Complicated grief therapy as a new treatment approach

Julie Loebach Wetherell, PhD*
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Abstract

Complicated grief therapy (CGT) is a relatively new psychotherapy model designed to address symptoms of complicated grief. Drawn from attachment theory and with roots in both interpersonal therapy (IPT) and cognitive-behavioral therapy, CGT includes techniques similar to prolonged exposure (repeatedly telling the story of the death and in vivo exposure activities). The treatment also involves focusing on personal goals and relationships. CGT has been demonstrated to be effective in a trial in which participants with complicated grief were randomly assigned to CGT or IPT; individuals receiving CGT responded more quickly and were more likely to respond overall (51 % vs 28%). This article briefly summarizes the conceptual underpinnings of CGT, discusses the empirical evidence for its efficacy, describes its techniques, and presents a case example of a client treated in a 16-session manualized CGT protocol. The article concludes with a description of future research directions for CGT.

Keywords: *bereavement*, *traumatic grief*, *treatment*, *psychotherapy*, *cognitive behavior therapy*

Description of the treatment

Facilitating recovery from loss has been a staple of psychotherapy since long before the entity known variously as “complicated grief,” “traumatic grief,” “complicated bereavement,” “prolonged grief disorder,” or “pathologic grief” was identified as a form of suffering distinct from normal bereavement or depression. Clinicians have described numerous forms of treatment for bereavement-related distress, relying on different conceptualizations of the problem and different therapeutic techniques,[1,2] including medications,[3,5] supportive therapy,[6,7] client-centered therapy,[8] meaning-oriented therapy,[9] brief dynamic therapy,[10,11] cognitive therapy,[12] cognitive behavioral therapy (CBT),[13-17] interpersonal therapy (IPT),[18] pastoral counseling,[19] play therapy,[20] logotherapy,[21] writing therapy,[22,23] Internet-administered therapy,[24,25] virtual reality,[26] and hypnosis.[27-29] These treatments have been tested with children.[30-34] and adults[10,22,35] and have included interventions for inpatients,[36] refugees,[17] couples,[37] parents,[35] and those bereaved by war,[38] natural disasters,[39] accidents,[23] suicide,[40] and violence.[41]

Relatively few of these interventions have targeted complicated grief (CG) symptoms specifically rather than depression and distress more generally. Three review articles have described the literature on these CG-specific interventions.[42-41] The most recent, a meta-analysis of randomized, controlled trials, found a pooled standard mean difference (a measure of effect size) of -0.53 (95% CI: -1.00 to -0.07) favoring interventions targeting complicated grief relative to supportive counseling, IPT, or wait list.[43] The four interventions that were

more efficacious than the comparison condition were all based, at least in part, on cognitive-behavioral principles. [14,24,45] An interpretive intervention focused on increasing clients* insight about conflict and trauma related to their loss was not efficacious.[46,47] The effects of the CG interventions appeared to grow larger at follow-up, although long-term data were only available from a single study.[14]

One form of complicated grief therapy (CGT) with strong empirical support has roots in both IPT and CBT[45] CGT is based on attachment theory, which holds that humans are biologically programmed to seek, form, and maintain close relationships. Attachment figures are people with whom proximity is sought and separation resisted; they provide a ”safe haven“ of support and reassurance under stress and a ”secure base“ of support for autonomy and competence that facilitates exploration of the world. In acute grief following the loss of an attachment figure, the attachment system is disrupted, often leading to a sense of disbelief, painful emotions, intrusive thoughts of the deceased individual, and inhibition of the exploratory system.[48] With successful mourning, the individual moves from a state of acute grief to integrated grief in which the finality of the loss is acknowledged, the trauma of the loss is resolved, emotions become more positive or bittersweet, the mental representation is revised to encompass the death of the attachment figure, and the exploratory system is reactivated, with life goals revised to integrate the consequences of the loss. This occurs through a ”dual-process model,“ with both loss- and restoration-focused activities.

In CG, the process of transition from acute grief to integrated grief is derailed.[49] Clients with CG typically experience prolonged, intense painful emotions; rumination, often around themes of self-blame; and maladaptive behaviors, including avoidance of triggers to the extent that functioning is disrupted.[50] Although the causes are not yet understood, the mechanism is believed to be incomplete processing of information about the death. Specifically, the mental representation of the attachment figure is disrupted, such that the loss is acknowledged in declarative memory but not in implicit memory. This leads to a lack of acceptance of the finality of the loss.

