Complicated grief treatment

The theory, practice and outcomes

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Abstract: Many people resist the notion that grief could be considered a mental disorder, but the depth of some bereaved people's distress can mean they experience very great difficulty in progressing through the natural healing process. This article outlines an attachment theory perspective on the concept of complicated grief and a research-validated treatment (complicated grief therapy) that has been found to be effective in helping people address impediments that keep them from integrating the new reality of their lives.

Keywords: Complicated grief, attachment theory, complicated grief treatment, dual process model, prolonged grief disorder

> 'The assertion that, because grief will be experienced by most of us sooner or later, it cannot be said to be an illness is not valid … If a bruise or a broken arm, the consequence of physical injury, is within the realm of pathology, why not grief, the consequence of a psychological trauma?' (Parkes, 1996, p5)

Most people are understandably wary of labelling grief as an illness, given the complex social and political issues that currently surround medicine. However, notwithstanding justifiable reticence, Parkes' argument has merit. People who are otherwise healthy can experience acute grief following the loss of a much loved person, and this grief can be very often more painful and disruptive than many physical illnesses. Bereavement can temporarily render a person a mere shadow of their former self, disoriented and besieged by intensely painful emotions. The bereaved person may feel intense yearning for the lost person; they can become so preoccupied with thoughts and memories of them that they find it difficult to care about anything else or to engage in ordinary activities, separating them from the rest of the world.

The suffering of bereaved people often confuses clinicians. On the one hand, it seems inhumane to leave such anguish untreated. On the other hand, if we regard grief as a normal human experience, this suggests it is not an appropriate focus for clinical treatment. Which is correct? Should we treat bereaved people or leave them to heal naturally? If we do provide treatment, when, why and how should we intervene? What outcome should we seek? The purpose of this paper is to describe how our clinical research group has answered these questions with respect to complicated grief – a condition we do treat. The paper covers principles, strategies and techniques of complicated grief treatment and reports the results of a study supporting its effectiveness.

The treatment approach rests on a conceptualisation of grief informed by attachment theory.

Attachment to others

There is considerable evidence that motivation to seek and maintain close attachments is an inborn, neurobiologically mediated instinct (Bowlby, 1980). Central to the brain's instinctive attachment system is an arrangement of cognitive-affective circuitry that Bowlby called a 'working model'. The working model probably contains elements of both explicit (fact-based, narrative and rule-based, semantic) and implicit (procedural or motor) memory. We store narrative and factual information about significant others derived from our rich history with them. We also develop rules that form the basis of our intuitive understanding of loved ones and that we use to make predictions that guide our expectations of these important people. We develop an intuitive, implicit knowledge of our loved ones as well.

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Implicit and explicit memory differ in the kind of information they include and in the manner in which they assimilate new information. People can learn narrative information quickly, especially when it is very salient; it takes longer to learn new rules. Rules are derived from repeated experiences, and there is resistance to changing these rules when new experiences occur. Implicit memory requires repeated physical or imaginal experiences. When there is a mismatch between experience and an important set of rules, people initially tend to discount the experience rather than change the rule. One definition of trauma is a mismatch between a life event and internalised rules related to personal safety (Janoff-Bulman, 1992). Attachment loss meets this definition of trauma.

Consider what happens when a loved one dies. Narrative memory rapidly incorporates the fact of the loved one's death, the narrative of how it occurred, and other related information. The semantic and implicit memory systems takes longer to develop new rules related to changed expectations of the deceased loved one. This means that, for a period of time after the death, old rules about the relationship persist. So, for example, there is a continued expectation that the loved one will return. This may explain why it is so common for bereaved people to experience a sense of disbelief about the death and to have an uncanny feeling that the deceased person is going to reappear.

Attachment researchers propose that separation activates the attachment system when reunion seems a possibility. This system is deactivated when reunion is thought unlikely (Mikulincer, Shaver & Pereg, 2003). Acute grief symptoms are manifestations of attachment system activation and these are gradually deactivated as information about the death is assimilated into semantic and implicit memory.

The working model of the deceased person is not dismantled, but rather is revised to include both narrative and rule-based information about the finality of the loss and its consequences and implications for the relationship to the deceased.

Facing the unwanted and highly consequential information of a loved one's death is one of life's most emotionally painful experiences. Yet it is necessary to grapple with psychological and social problems that arise as a consequence of the loss. People often solve a complex problem by trying to figure it out, setting it aside and then revisiting it, and this seems to occur when the problem is a loved one's death. Recalling and re-imagining the narrative of the death is helpful for implicit learning. Spending time thinking about the present and future, about the world without the deceased loved one, is also likely to be helpful in revising the working model. This revision, in turn, is a part of rebuilding capacity for restoration of well-being, satisfaction, joy and pleasure.

