

Grief counselling and therapy

The case for hope



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Abstract: Grief counselling and therapy are in a period of ferment as emerging claims and models are developed that challenge our assumptions about how people accommodate loss and how counsellors and therapists can best help them to do so. This article reviews recent developments in bereavement research and practice that studies show are effective in helping bereaved people who are struggling to rebuild their lives following loss.

Keywords: Grief counselling, grief therapy, attachment theory, meaning reconstruction, complicated grief

Grief counselling and therapy are in a period of ferment, as long-held assumptions are being questioned (Bonanno, 2004; Wortman & Silver, 2001), new models of mourning are being advanced (Neimeyer & Gamino, 2006), measures of important, grief-related constructs are being developed (Neimeyer, Hogan & Laurie, 2008), and research is burgeoning on all fronts (Parkes & Prigerson, 2009; Stroebe *et al*, 2008). As a result, spirited debates have arisen in the field, such as that about the efficacy of bereavement interventions published in the previous issue of this journal. In this climate of questioning, boundary-breaking and debate, those of us who work with bereaved people can be forgiven if we experience some level of conceptual vertigo, as we struggle to glean the promising possibilities for our practice from the proliferation of publications.

This article will briefly review what I consider to be some of the more constructive developments in the field: those that offer immediate and practical benefits for our work as grief counsellors. As I will argue, I believe these trends indicate that we have much to offer those dealing with the devastating loss of a loved one, both through a keener appreciation of the mysteries of mourning and a more ample responsiveness to the issues the bereaved bring to us as they attempt to reaffirm or reconstruct their lives.

The expanding horizon

Perhaps the clearest conclusion that can be drawn from the outcomes of the 60-plus controlled studies of bereavement

interventions available to us is that we are most helpful in our intervention efforts when we offer them to those who are suffering substantially; therapy extended to bereaved people who may already be coping adaptively or resiliently with their loss is unlikely to show much benefit (Currier, Neimeyer & Berman, 2008; Neimeyer & Currier, 2009). Of course, a considerable range of familiar symptoms and struggles, from clinical depression and anxiety disorders to spiritual crises and family conflict, might serve as 'markers' that something more than general support is needed by any given client. But it is also probable that some of the risk factors that suggest the urgency of intervention are bereavement-specific, linked to the disruption of a security-enhancing attachment bond that helps frame life's purpose and meaning. This implies that close scrutiny of a client's grief responses *per se*, as distinct from their other visible and audible forms of distress, could play a critical role in the design and delivery of effective therapies.

One major development along these lines is the refinement and validation of criteria for identifying complicated grief, also referred to as prolonged grief disorder (PGD) (Prigerson *et al*, 2010), which large cohort studies suggest is the extreme end of a continuum of grief responses that range from adaptive grieving to disabling preoccupation with loss (Holland *et al*, 2009). Substantial evidence from several research teams in different countries converges on the diagnosis of this condition, the prevalence of which hovers around 10% of the general bereaved population, but may be 30% or higher in certain groups struggling with particularly difficult losses, such as

parents grieving the death of a child (Keesee, Currier & Neimeyer, 2008). Left untreated, the psychological and medical consequences of PGD are considerable, including substantially heightened depression, anxiety and substance abuse, but also adverse physical outcomes, including hypertension and myocardial infarction. Although PGD is not the only way in which a person can be disabled by grief (other psychiatric disorders, emotional loneliness and social alienation, attachment avoidance and other deleterious outcomes are also possible), the refinement of diagnostic criteria for this condition should help pinpoint one significant subset of the bereaved who both need and are likely to benefit from formal intervention.

Conceptual advances

Conceptual advances in the understanding of grief also hold promise of offering new directions in the development of specific and effective therapies. For example, in keeping with Bowlby's (1980) early work, growing evidence suggests that individuals who experience insecure styles of attachment are more prone to chronic grief trajectories (Bonanno, Wortman & Nesse, 2004), perhaps contributing to maladaptive rather than adaptive forms of continuing bonds with their deceased loved ones (Field, Gao & Paderna, 2005). Other useful models posit a dialectical process in grief adaptation, such as the Dual Process Model (Stroebe & Schut, 1999), which captures the typical oscillation the bereaved experience over time between processing the loss and adapting to a changed life, or the Two-Track Model (Rubin, 1999), which focuses both on the biopsychosocial functioning of the bereaved and on their ongoing processing of their evolving relationship to the deceased.