Moreover, the exploratory system does not re-engage, such that the grieving individual can become distanced from other people and the world generally.

Thus, the basic principle underlying CGT is that grief is a natural, adaptive process.[51] This implies that treatment of CG involves removing the impediments to successful resolution of the grieving process. Through a variety of loss- and restoration-focused techniques, the therapist works to facilitate the progress of grief to help the client come to terms with the death.

A number of investigations have provided empirical support for this model of treatment. After initial pilot studies showed promising results,[52,53] CGT was compared with standard IPT in a randomized trial with 83 adult outpatients with complicated grief.[45] Participants in both conditions received 16 individual sessions of psychotherapy. Treatment response was defined as a score of 1 or 2 (“very much improved” or “much improved”) on the interviewer-rated Clinical Global Impression Improvement scale and as time to a 20-point or better decrease in scores on the self-reported Inventory of Complicated Grief. Response rates were higher (51 % vs 28%) and time to response faster in the CGT group than in the IPT group.

A secondary analysis examining the impact of naturalistic pharmacotherapy on participants in this trial found that response rates in the CGT group were higher among those taking

antidepressant medications, and that this effect was mediated by reduced attrition among those taking medications.[54] Among patients receiving CGT, 42% of those not taking antidepressants, vs only 9% of those taking such medication, terminated the trial prematurely. By contrast, in the IPT condition, only 30% of those taking medications and 23% of those not taking medications dropped out. These data suggest that CGT may be a challenging treatment, particularly for individuals who are not also taking medication.

Investigators have subsequently tested CGT with Japanese women bereaved by violent death[55] and in substance abusers[56]; results suggest that the benefits of treatment are not restricted to Western cultures or individuals without comorbid drug or alcohol abuse.

Description of the treatment

As noted above, the theory includes elements drawn from both IPT and CBT. In general, the CBT techniques target the loss-related processes and focus on symptoms of painful intrusive memories and behavioral avoidance. The IPT elements focus on restoration by helping clients re-establish relationships and connection with valued life goals.

Although CGT can be flexibly applied in clinical practice, the manualized form tested in research studies consists of 16 sessions, each approximately 45 to 60 minutes long. Each session is structured, with an agenda that includes reviewing the previous week's activities, doing work in session, and assigning tasks for the coming week. The treatment is typically divided into three phases. In the introductory phase, which usually takes place over the first three sessions, the primary goals are to establish a strong therapeutic alliance, obtain a history of the client's interpersonal relationships, provide psychoeducation about the model of complicated grief, and describe the elements of treatment. A supportive person usually attends the third session. In the intermediate phase, which typically comprises sessions 4 to 9, the client performs a number of exercises inside and outside of the session designed to come to terms with the loss and address restoration of the capacity for joy and satisfaction in life. In the final sessions (10 to 16), the therapist and client review progress and collaboratively decide how to use the remaining sessions to complete the work and consolidate treatment gains. For some clients, this portion of the treatment may resemble IPT. A more detailed, session-by-session description follows.

Session 1

The goals of the first session are to welcome clients and orient them to CG and its treatment. Consistent with CGT's roots in interpersonal therapy, the primary focus of session 1 is to obtain an interpersonal history including early family relationships, other losses, the relationship with the deceased and the story of the death, and current relationships. The therapist and client discuss the client's current life situation, including stressors and coping resources. The therapist also provides a very brief introduction to the rationale and processes involved in CGT. Finally, the therapist introduces between-session assignments (sometimes known as homework): the grief monitoring diary, on which clients record daily triggers and less distressing moments; interval plans, which can include at-home practice of CG exercises as well as individualized activities designed to help clients move closer to their aspirations; and a handout that describes in detail the model of CG and an overview of the treatment.

