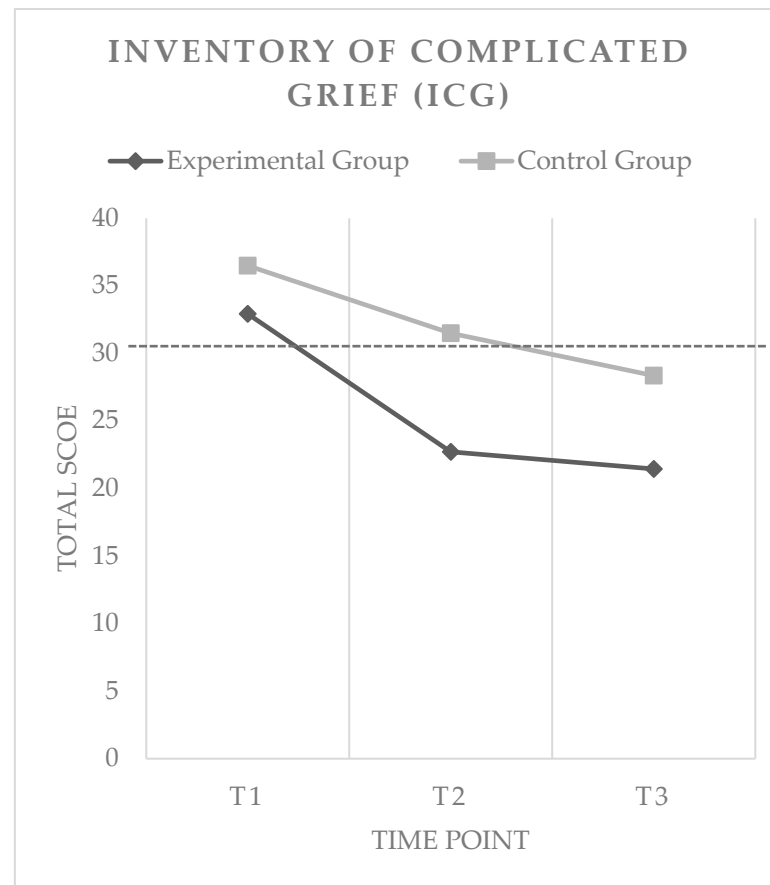


Figure 1. Trends in the Inventory of Complicated Grief (ICG) total scores over time for the experimental and control groups. The graph demonstrates a significant reduction in grief-related distress following IADC therapy, with the improvements sustained at the six-month follow-up. In contrast, the control group showed a more gradual and less pronounced decline in the ICG scores. Post hoc pairwise comparisons confirmed that the reduction in the ICG scores was statistically significant for the IADC group, both immediately after the intervention and at follow-up ($p < 0.01$), while the control group exhibited more modest improvements over time. This pattern suggests that IADC therapy facilitates a faster and more substantial alleviation of grief symptoms compared to other grief interventions.

In summary, the results suggest that while no significant differences were present at baseline, the experimental group demonstrated greater reductions in the Clinical Score values compared to the control group, with significant differences emerging by the follow-up assessment (see Figure 2).

A repeated measures ANOVA was conducted to assess the changes in the Continuing Bond (CB) scores across time points (pre-treatment, post-treatment, follow-up) and between groups (experimental vs. control). The assumptions of sphericity and the homogeneity of variances were met, as indicated by Mauchly's test ($p > 0.05$) and Levene's test ($p > 0.05$). The analysis revealed no significant main effect of time, $F(2, 166) = 2.498$, $p = 0.085$, $\eta_p^2 = 0.029$, suggesting no overall change in the CB scores across the three time points. Similarly, no significant main effect of the group was observed, $F(1, 83) = 2.217$, $p = 0.14$, $\eta_p^2 = 0.026$, indicating no overall difference in the CB scores between the experimental and control groups. However, a significant interaction effect between time and

group was identified, $F(2, 166) = 17.563$, $p < 0.001$, $\eta_p^2 = 0.175$, suggesting that the changes in the CB scores over time differed between the groups.