Bowlby (1980) pointed out that most people confront information about a painful death in 'bouts and moratoria'. He explained: 'During a bout certain of the implications of the information already received are considered or reconsidered … During each moratorium, by contrast, some or all of the information … is likely to be excluded and the old models and old beliefs … reinstated' (p231). Stroebe and Schut (1999) focused on the multiplicity of stressors entailed in bereavement and proposed the usefulness of an oscillating 'dual process' coping approach to loss and restoration-related stressors. Parkes (1996) makes the case for grief as a process, not a state.

In our model, grief symptoms at any given time reflect the current status of a dual process of coming to terms with the finality of the loss and re-envisioning life goals and plans. In the beginning, this process is emotionally charged, cognitively demanding, behaviourally inhibiting and socially disruptive. Thoughts and feelings about the loss and its consequences dominate the mind of the bereaved person; natural behavioural tendencies to engage with others and explore the world are restrained. Daily rhythms may be disorganised and bodily functions like sleep, appetite and energy are often disrupted. It is a testament to human vitality and hardiness that most people adjust to the loss of their closest companions. Somehow people find a way to accept and integrate the unwanted reality of the death and restore their capacity for enthusiasm, joy and satisfaction. Sometimes, though, this process is waylaid and complicated grief develops. People suffering from complicated grief are caught in a seemingly endless cycle of acute grief, and need help to find their way forward.

Complicated grief

An estimated 10–20% of bereaved people develop the painful and debilitating syndrome of complicated grief (CG), which is characterised by the symptoms outlined in Table 1. People can suffer in this way for years, or even decades, after a loved one dies. CG usually occurs after the loss of someone who was a very important person in the bereaved individual's life – someone with whom they enjoyed a strong and very satisfying relationship. Often there is a history of mood or anxiety disorders, which we believe are risk factors for developing CG. Sometimes the bereaved person has a history of a difficult relationship with their childhood caregivers, which makes the strong, positive relationship with the deceased even more important.

Bereaved people with CG may find themselves ruminating about what they could have done to prevent this death, or how someone else was responsible for the death. They may resist acceptance of the finality of the loss, focusing instead on how their loved one should never have died in this way. Overwhelmed with distressing thoughts and painful emotions, they may try to avoid people, places or activities that trigger these feelings or provoke preoccupying thoughts and memories. Caught up in the pain of this loss, and perhaps feeling guilty about their own survival, they may feel that life has lost all meaning and are unable to find joy or satisfaction in activities or people who are still in their life.

Table 1: Clinical features of complicated grief

Acute grief symptoms that persist for more than six months following the death of a loved one, including:
1 feelings of intense yearning or longing for the person who died – missing the person so much it's hard to care about anything else
2 preoccupying memories, thoughts or images of the deceased person, that may be wanted or unwanted, that interfere with the ability to engage in meaningful activities or relationships with significant others; may include compulsively seeking proximity to the deceased person through pictures, keepsakes, possessions or other items associated with the loved one
3 recurrent painful emotions related to the death, such as deep, relentless sadness, guilt, envy, bitterness or anger, that are difficult to control
4 avoidance of situations, people or places that trigger painful emotions or preoccupying thoughts related to the death
5 difficulty restoring the capacity for meaningful positive emotions through a sense of purpose in life or through satisfaction, joy or happiness in activities or relationships with others.

There are, as yet, no formal criteria for CG in the American Psychiatric Association's Diagnostic and Statistical Manual (DSM – it lists the symptoms that make up the various formally recognised psychiatric disorders), although these have been proposed (Prigerson *et al*, 2009; Shear *et al*, under review). The criteria proposed by Prigerson and colleagues derive from a community sample of 317 older people (mean age 61.8 years) with relatively few people (n = 28) diagnosed with CG (renamed by the authors 'prolonged grief disorder'). Those proposed by our group are derived from our clinical population. The criteria proposed by both groups closely resemble those in Table 1.

Complicated grief treatment

The complicated grief treatment (CGT) we developed is based on the attachment model of grief described above. We see grief as an instinctive process that will progress naturally if it is not impeded.

The progress of acute grief entails coming to terms with the finality of the loss and its consequences and redefining life goals and plans. These generally proceed together during acute grief. CG occurs when psychological and social impediments prevent this natural progression.

Typical thoughts and beliefs that impede grief are often related to prominent separation anxiety, bitter protest or caregiver self-blame. For example, a bereaved person may believe that she can never be happy without the deceased or that she will not be able to manage without this person. She may think the death was wrong or unfair: that this good person did not deserve to die when there are so many bad people in the world. She may think that it's not right to be happy if her loved one can no longer enjoy life. She may blame herself for not preventing or delaying the death. These kinds of thoughts often occur to bereaved people. However most bereaved people balance these thoughts with ones that are more optimistic and accepting of the new reality. The person with CG has trouble doing so.