Session 2

In the second session, the therapist and client review the grief monitoring diary, examining triggers throughout the week and times when grief was relatively manageable to look for patterns. They also use the handout to discuss the model of CG and ways in which it relates to the client's situation. The therapist then provides an overview of the treatment. Finally, the client is encouraged to think about personal aspirations, activities that have the potential for reawakening the capacity for joy and meaning in life. The client is also given another copy of the CGT handout to provide to a supportive person who will attend the third session.

Session 3

Usually session 3 includes a supportive person such as a family member or close friend, either in person or, if necessary, by telephone. The rationales for including a supportive person are that individuals experiencing complicated grief often lose a sense of connection with others, which the treatment aims to help restore; an outside perspective on the client and the way that grief is affecting his or her life can be helpful for the therapist; and a friend or family member can facilitate the treatment by understanding what the client is doing and why, and providing support throughout the process, which is often difficult and painful. During the session, this individual is asked to describe the client since the death, his or her reactions to grief, and any avoided situations or activities. The therapist then provides an overview of the CG model and treatment to the support person. The client and support person discuss ways in which the latter can be helpful as the client progresses through the treatment. During the last 15 minutes or so, the client is seen alone to review the grief monitoring diary and provide an update on goal work.

Session 4

The heart of CGT begins in this session, with the introduction of imaginal revisiting. Imaginal revisiting is a core element of CGT that in some ways resembles prolonged exposure, an empirically supported therapy for trauma and post-traumatic stress disorder (PTSD).[57,58] In this technique, the client briefly (for approximately 5 minutes) visualizes and tells the story of when he or she became aware of the loved one's death into a tape recorder and then debriefs with the therapist. The goal of the exercise is to help the client come to terms with the loss by processing it at an emotional level and integrating that emotional processing with the rational knowledge that the loved one has died. In the debriefing portion of the exercise, the client describes what he or she observed while telling the story; the function of this discussion is to encourage the client to reflect on the story from the vantage point of the present. The client then participates in another visualization exercise in which the story is put away. Finally, clients identify a reward they can give themselves for doing the hard, painful work of revisiting, both in session and during the assignment of listening to the tape every day between sessions. Other elements that continue throughout the treatment include the grief monitoring diary and restoration-oriented work to help the client move toward a personal goal that is unrelated to grief, in order to begin to visualize life with the capacity for joy and satisfaction without the loved one who died.

Session 5

This session includes a review of the grief monitoring diary, imaginal revisiting, and restoration work. Situational revisiting is a new element introduced during this session, in which the client identifies activities or places previously avoided because they trigger grief or

serve as reminders of the loved one. The client is encouraged to engage in a situational revisiting activity every day.

Sessions 6 to 9

In addition to reviewing the grief monitoring diary, imaginal and situational revisiting, and aspirations work, the client completes a series of forms identifying pleasant memories and positive aspects or characteristics of the person who died as well as unpleasant memories/less positive aspects. Clients usually bring photographs and other mementos to some of these sessions.

Session 10

In this session, the therapist uses one or more structured questionnaires, such as the Inventory for Complicated Grief, to help the client evaluate progress and identify "stuck" points. Together, they decide on a direction for the remainder of the treatment. These can include work on other losses or IPT-oriented relationship work related to interpersonal disputes or role transitions.

Sessions 11 to 16

In these sessions, clients continue to complete grief monitoring diaries, situational revisiting exercises, and aspirations work. Although typically imaginal revisiting work is no longer necessary (as determined by distress ratings remaining low throughout the exercise), additional exercises may be conducted if needed. One final exercise that can be helpful in bringing a sense of closure and closeness with the deceased loved one is the imaginal conversation. In this exercise, the client imagines that the loved one has just died but is able to hear and speak. The client then engages in an imaginal conversation, playing both the role of the self and also of the loved one. During this conversation, the client can ask questions and, speaking as the dead person, can respond and/or offer reassurance. Although this exercise is optional (and best performed in cases in which the relationship was positive), it can be a moving and meaningful experience for clients.

If the client is experiencing CG from multiple losses, exercises such as imaginal and situational revisiting may be performed around another death. Usually the progress of therapy for treating other losses is faster after completion of the process for the initial, most distressing loss. Clients may also choose to engage in other work that is less directly related to CG and is usually consistent with the IPT targets of role transition or relationship conflict. Techniques can include standard IPT techniques such as close analysis of problematic interactions and role plays.