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Research on both these models is benefiting from the recent development of measures to assess their central mechanisms (Caserta & Lund, 2007; Rubin *et al*, 2009). Finally, a focus on meaning reconstruction as a centrally relevant process in grieving (Neimeyer, 2001; Park, 2008) has yielded a good deal of evidence that an inability to make sense of the loss in spiritual, secular or practical terms plays a pivotal role in adaptation to bereavement, accounting for greatly more of the intensity of persistent grief symptomatology than objective factors such as the cause of death or the passage of time (Keesee, Currier & Neimeyer, 2008), and perhaps even mediating the impact of violent death on complicated grief responses (Currier, Holland & Neimeyer, 2006). The related cognitive-behavioural formulation of complicated grief by

Boelen and his colleagues (2006) similarly posits a struggle on the part of the bereaved to integrate the reality of loss into autobiographical memory as a key factor in the disorder. Both of these latter two perspectives lend themselves to research on the role of loss in challenging or positively transforming the self-narrative of the griever (Neimeyer, 2006), as well as to the refinement of narrative interventions in the context of grief therapy, as noted below.

New models of treatment

Finally, we are witnessing a burgeoning collaboration between clinicians and researchers in developing and documenting new models of treatment that have demonstrated their effectiveness in randomised controlled studies. One such is the Complicated Grief Therapy (CGT) devised by Shear and colleagues (Shear *et al*, 2005), which draws on the Dual Process Model (DPM) of Stroebe and Schut (1999) to both foster accommodation of the loss and promote restoration of life goals and roles. The former entails procedures for revisiting or retelling the story of the death in evocative detail while promoting cognitive and emotional mastery of the experience; engaging in imaginary conversations to rework the attachment relationship to the deceased, and writing about and reviewing pleasant and troubling recollections related to the deceased to help the client consolidate a more balanced memory of their life together. In addition, in keeping with the restoration focus of the DPM, clients review and revise life goals to align them with the changed circumstance of their lives. Sixteen sessions of CGT was found to be far more effective than interpersonal psychotherapy in alleviating complicated grief symptomatology, although both groups of clients showed improvement.

Likewise, Boelen and colleagues (2007) drew on a cognitive-behavioural model of complicated grief to formulate a two-phase treatment featuring cognitive restructuring and sustained exposure exercises. Cognitive interventions used familiar procedures to identify, challenge and change negative automatic thoughts in the course of grieving. Exposure treatment entailed inviting clients to tell the story of their loss in detail, followed by a homework assignment to write down all the internal and external stimuli – ranging from specific memories to people and places – that they tended to avoid. These were then organised in a hierarchical list and worked on using imagery and behavioural interventions in the remaining sessions. Outcomes indicated that 12 sessions of cognitive-behavioural treatment outperformed supportive treatment, and that exposure treatments were especially effective in ameliorating grief symptomatology. A recent meta-analysis of the literature on interventions using similar CBT methods supports their general efficacy, although it is unclear whether they are more effective than other existing therapies if investigator allegiance to a CBT paradigm is taken into account (Currier, Holland & Neimeyer, 2010).

Recently, Lichtenthal and Cruess (2010) conducted a controlled trial of a narrative intervention for bereavement,

drawing on meaning-oriented models that emphasise the role of sense-making and benefit-finding in the wake of loss. Participants were randomly assigned to one of four conditions: emotional disclosure (ED), sense-making (SM), benefit-finding (BF), or a control (CC) group. All participants were asked to write for three 20-minute sessions over the course of a week either about their deepest thoughts and emotions related to their loss (ED), or about its causes and place in their lives (SM), or about any positive life changes that came about as a result of their loss experience (BF) or simply about the room in which they were sitting (CC). Writing about the loss experience itself (ie. the ED, SM and BF groups) was associated with a greater reduction in PGD three months post-intervention than writing about a neutral topic (CC). The BF meaning-making intervention appeared especially effective. Significant improvements in depressive and post-traumatic stress disorder (PTSD) symptoms also emerged, particularly among those in the BF condition.