Excessive avoidance and compulsive proximity-seeking also get in the way of an effective grief process. People with CG may avoid a range of situations that trigger painful emotions or prompt a period of preoccupying thoughts about the person who has died. For example, a patient said she could not dispose of her husband's clothing because, when she tried to sort through his garments, she would become preoccupied with memories:

> 'I would hold up his vest and start to remember all the times he wore it – and then I would start to miss him so much and I would just stand there for half an hour and then I just put the vest away. I had gotten nowhere. Eventually I saw the futility of what I was doing and just stopped trying.'

Another patient would avoid the Bible because her mother read it every day. Another had eliminated oatmeal from his diet because it was too painful to recall his daily oatmeal breakfast with his wife.

People with CG struggle with both loss-related and restoration-related problems and they usually find it difficult to balance attention to them. Rather than proceeding in a pattern of damped oscillation that gradually integrates thoughts and memories of the deceased into plans and goals for the future, these people experience an erratic pattern of shifting attention. Loss-focused attention remains intensely painful and infused with deep longing. Restoration-focused attention is associated with a sense of disbelief and protest and, in the best of cases, a feeling of resignation that life must go on, although there is little sense of purpose, joy or satisfaction.

The treatment is typically delivered in 16 sessions over a four-month period. The overall framework comprises:

1 information about grief, CG and CGT
2 use of a grief monitoring diary
3 involvement of a significant other
4 facilitation of optimal interpersonal functioning
5 work on personal goals and self-care
6 revisiting the story of the death, its implications and consequences
7 revisiting places and activities that are avoided
8 working with memories, pictures
9 imaginal conversation with the deceased.

Table 2: Strategies used in CGT

Loss focus	Restoration focus	Both
Imaginal revisiting and debriefing	Personal goals and self-care	Provide information and instill hope
Imaginal conversation	Involvement of significant other	Grief monitoring diary
Memories and pictures	Optimise relationship functioning	Situational revisiting

Psychological impediments to grief progress are identified and targeted, including thoughts, feelings and behaviors that activate the attachment system and/or impede its deactivation.

Core strategies and techniques

CGT integrates strategies derived from interpersonal psychotherapy (IPT), cognitive behavioural treatment for PTSD (CBT) and motivational interviewing (MI), in order to include both loss-related and restoration-related strategies (Table 2). Briefly, we use IPT strategies to support the bereaved person's current close relationships. We encourage the development of pleasurable and satisfying social relationships and help problem-solve any relationship difficulties.

Strategies derived from CBT include use of a grief monitoring diary and homework. Imaginal and 'in vivo' exercises are used to facilitate emotion processing, reduce situational avoidance, identify psychological and social impediments to grief and assist in coming to terms with the loss. We ask people to monitor grief levels on a daily basis throughout the treatment. Imaginal revisiting exercises are completed for about 15 minutes during the first half of sessions four to eight, and extended beyond this as needed. The exercises are recorded and the bereaved person listens to the recording between sessions. After completion of revisiting we conduct an imaginal conversation with the deceased.

The grief monitoring diary includes daily ratings of the person's highest and lowest level of grief, with a brief note indicating the situation in which this occurred and a rating of the average level of grief for the day. These ratings are used to help the person see that grief fluctuates naturally. People with CG often feel buffeted about by these changes in grief intensity. One goal of CGT is to help them recognise the situations associated with high and low levels of grief so they feel less out of control. The average levels provide a rough estimate of reduction in overall grief intensity in response to treatment.

Imaginal revisiting bears some resemblance to prolonged exposure used in treatment of PTSD (Foa *et al*, 1999). Revisiting in CGT is a brief exercise intended to facilitate ability both to think about the death and to set it aside. This is done to facilitate the establishment of an effective rhythm of oscillating attention towards and away from the painful reality of the death. One reason for revisiting is to help the person with CG feel less afraid of her emotions and her thoughts about the death. Additionally, we conduct an extensive debriefing of the revisiting exercise, focusing on identifying problematic beliefs that are sticking points in processing the loss. We work to help the bereaved person act as both reporter and observer in retelling the story of the death. At the end of the debriefing period, we use a visual exercise to help the person imagine how they might 'put the story away'.

Restoration-related activities continue in parallel with these loss-focused interventions. Personal goals work is introduced at the end of session 2 and continues in each session thereafter. Therapists are encouraged to individualise CGT, and so there is some flexibility to balance the time spent on loss and restoration-focused work. The idea of personal goals work is to help the person with CG re-envision their future with an expectation that it will bring a restoration of positive emotions and a sense of purpose. To this end, we invite the bereaved person to consider what she or he would want to do if we could 'wave a magic wand' so that their grief was at a level where it no longer interfered with their life. We seek to help the person identify practical, long-term goals that create a sense of interest, excitement and the possibility of personal fulfilment. We use a motivational interviewing (MI) approach (Miller & Rollnick, 2002) to personal goals work. However MI focuses on personal treatment goals; in CGT we are working towards goals that will continue to guide the person's life plans past the 16-week therapy period.