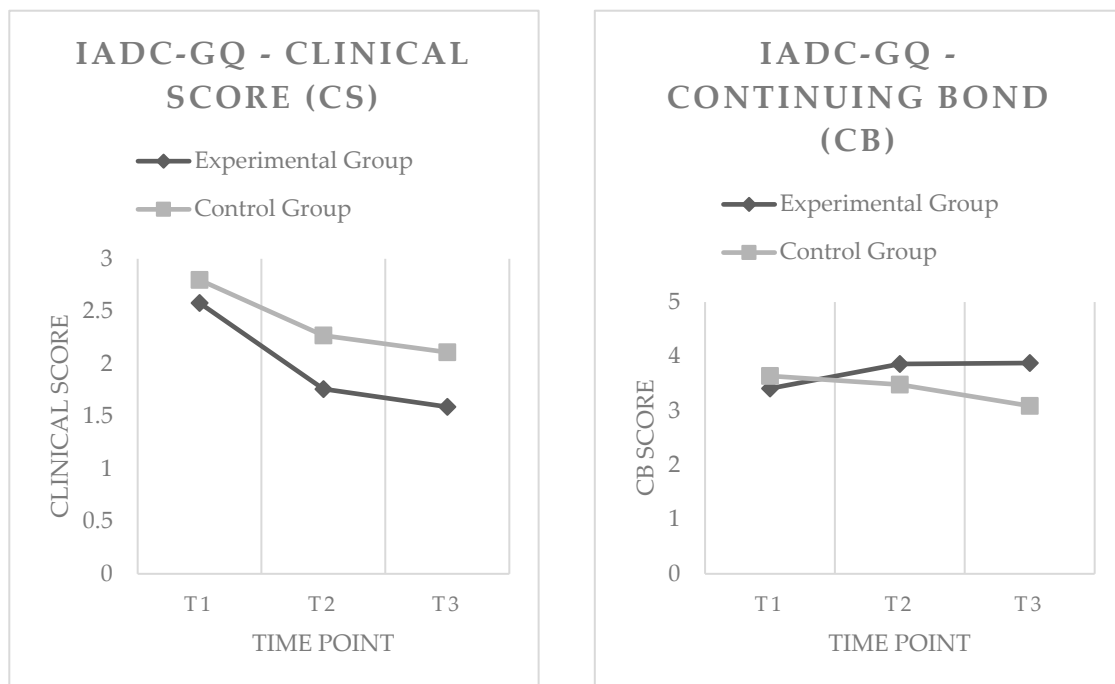


Figure 2. Trends in the Clinical Score (CS) and Continuing Bond (CB) subscales of the IADC-GQ over time for the experimental and control groups. The results indicate that participants in the IADC group reported significantly greater reductions in grief-related suffering ($p < 0.01$) while simultaneously experiencing an increase in the perceived connection with the deceased, an aspect that distinguishes IADC therapy from standard grief interventions. This dual effect of reducing distress while fostering adaptive continuing bonds suggests that IADC therapy may help individuals integrate their loss in a more meaningful way, potentially contributing to its sustained benefits at follow-up.

To further explore the significant interaction effect, post hoc comparisons with the Bonferroni correction were conducted to examine the differences between time points within each group and the differences between groups at each time point. The within-subject comparisons revealed no significant difference in the CB scores between pre-treatment and post-treatment (mean difference = -0.144 , $p_{\text{Bonf}} = 0.327$) or between pre-treatment and follow-up (mean difference = 0.038 , $p_{\text{Bonf}} = 1.000$). A trend toward significance was observed between the post-treatment and follow-up CB scores (mean difference = 0.182 , $p_{\text{Bonf}} = 0.099$).

The between-subject comparisons indicated no significant difference in the CB scores between the experimental and control groups at pre-treatment (mean difference = -0.223 , $p_{\text{Bonf}} = 1.000$). At post-treatment, the experimental group showed significantly higher CB scores compared to the control group (mean difference = -0.443 , $p_{\text{Bonf}} = 0.011$). Similarly, at follow-up, the experimental group maintained significantly higher CB scores compared to the control group (mean difference = -0.468 , $p_{\text{Bonf}} = 0.003$). Within the control group, a significant increase in the CB scores was observed between post-treatment and follow-up (mean difference = 0.388 , $p_{\text{Bonf}} = 0.022$).