The final task of sessions 11 to 16 is termination with the therapist. For some clients, this is seen as a positive development, a "graduation" marking the progress from intense and debilitating grief to a sense of healing and wholeness. For other clients, discussion is required to process the feelings of loss of the therapeutic relationship.

Case example

The client, “Ann,” was a 52-year-old woman mourning the loss of her husband 4 years previously from a sudden cardiac arrest. She had been abused in childhood, and the only truly satisfying relationship of her life had been with her husband, whom she met in her late 30s. She described him as a soul mate and best friend. They had chosen not to have children and in her words, “were everything to each other.” In addition to her emotional loss, her financial status deteriorated dramatically after his death, resulting in major life changes and a drop in her standard of living. She indicated that her husband had left their financial affairs in disarray, with records stored in boxes in the closet, but she did not feel capable of sorting through the boxes and dealing with the estate or taxes.

At the outset of therapy, Ann met criteria for major depression and PTSD as well as CG. She described crying every night, with great difficulty sleeping. She felt isolated from other people and did not socialize with former friends or colleagues at work. She stated that spending time with people she used to spend time with as part of a couple was too painful, and that although she knew it was irrational, she found herself feeling envious and resentful of other people's relationships. She reported that she spent hours every day engaged in reveries about her life with her husband; her inattentiveness had drawn reprimands from her supervisor and she was now worried about losing her job, which she detested but needed for financial reasons. She had nightmares and flashbacks about waking to discover her husband's body in their bed. She also reported episodes of rage, usually triggered by hearing about what she perceived as medical malpractice or instances of poor medical care. She held her husband's physicians responsible for his death because they never diagnosed his heart problem. Although she had formerly been a talented amateur musician, playing guitar in a local band, she had not played since her husband's death. She told the therapist that although she would never consider suicide, she could not imagine a future for herself without her husband.

Ann was able to complete the grief monitoring diary and rapidly recognized a pattern: although she disliked her job, work was a useful distraction from the pain she experienced as unrelenting in the evenings and on weekends. She found the description of CG in the handout reassuring, because it gave a name to her experiences. She saw many aspects of herself and her situation in the material. Upon hearing about the revisiting exercises, particularly the imaginal revisiting, she became very anxious. She asked many questions about how telling the horrifying story of waking up in bed next to her deceased husband could possibly be helpful. In addition to explaining several times the ways in which this technique facilitates healthy grieving, the therapist also repeatedly reassured Ann that she would not be going through this experience alone.

Because she did not have any close friends who lived locally, she arranged to have her sister attend the third session by conference call. She was surprised at how supportive her sister was. The sister indicated that she was aware that Ann was suffering a great deal but had not known how to help and was “afraid to make things worse by saying the wrong thing.” She agreed to text Ann every day and talk with her twice a week, including the evening of her therapy appointments.

Ann initially had difficulty with imaginal revisiting. At the beginning of session 4, she asked a lot of questions about the rationale and procedures for the exercise; most of these were the same questions she had asked during session 2. The therapist normalized her concerns and praised her willingness to do something painful to help resolve her grief and come to terms with the loss. Because Ann was so hesitant to begin, the therapist also told her only to spend

2 minutes during the first exercise. Ann did so and was, as she expected, very distressed. During the debriefing process, Ann sobbed as she expressed her guilt over having slept through her husband's passing and her agony at not knowing whether she could have saved him had she been awake. She also expressed anger toward her husband's primary care doctor, who had performed routine annual physical examinations but had never diagnosed cardiac problems. She was able to perform the visualization exercise aimed at putting the story away and reported a decrease in distress to manageable levels. Although she agreed to listen to the tape between sessions and scheduled a telephone check-in with her therapist after completing the exercise the first time, when the time came, Ann told the therapist she was not yet ready.

After doing the imaginal revisiting exercise again in session 5, Ann reported that it was still very distressing, but she was willing to try listening to the tape at home. She and the therapist talked about ways Ann could reward herself for her hard work. She decided she would try to play her guitar, which had always been very pleasant. This time, she was able to complete the imaginal revisiting several times during the week and reported that although it was painful, it was less hard than she had imagined it would be. Throughout the next 6 sessions, she continued to engage in exercises and spent most of the debriefing time focused on the issues of guilt, uncertainty, and anger, which Ann and the therapist agreed were the key factors contributing to her CG.