Treatment outcome

The outcome we seek with CGT is to free the natural grief process. A difficult loss is not fully processed in a few months or even a few years; rather, as Neimeyer (2001) says, we revisit the consequences of important losses and their meaning to our own lives repeatedly throughout our life. When grief begins to progress, we see an overall improvement in the person's grief symptoms and sense of well-being. To measure this

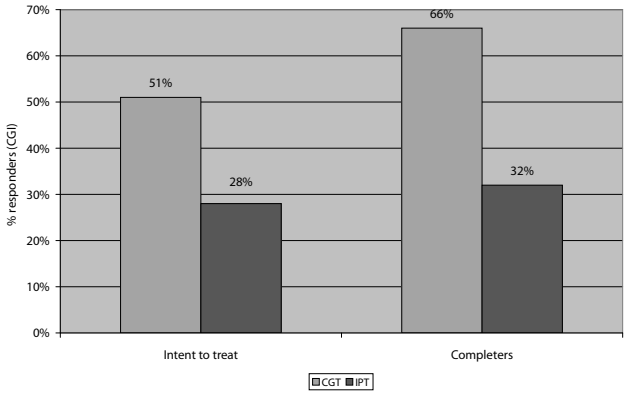
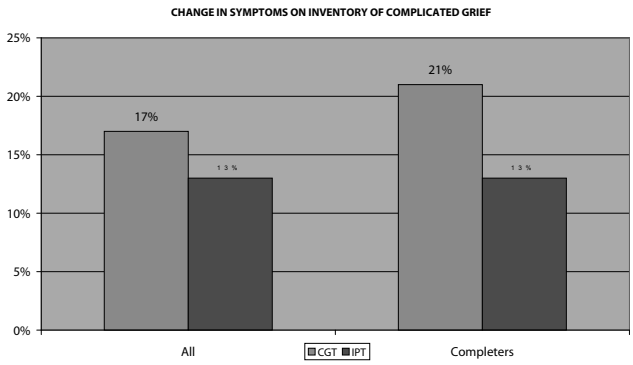


Figure 1: Rate of response to CGT compared with IPT



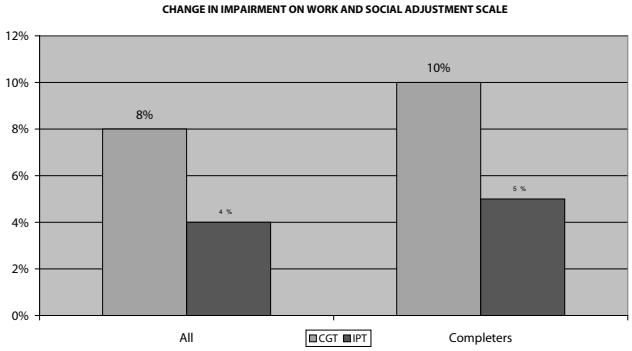


Figure 2: Results from CGT compared with IPT

improvement we use a simple scale called the clinical global impression improvement scale (CGI-I) (Shear *et al*, 2005). We measure symptoms of complicated grief using the Inventory of Complicated Grief (ICG) (Prigerson *et al*, 1995) and improvement in work and social adjustment using the Work and Social Adjustment Scale (WSAS) (Mundt *et al*, 2002). We conducted a randomised controlled study (Shear *et al*, 2005) that compared CGT with standard interpersonal psychotherapy (IPT) (Weissman, Markowitz & Klerman, 2000, 2007). We found that CGT was more effective than IPT in reducing the symptoms of grief and improving functioning, including work, home management, social situations and leisure time. Figures 1 and 2 show the results of the trial on these measures.

We allowed the people in this study to remain on antidepressant medication if they had been taking it for at least three months prior to starting the CGT. About half of each group started the treatment on this medication and their outcomes were somewhat better than those who were not taking medication (Simon *et al*, 2008). This finding is provisional and requires a prospective randomised controlled study to verify it. We have now obtained funding from the National Institute of Mental Health to conduct a four-site study to test the hypothesis that CGT in combination with serotonin-active antidepressant medication (citalopram) is the optimal treatment for CG. Other initiatives underway at our centre include the development of CGT for older adults (MH70741) and a pilot study of CGT with people bereaved by suicide, funded by the American Foundation for Suicide Prevention. We are also beginning work to modify CGT for people with developmental disabilities and for those with serious mental disorders, including psychotic disorders. ■

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