The results showed that the experimental group demonstrated significantly higher CB scores compared to the control group at post-treatment and follow-up (see Figure 2). Within the control group, a significant increase in the CB scores was observed between post-treatment and follow-up. No significant differences were observed at pre-treatment or for other comparisons.

3.2. Patient Satisfaction with the Treatment Received

Patient satisfaction with the IADC treatment was assessed using Item 10 of the IADC-GQ, “I feel satisfied with the treatment I received”, measured at two time points: post-treatment and follow-up. The satisfaction scores showed no significant difference between post-treatment ($M = 4.45$, $SD = 0.83$) and follow-up ($M = 4.31$, $SD = 1.16$), as indicated by a Wilcoxon signed-rank test ($W = 128.50$, $z = 0.88$), suggesting that satisfaction remained high and stable over time.

3.3. Additional Participant Variables Influencing Grief Processing

To explore potential factors affecting the effectiveness of grief processing, we analyzed the relationship between the pre- and post-treatment changes (T2-T1) in key outcomes and various participant variables (see Table 1). These included levels of spirituality and religious affiliation, previous experiences with ADC, use of psychotropic medications, and the cause of death of the deceased. As no significant differences were found between the experimental and control groups for these variables, the analysis was conducted on the entire sample.

A moderately positive Spearman correlation was observed between spirituality and reductions in the ICG scores ($\rho = 0.29$, $p = 0.01$) and CS scores ($\rho = 0.26$, $p = 0.02$), indicating that higher levels of spirituality were associated with greater improvements in grief intensity and stress symptoms. However, no significant correlation was found between spirituality and changes in the CB scores ($\rho = -0.04$, $p = 0.69$). These findings underscore the potential role of spirituality in mitigating grief symptoms.

Regarding religious affiliation, the Mann–Whitney U test revealed a marginally significant difference in the CB score changes ($U = 626$, $p = 0.050$) between participants identifying as Catholic and those with other forms of spirituality, faith, or atheism. Specifically, participants in the latter group reported a higher mean increase in the CB scores (mean = 0.41, $SD = 1.00$) compared to Catholics (mean = -0.01 , $SD = 0.75$), suggesting that individuals with non-Catholic affiliations may experience a greater sense of connection with the deceased following the intervention. No significant differences were observed for the ICG and CS scores (all $p > 0.20$).

The Mann–Whitney U test revealed no significant relationships between the pre- to post-treatment changes in the scale scores and participants’ previous experiences with ADC, use of psychotropic medications, or cause of death (natural illness vs. violent death, including accidents, suicide, or homicide) (all $p > 0.10$). These findings indicate that these variables did not significantly influence the changes in grief or related outcomes following the intervention.

The absence of significant relationships between the pre- to post-treatment changes in the scale scores and participants’ previous experiences with ADC, use of psychotropic medications, or the cause of death (natural illness vs. violent death) suggests that these variables did not play a substantial role in shaping the outcomes of the psychotherapy. This finding indicates that the effectiveness of the psychotherapy may be relatively robust across different personal histories and circumstances of loss.

The absence of an impact of previous ADC experiences on the effectiveness of the intervention in both groups suggests that the therapeutic effects of IADC therapy are not dependent on prior familiarity with after-death communication. Similarly, the use of psychotropic medications did not appear to modulate the therapeutic benefits. Finally, the nature of the loss, whether due to natural or violent causes, also did not differentially affect grief or related outcomes, indicating that the intervention’s benefits are broadly applicable across varied bereavement contexts. These findings highlight the potential universality of the therapeutic mechanisms underlying the psychotherapy.

3.4. Characteristics of the Therapists

The experimental group included eight therapists, of whom seven were female and one was male. Regarding the clinical orientation, the therapists primarily followed a cognitive behavioral therapy (CBT) approach ($N = 3$) and a systemic–relational approach ($N = 3$), while one therapist used an integrated approach, and one followed a psychodynamic approach. In terms of eye movement desensitization and reprocessing (EMDR) training, the majority ($N = 5$) had completed Level 2 certification, while two therapists had Level 1 training, and one therapist had no EMDR training. The therapists had varying years of clinical experience, with five reporting more than five years of practice, while three had between three and five years of experience. Regarding spiritual beliefs, the therapists reported a mean score of 3.38 ($SD = 0.74$) on the importance of spirituality scale. Two therapists identified as Christian, while three reported affiliations with other faiths, and the remaining three declared no religious affiliation. Finally, in terms of previous after-death communication (ADC) experiences, three therapists reported having had such experiences, whereas five had not.