In contrast to the imaginal revisiting, Ann took a great deal of satisfaction from the situational revisiting, which began in session 5. She began by dining in a few of her husband's favorite restaurants that she had not visited since his death. She opted for lunches rather than dinners, invited acquaintances from work to accompany her, and found that rather than being distressed, she enjoyed both the food and the company. She then began the task of going through the files and dealing with the financial and tax issues. Although this was clearly not pleasant, Ann felt very proud of herself for taking responsibility and was able to make progress over the course of her treatment.

During session 2, Ann had identified playing in a band as one of her aspirations, and she began playing guitar again as a reward for doing the imaginal revisiting. She was soon back in her former routine of daily practice. After 2 months, she reported to her therapist that she had attended an informal jam session at a local bar and met a couple of musicians who were looking for a guitarist. They began practicing together and by the end of treatment had made plans to appear together as a band at the same bar for a performance that had the potential to turn into a monthly gig. Ann was delighted to be playing regularly and had begun to consider her new bandmates as friends.

Ann's ninth session was the week of what would have been her 10th wedding anniversary. The therapist began discussing this potentially painful time several weeks in advance. Two weeks before the anniversary, the therapist provided Ann with a handout on dealing with difficult times. With mixed feelings, Ann made plans to leave town for a long weekend to attend a music festival that she knew her late husband would not have enjoyed. Although she reported feeling very sad, she did enjoy the festival and felt relieved that she had not spent the time “moping” at home.

By the end of treatment, Ann had made a great deal of progress. She no longer met criteria for major depression, PTSD, or complicated grief. Although she continued to experience some moments and even days of sadness, these were not prolonged or incapacitating. She no longer experienced nightmares or flashbacks. She no longer felt guilty and felt much less

angry toward doctors and the medical profession. She no longer avoided pictures or places that reminded her of her husband. She now considered her bandmates and several of her coworkers as friends and had forged a closer relationship with her sister. She had also made progress on disentangling her financial affairs, although some of the issues were still unresolved. She was playing guitar in a band once again, which gave her great satisfaction.

Termination with the therapist was an easy process for Ann. She expressed gratitude for the help and accepted praise for her hard work, particularly in sticking with the imaginal revisiting exercise, which she was able to acknowledge helped reduce the power and pain of the memory of finding her husband's body. She agreed that she was doing much better and did not feel the need for further counseling at this time.

Current and future directions for research on complicated grief therapy

Research on CGT is ongoing. One currently unresolved issue is the role of pharmacotherapy in the recovery from CG. One investigation based on naturalistic data suggested that concurrent use of antidepressant medications may facilitate CGT by enabling clients to tolerate the painful work of imaginal and situational revisiting.[54] An open-label pilot study suggested that selective serotonin reuptake inhibitors may be sufficient to treat CG even in the absence of psychotherapy.[5] Because CGT is a challenging treatment not yet widely available, a finding that medication alone is sufficient to alleviate suffering in many individuals would have important public health significance.

Currently, a large-scale trial is underway in four sites to investigate these questions. Clients with CG as indicated by a score of 0 or more on the Inventory of Complicated Grief[59] are randomly assigned to citalopram, pill placebo, CGT plus placebo, or CGT plus citalopram. The primary aim is to determine whether citalopram is more effective than placebo in reducing the symptoms of CG, as measured by the Clinician Global Impression - Improvement.[60]

Another area ripe for exploration is the disseminability of CGT. Drawing as it does from both IPT and CBT, it can be challenging to learn for therapists who have a strong background in one model but not in the other. Like other therapies that deal with intense pain, it can also be emotionally draining. To date, the process for obtaining the requisite skills to conduct CGT competently has involved a multi-day didactic workshop followed by intensive supervision of at least two cases, with an expert supervisor listening to audiotapes on an hour-for-hour basis. This level of training and supervision may not be readily available for all potential therapists. It would be of interest to investigate whether a less stringent, time -intensive training process is sufficient to produce good outcomes; such a finding would greatly increase the public health significance of this promising new therapy.

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