Another randomised controlled trial of an internet-mediated writing therapy featuring prompts for perspective-taking on the loss reinforces these general conclusions (Wagner, Knaevelsrud & Maercker, 2006). Non-directive expressive writing about loss is of uncertain benefit as a treatment for bereavement (Neimeyer, van Dyke & Pennebaker, 2009), but these findings suggest that narrative procedures that prompt positive meaning-making about the loss could play a constructive role either as a homework assignment in the context of bereavement support or grief counselling, or as a stand-alone treatment.

Finally, Kissane and his associates have devised a family focused grief therapy (FFGT) provided as a brief, four to eight session intervention for distressed relatives of patients receiving end-stage treatment in palliative care settings (Kissane & Bloch, 2002). As an alternative to the individual orientation of the other research-tested therapies described above, theirs is based on an assessment of family functioning, defined in terms of members' self-reported levels of cohesiveness, expressiveness and capacity to deal with conflict. Importantly, Kissane and his colleagues offered professional therapy only to those families whose family processes placed them 'at risk' for poor bereavement outcomes; 'supportive' families that enjoyed high cohesion and 'conflict resolving' families that dealt with problems through effective communication were judged as inappropriate for intervention. Therapy concentrated on telling the story of the illness and related grief while enhancing communication and conflict resolution.

A large randomised comparison of FFGT with treatment-as-usual produced equivocal effects. However, significantly greater improvement in general distress and depression (but not social adjustment) was shown by the 10% of FFGT-treated family members who were most troubled at the outset of treatment. Importantly, members of 'sullen' families characterised by muted anger and a desire for help showed the most improvement in depression as a result of FFGT.

In contrast, 'hostile' families characterised by high conflict actually did worse in FFGT than in the control condition (Kissane *et al*, 2006). These findings suggest that family-level bereavement interventions are effective but only with those most likely to benefit, and that they should not be offered to those who would fare as well or better without them.

Such developments will strengthen the bridge between science and practice and the bridge between the domain of grief and a changed life that affirms the resilience of the grieving person

Thus, a variety of experiential, cognitive-behavioural, narrative and family focused methods are being developed and are showing demonstrable promise in the treatment of bereavement related distress. Common features of these treatments include (a) a grounding in contemporary, research-informed models of grief; (b) the presence of significant levels of distress or complicated grief as a criterion for treatment; (c) inclusion of oral or written 'retelling' of the loss experience, often in evocative detail and, typically, (d) the prompting of some form of meaning-making, in the form of consolidation of positive memories, cognitive restructuring of fatalistic thoughts, integration of the loss into the person's self-narrative, or finding of unexpected benefits in terms of personal growth, reordered life priorities, and the like.

My hope is that such common factors, in combination with novel procedures featured in some of the therapies (for example, directed imaginary dialogues with the deceased or writing letters to the loved one or to hypothetical others who have experienced a similar loss) will continue to inspire experimentation with new models and methods in order to enrich and deepen the scope and focus of grief counselling.

Conclusion

As a field, those of us who practise grief counselling and therapy confront both problems and prospects as we face a changing landscape of loss marked by keener awareness of the individuality of bereavement as a function of the different challenges imposed by various modes of dying, the complexity of social responses to the death of a member of the family or community, and the personal and cultural diversity of mourners themselves. Not surprisingly, engaging with these challenges in a theoretically sophisticated, empirically informed and humanly responsive way can engender a sense

of humility that there is much more we need to know about how people naturally integrate cardinal losses into their life stories. But I also believe that this same climate of questioning and conceptual ferment gives cause for considerable hope, as we learn more about how counselling and psychotherapy might assist in this process when the bereaved encounter obstacles to such integration. Ultimately, I trust that the field of bereavement care will benefit from such developments, strengthening the bridge between science and practice, as well as the bridge between the domain of grief and a changed life that affirms the ultimate resilience of the grieving person. ■

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