All the therapists in the control group had over five years of clinical experience and were trained in EMDR. The predominant therapeutic approaches within this group were CBT and systemic–relational therapy. The available data suggest that the therapists in the control group shared comparable levels of professional experience and expertise with the experimental group. Moreover, it was not possible to reliably link the therapists' individual data to all the cases they treated within the control group. As a result, there is insufficient information to conduct statistical analyses on therapist-specific factors or their potential influence on treatment outcomes in the control group.

3.5. Characteristics of the IADC Experience

Data on the IADC experiences were collected for 17 cases within the experimental group. These results, summarized in Table 4, show that the duration of the IADC experiences varied widely, ranging from 10 to 180 min, with an average of 98.53 min ($SD = 56.62$). The therapists observed a high degree of patient conviction regarding the objective nature of the experience ($M = 8.59$, $SD = 0.87$), interpreting it as a sensory event rather than a sequence of mental images. Similarly, the therapists rated the emotional intensity of the experience as high ($M = 8.65$, $SD = 0.86$), with both measured on a 0-to-10 scale.

Table 4. Descriptive statistics of the IADC experiences: duration, conviction, and emotional intensity ($N = 17$).

IADC Experiences	Mean	Std. Deviation	Minimum	Maximum
ADC Duration (minutes)	98.53	56.62	10	180
Patient's conviction of experiencing an objective event	8.59	0.87	7	10
Patient's emotional intensity	8.65	0.86	7	10

Table 4 summarizes the therapist-observed characteristics of the IADC experiences, including their duration, perceived conviction, and emotional intensity. The data indicate that patients generally exhibited a strong sense of certainty in the experience and displayed significant emotional engagement. These observations suggest that IADC experiences are not only subjectively meaningful but also elicit profound emotional responses, reinforcing their potential therapeutic impact in grief processing.

Furthermore, patients in the experimental group reported a range of sensory channels activated during the IADC experience. The most frequently reported channels were auditory/telepathic ($N = 16$) and visual ($N = 15$). The tactile and olfactory channels were each reported by two participants, while the gustatory channel was mentioned by one participant. Notably, a substantial majority (14 out of 17 participants) reported simulta-

neous activation of both the visual and auditory/telepathic channels, underscoring the multisensory nature of the IADC experience in most cases.

These findings suggest that the IADC experiences in the experimental group were both substantial in duration and perceived as highly convincing and emotionally intense.

4. Discussion

The primary objective of this study was to evaluate the effectiveness of induced after-death communication (IADC) therapy in alleviating grief-related distress. By comparing IADC therapy with standard grief interventions, we aimed to determine whether this approach offers distinct therapeutic benefits, particularly in fostering a reduction in grief intensity and distress symptoms while simultaneously facilitating adaptive continuing bonds with the deceased. Additionally, this study sought to explore the long-term impact of IADC therapy by assessing its effectiveness at a six-month follow-up, providing insight into the sustainability of its therapeutic effects.

The findings showed that IADC therapy led to significant and sustained reductions in grief intensity, as measured by the Inventory of Complicated Grief (ICG), and in distress symptoms captured by the Clinical Score (CS) subscale of the IADC-GQ. These improvements were particularly pronounced immediately following the intervention and were maintained over time. The control group, in contrast, exhibited a more gradual reduction in symptoms, with lower overall improvement compared to the experimental group, despite the fact that they continued psychotherapy until the follow-up, whereas only 50% of the experimental group pursued further psychotherapy. Notably, the IADC intervention effectively reduced the ICG scores below the clinical cut-off threshold after just two sessions, in line with early studies on the effectiveness of IADC therapy ([Hannah et al., 2013](#); [Holden et al., 2019](#)). This is particularly striking given that two items of the ICG related to potential after-death communication experiences (i.e., item 15, “*I hear the voice of the person who died speak to me*”, and item 15, “*I see the person who died stand before me*”) ([Prigerson et al., 1995](#)) may inflate the total score in the context of IADC therapy, where such experiences are actually reframed as positive and meaningful aspects of the grieving process ([St. Germain-Sehr & Maxey, 2019](#); [Penberthy et al., 2023](#)).

These results show that IADC therapy can quickly and deeply relieve grief by helping patients feel reconnected with their deceased loved ones, making it easier for them to accept the loss. The brevity of the IADC intervention, comprising two sessions totaling approximately four hours and achieving outcomes comparable to or surpassing more prolonged treatments, has significant implications for cost-effectiveness ([St. Germain-Sehr & Maxey, 2019](#)). The comparable or superior outcomes achieved by the more time-efficient IADC therapy suggest that it may offer a valuable alternative, providing effective relief from grief-related distress in a shorter timeframe. This efficiency could translate into reduced treatment costs and increased accessibility for individuals seeking support during bereavement.

In contrast to its effects on grief intensity and distress, the intervention’s impact on the Continuing Bond (CB) subscale of the IADC-GQ revealed a more nuanced pattern. While no overall changes in the CB scores were observed in the experimental group over time, this group consistently reported higher scores compared to the control group at post-treatment and follow-up. This is important because the resolution of grief involves continuing bonds that survivors maintain with the deceased ([Klass et al., 1996](#)). These findings suggest that IADC therapy may enhance the quality of the ongoing connection with the deceased ([St. Germain-Sehr & Maxey, 2019](#)). IADC therapy is an experiential therapy. The concept of corrective emotional experience ([Alexander & French, 1946](#)) expresses what happens in the

IADC experience. Indeed, the experience of reunion changes the meanings attached to the experience of loss and, through this change of perspective, promotes acceptance of this.

The results regarding patient satisfaction with the IADC treatment indicate a consistently high level of satisfaction, both immediately following the treatment and at follow-up. The lack of a significant difference between the two time points suggests that the positive perception of the treatment's impact was sustained over time. This stability is a promising outcome, as it reflects the enduring value of the therapeutic intervention in addressing patient needs. The high mean satisfaction scores at both time points suggest that participants found the IADC treatment to be both effective and meaningful.

In this study, we focused specifically on pre-to-post changes, as the immediate effects of the intervention provide clearer insights into how these factors interact with the therapeutic process. By limiting the analysis to this time frame, we aimed to reduce potential confounding effects that might emerge over longer follow-up periods due to external influences or additional interventions.

The observed positive correlations between spirituality and reductions in the ICG and CS scores highlight the potential influence of spirituality on alleviating grief intensity and stress-related symptoms. These findings suggest that individuals with higher levels of spirituality may possess greater emotional or cognitive resources to process grief and manage stress effectively (Ungureanu & Sandberg, 2010). Spiritual beliefs and practices may provide a framework for meaning-making and emotional regulation, particularly in the context of bereavement. This aligns with prior research emphasizing the protective role of spirituality in promoting resilience during periods of significant emotional distress (Captari et al., 2018; Biancalani et al., 2022). However, despite this protective role, the lack of a significant correlation between spirituality and changes in the Continuing Bond (CB) scores, as measured by the IADC-GQ, suggests that spirituality might not strongly influence the maintenance or transformation of an ongoing emotional connection with the deceased. According to the continuing bond theory, maintaining a healthy and adaptive connection with the deceased is a central component of grief resolution (Klass et al., 1996). In this context, our findings indicate that while spirituality may facilitate emotional healing and stress reduction, it may not directly shape the nature or quality of the ongoing bond with the deceased. This aligns with existing research on spontaneous after-death communications (ADCs), which suggests that these experiences occur across diverse religious and cultural backgrounds, independent of specific spiritual or doctrinal beliefs (Streit-Horn, 2011; Haraldsson, 2009). The widespread prevalence of ADCs in the general population, regardless of religious affiliation, supports the idea that maintaining a connection with the deceased is a universal human experience, shaped more by individual psychological and existential factors than by formal religious frameworks. This may explain why, in our study, spirituality influenced emotional regulation but did not significantly impact the nature of continuing bonds.

The findings of this study provide further support for the profound and multisensory nature of induced after-death communication (IADC) experiences. The considerable variation in the duration of IADC experiences, ranging from 10 to 180 min, suggests significant individual differences in how patients engage with and process these events. However, the relatively high average duration (98.53 min) indicates that, for most participants, the IADC experience was not fleeting but rather a sustained and immersive event. Moreover, the therapists observed that patients exhibited a strong sense of conviction regarding the objective nature of their experience, perceiving it not merely as a sequence of mental images but as a genuine sensory event. Similarly, the therapists rated the emotional intensity of these experiences as high, reinforcing the idea that IADCs induced through the therapy are deeply

impactful. These observations align with prior research suggesting that IADCs are often described as vivid and emotionally transformative encounters (Botkin & Hogan, 2005).

The multisensory nature of IADC experiences further underscores their psychological salience. The predominance of auditory/telepathic and visual channels suggests that these are the primary modalities through which patients experience communication with the deceased. The frequent co-occurrence of both sensory channels highlights the immersive quality of these experiences, which seem to involve complex, integrated perceptual processes. Although tactile, olfactory, and gustatory sensations were less frequently reported, their presence in some cases suggests that IADC experiences may manifest through a wide range of sensory modalities, further contributing to their realism.

These findings support the hypothesis that IADC therapy facilitates an emotionally powerful and subjectively convincing experience of reconnecting with a deceased loved one. This may, in turn, play a crucial role in the therapeutic effects of IADC, as previous research has suggested that the sense of reconnection can significantly alleviate grief-related distress (Botkin & Hogan, 2005; Klass et al., 1996). The observed combination of extended experience duration, high emotional intensity, and therapist-rated patient conviction in the reality of the event suggests that IADC therapy engages deep cognitive and emotional mechanisms that warrant further investigation. Future studies should explore the potential mediators of these effects, such as the role of expectancy, individual differences in susceptibility to altered states of consciousness, and the neural mechanisms underlying the multisensory nature of IADC experiences. Additionally, research comparing IADC with spontaneous ADCs could provide further insights into the psychological and neurobiological underpinnings of these phenomena.

4.1. Theoretical Implications

The findings of this study contribute to the growing body of research on grief interventions, particularly in the context of induced after-death communication (IADC) therapy. By demonstrating significant reductions in grief intensity and distress symptoms, this study provides empirical support for IADC as a structured therapeutic approach that differs from traditional grief interventions. The results align with theories emphasizing the role of continuing bonds in adaptive grief processing (Klass et al., 1996), suggesting that IADC therapy may facilitate a meaningful connection with the deceased, which, in turn, aids in grief resolution (Stroebe et al., 2010).

Moreover, our findings support the notion that multisensory experiences of after-death communication may serve as a psychological mechanism for emotional healing. While past research has often framed spontaneous after-death communications (ADCs) as anomalies (Kamp et al., 2019), our study suggests that, when facilitated within a structured therapeutic setting, such experiences can have predictable and beneficial effects on grief-related distress. These insights contribute to the broader discussion on how transpersonal experiences can be integrated into psychological treatments for bereavement (Neimeyer et al., 2006).

Attachment theory posits that individuals form deep emotional bonds with significant others, and the loss of such bonds can lead to profound grief and suffering (Bowlby, 1980). The concept of continuing bonds refers to the ongoing emotional or symbolic connection with the deceased, which can facilitate adaptation to loss. IADC therapy, by inducing experiences of communication with the deceased, may strengthen these continuing bonds, providing the bereaved with a sense of ongoing support and closeness. This process can be viewed as an extension of attachment theory, wherein the connection with the loved one persists beyond death, promoting healthier grief processing and reducing distress symptoms (Field et al., 2005).

4.2. Practical Implications

The findings of this study have significant practical implications for clinical practice and mental health interventions for grief. The brevity of the IADC protocol, which typically consists of only two sessions, makes it a highly time-efficient and cost-effective intervention compared to other grief therapies, which often require longer treatment durations to achieve similar outcomes. This efficiency suggests that IADC therapy could be integrated into public health services as a viable option for individuals experiencing PGD or CG, providing an accessible and structured approach to grief resolution.

Despite their widespread prevalence, ADCs are often overlooked or stigmatized, leading individuals to avoid disclosing such experiences due to fear of judgment or misinterpretation (Streit-Horn, 2011). Given their potential clinical relevance in grief processing, it is crucial to reconsider their role within therapeutic settings and explore ways to incorporate them into evidence-based interventions. Clinical observations suggest that ADCs can emerge spontaneously during psychotherapy, particularly in EMDR sessions (Botkin & Hogan, 2005). However, despite these insights, persistent stigma surrounding ADCs could continue to hinder their integration into clinical practice. Many therapists remain unaware of both their prevalence and their therapeutic potential, which may prevent them from recognizing and utilizing ADC experiences when they arise spontaneously during therapy. Increasing awareness and education among mental health professionals is therefore essential to fostering an open and supportive therapeutic environment, where patients feel comfortable discussing their ADC experiences without fear of pathologization. By acknowledging ADCs as natural and potentially meaningful components of the grieving process, therapists can enhance their ability to facilitate adaptive grief processing. An informed approach would allow clinicians to identify spontaneous ADCs when they occur in therapy and help patients integrate these experiences in ways that promote healing rather than distress. Ultimately, destigmatizing ADCs and incorporating them into grief interventions could contribute to a more comprehensive and person-centered approach to bereavement care, expanding the range of effective therapeutic strategies available for grieving individuals.

Finally, the findings on patient satisfaction and long-term benefits highlight the potential of IADC therapy as an adjunct to other grief interventions. Although IADC therapy is extremely effective as a treatment for grief, it does not preclude some aspects of grief from being addressed by other therapies in which psychotherapists are trained.

4.3. Limitations and Future Research

While this study provides valuable insights into the effectiveness of IADC therapy and its potential role in grief processing, several limitations should be acknowledged. By maintaining a focus on CG, this study leverages a well-established construct to explore the effectiveness of IADC therapy while remaining consistent with the existing body of grief research. Future research may build on these findings to further examine the specific diagnostic criteria of PGD.

While the approach of this study reflects real-world clinical practice, allowing for an ecologically valid assessment of IADC therapy within diverse therapeutic contexts, the lack of a standardized protocol for the control group introduces variability that could influence the comparability of the results. The combination of talk therapy and EMDR was not systematically structured across all the participants, potentially leading to differences in treatment intensity and focus. On the one hand, this naturalistic design enhances the external validity, capturing the variability inherent in routine clinical practice. On the other hand, the heterogeneity of the interventions within the control group limits the ability to isolate the specific effects of IADC therapy, as differences in therapeutic

outcomes may, at least in part, be attributable to variations in treatment approaches rather than the distinct characteristics of IADC itself. Future studies should aim to establish a more standardized comparison condition by defining clear treatment protocols for control interventions, thereby ensuring greater methodological rigor in evaluating the relative effectiveness of IADC therapy.

Our findings indicate that the benefits of IADC therapy were sustained at the six-month follow-up, with participants maintaining significant reductions in grief intensity and distress symptoms over time. This suggests that the intervention has a lasting impact, even in the absence of continued psychotherapy. However, while the six-month follow-up provides preliminary evidence of the durability of IADC therapy's effects, longer-term evaluations are necessary to determine the stability of these improvements over extended periods. Grief processing is a dynamic and evolving process, and it remains unclear whether the therapeutic gains observed at six months persist beyond this time frame or whether some individuals may experience a resurgence of grief-related distress over time (Bonanno et al., 2002). Future research should incorporate follow-up assessments at 12 months or beyond to assess the long-term trajectory of IADC therapy outcomes. Additionally, longitudinal studies could explore potential factors that contribute to the maintenance of therapeutic benefits, such as continued personal meaning-making, ongoing spiritual or emotional integration of the experience, or engagement in complementary grief-support interventions. Understanding these factors could help optimize the long-term efficacy of IADC therapy and provide insights into whether periodic booster sessions might be beneficial for some individuals.

Another limitation is related to statistical power. Although this study provides meaningful insights, the sample size may have been insufficient to detect smaller but clinically relevant effects, particularly when analyzing subgroup differences or moderating variables. Indeed, although the relatively small sample size exceeds the minimum threshold determined by the power analysis, it still limits the generalizability of the findings. Future studies should aim to replicate these results with larger and more diverse samples to ensure broader applicability across different populations. Future research should also explore the role of individual differences, such as the personality pattern and the affective style. Understanding these moderating factors could help tailor interventions to individual needs and improve the overall efficacy. Furthermore, the number of therapists administering the intervention was limited, with only eight professionals delivering IADC therapy. While previous studies have suggested that IADC therapy maintains consistency across different practitioners (Botkin & Hannah, 2013), expanding the pool of therapists would provide a more comprehensive evaluation of the replicability of the treatment effects. A larger and more diverse pool of therapists would provide a broader perspective on the efficacy and replicability of IADC therapy across different clinical contexts.

Regarding the therapist-related variables, although we collected data on clinical orientation, EMDR training level, and years of professional experience, our study did not explore the direct impact of these factors on the treatment outcomes. While previous research suggests that IADC therapy is consistently effective across different practitioners (Botkin & Hannah, 2013), individual therapist characteristics—such as therapeutic style, attitudes toward grief-related interventions, and ability to facilitate emotional processing—may play a role in determining patient responses (Feinstein et al., 2015). Future research should examine these variables systematically, exploring whether specific therapist traits enhance or moderate the effectiveness of IADC therapy.

Previous research indicates that ADC experiences occur across various cultural and religious backgrounds (Streit-Horn, 2011; Haraldsson, 2009), but the way they are interpreted and integrated into one's belief system may vary significantly. In our study, spirituality was

moderately correlated with reductions in grief intensity and distress symptoms, suggesting that it may play a role in how individuals process loss and integrate the IADC experience. However, beyond the immediate therapeutic benefits, the long-term effects of IADC therapy on an individual's worldview, meaning-making processes, and spiritual orientation warrant further investigation. Experiencing an ADC within a therapeutic context may not only facilitate grief resolution but also contribute to broader existential reflections, potentially altering one's relationship with death, the afterlife, and personal spirituality. In some cases, this shift may lead to increased psychological resilience and a more profound sense of continuity with the deceased. Conversely, individuals from cultural backgrounds with different conceptualizations of death and spiritual phenomena may interpret the experience in ways that influence its therapeutic impact. Future studies should explore how these cultural and spiritual dimensions interact with IADC therapy, examining whether prior beliefs, openness to transpersonal experiences, and the integration of ADCs into one's existing worldview affect both the short-term and long-term therapeutic outcomes. Cross-cultural research would be particularly valuable in identifying how different populations perceive and respond to IADC therapy, ensuring that its clinical application remains both ethically and culturally sensitive.

5. Conclusions

This study provides further empirical support for induced after-death communication (IADC) therapy as an effective and time-efficient intervention for individuals experiencing grief. The findings indicate that IADC therapy facilitates a significant reduction in grief intensity and distress while promoting a more adaptive connection with the deceased. These improvements were observed shortly after the intervention and remained stable over time. The short duration of IADC therapy, typically consisting of just two sessions, underscores its potential as a cost-effective alternative to traditional grief interventions while delivering comparable or even superior outcomes. Participants reported high levels of satisfaction with the treatment, reinforcing its acceptability and perceived effectiveness. By facilitating an experiential connection with the deceased, IADC therapy appears to promote a meaningful restructuring of continuing bonds, aiding in grief resolution. The findings further highlight the role of spontaneous after-death communications (ADCs) in therapeutic settings. Recognizing and integrating these experiences into grief therapy may provide an additional pathway for healing. Despite these promising results, further research is needed to explore the long-term effects of IADC therapy, its applicability across different cultural and religious contexts, and the influence of therapist characteristics on treatment outcomes.

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Abbreviations

The following abbreviations are used in this manuscript:

ADC	After-death communication
CG	Complicated grief
EMDR	Eye movement desensitization and reprocessing
ICG	Inventory of Complicated Grief
IADC	Induced after-death communication
IADC-GQ	IADC Grief Questionnaire
PGD	Prolonged grief disorder

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