

Treating Prolonged Grief

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Abstract

Prolonged grief disorder (PGD) is characterized by disabling grief symptoms, such as intense yearning for the deceased, that persist for more than six months after the death of a loved one. This article contrasts normal grief reactions with PGD and describes diagnostic criteria, assessment instruments, and risk factors for the disorder. Individual, internet-based, and group psychotherapies for PGD, as well as the evidence supporting them, are reviewed. Recommendations for practice are provided.

Keywords: complicated grief, pathological grief, prolonged grief, psychotherapy, traumatic grief, treatment

Treating Prolonged Grief

Grief has often been defined as the psychological distress that may follow a significant loss. Various events can precipitate grief reactions, including loss of marriage, employment, housing, health, and freedom. Loss of a loved one through death, however, has been the primary focus of mental health clinicians interested in grief. This chapter will provide an overview of historical and current thinking about people's responses to bereavement. Particular attention will be paid to prolonged grief disorder, a pathological form of grieving. Treatments for prolonged grief, and the evidence for their efficacy, will be reviewed.

Normal Grief

Historical Conceptions

Historically, leading theorists of grief have emphasized certain psychological processes or trajectories that people must follow after a loved one dies in order to achieve adequate post-loss adjustment. Freud (1917/1957) wrote about the necessity of fully, consciously engaging with difficult emotions that may arise concerning the deceased, including guilt and anger. These emotions must be quickly acknowledged and worked through in order to break ties to the deceased and open oneself up to forming new attachment bonds to other people. Failure to let go of the deceased in this way may result in depression, according to Freud. Similarly, Lindemann (1944) argued that psychological and somatic symptoms were expected during bereavement, and that bereaved individuals who did not exhibit significant distress could benefit from facilitation of emotional expression by mental health providers. Repression of grief was thought to encourage later pathology. In another model of grief that has had wide influence in popular culture, Kubler-Ross (1969) described a sequence of stages—denial, anger, bargaining,

depression, and acceptance—that bereaved individuals must pass through to reach healthy resolution.

Contemporary Research

Empirical research on bereavement has not supported these prescriptive conceptions of grief. In one large study, almost half of the participants showed only modest to moderate levels of distress after the death of a loved one, and these individuals' relatively mild initial emotional responses did not predict any later pathological reactions (Bonanno, Wortman, & Lehman, 2002). Some individuals even showed improved functioning after their loss, likely due to decreases in caregiver burdens. Other individuals developed acute distress that diminished over the course of several months, while still others developed chronic, debilitating levels of grief. Normal bereavement reactions are thus highly heterogeneous, and there is no evidence for a particular set of emotions or psychological sequence that individuals must pass through in order to reach a satisfactory adjustment to their new lives without their loved ones (see Wortman & Silver, 1989). Nonetheless, researchers have identified tasks that grieving individuals commonly complete in the course of their post-loss adjustment. These include confronting stressors that serve as reminders of the reality of the loss, such as old photos of the deceased, and engaging with activities that help the individual to function independently of the lost loved one, such as spending time with new people (Stroebe & Schut, 1999).

Prolonged Grief Disorder

Diagnostic Criteria

Although most grievers show natural resilience or recovery with the passage of time (Bonanno et al., 2002), a subset of individuals develop severe grief symptoms that do not abate even years after the death of a loved one. Research on these individuals has led to the

development of evidence-based diagnostic guidelines for prolonged grief disorder (PGD) (Prigerson et al., 2009), sometimes called complicated grief, traumatic grief, or pathological grief. To qualify for the PGD diagnosis, at least six months must have passed since the loss of a loved one, and the bereaved person must continue to show daily or disabling levels of yearning for the deceased, along with at least five of nine associated grief symptoms. These include confusion about self-identity or life role; difficulty accepting the loss; avoidance of reminders of the loss; inability to trust others since the loss; anger related to the loss; difficulty moving forward with life; emotional numbness since the loss; feelings of meaninglessness since the loss; and feeling stunned by the loss.

Distinction from Depression and PTSD

PGD is often seen co-occurring with other disorders that may arise in the wake of loss, such as major depressive disorder and posttraumatic stress disorder (PTSD; Simon et al., 2007). Although some aspects of PGD (e.g., confusion about one's life role and difficulty accepting the loss) are entirely distinctive from these other disorders, and many features of depression (e.g., appetite changes) and PTSD (e.g., nightmares) are distinctive from PGD, there is also significant conceptual overlap in symptomatology between the three syndromes. To identify the primary problem when sadness and loss of interest are prominent features, it is helpful to focus on how specific the symptoms are to the loss of the loved one. Whereas depression involves unhappiness across life domains and withdrawal from most previously pleasurable activities, the sadness of PGD is more narrowly focused on the absence of the loved one, and behavioral constriction primarily involves avoidance of reminders of the reality of the loss. To identify the primary problem when avoidance of loss reminders is a prominent feature, it is helpful to focus on the emotions driving the avoidance. Whereas in PTSD the avoidance is driven by anxious arousal

and a sense of threat triggered by such reminders, in PGD the reminders are more likely to cause feelings of sadness and emptiness.

Assessment

Brief and reliable symptom inventories are available to assist in the assessment of PGD. These should be administered at least six months after the death of the loved one, consistent with diagnostic guidelines for PGD (Prigerson et al., 2009). The Inventory of Complicated Grief (Prigerson et al., 1995) consists of 19 symptoms (e.g., “I feel myself longing for the person who died”) and has been widely used in research studies of PGD. Individuals rate the degree to which they experience each of the symptoms, with a total score of above 25 or 30 generally considered suggestive of PGD. When time is even more limited, the Brief Grief Questionnaire (Ito et al., 2012) consists of only five symptoms. Individuals indicate the degree to which they have each of the grief symptoms, with a total score of 8 or above suggesting likely PGD (Shear et al., 2006).

Prevalence, Risk Factors, and Associated Problems

Studies have found that approximately 10-20% of bereaved individuals go on to develop PGD (Kersting, Braehler, Glaesmer, & Wagner, 2011; Shear et al., 2011), and that over a third of general psychiatric outpatients may have significant levels of prolonged grief (Piper, Ogrodniczuk, Azim, & Weideman, 2001). A greater likelihood of developing this disorder is found in people who have a history of previous traumas or losses, or a history of mood and anxiety disorders, such as major depression and generalized anxiety disorder (Lobb et al., 2010). Insecure attachment style, lack of preparation for the death, and low perceived social support following the death are also risk factors for PGD (Lobb et al., 2010). Once established, PGD has a poor prognosis and is associated with reduced social and occupational functioning, reduced quality of life, sleep problems, substance use problems, physical health problems, and suicidal

thoughts and behaviors, even when controlling for co-occurring depression and PTSD (Bonanno et al., 2007; Latham & Prigerson, 2004). Effective treatments for this disorder therefore have the potential to alleviate large amounts of distress and impairment.

Treatments for Prolonged Grief Disorder

An analysis of over 60 research studies found that treatment of ordinary grief does not provide benefits beyond those that can be expected to occur naturally with the passage of time (Currier, Neimeyer, & Berman, 2008), and most experts advise against universal intervention for the bereaved (e.g., Bonanno & Lilienfeld, 2008; Schut & Stroebe, 2005). However, psychotherapy for those individuals who suffer severe and unremitting grief reactions—that is, PGD—has been shown to produce lasting benefits (Currier et al., 2008; Wittouck, Van Autreve, De Jaegere, Portzky, & van Heeringen, 2011). Below, key PGD treatments that have been shown to be superior to a control condition are reviewed.

Individual Psychotherapy

Three different cognitive-behavioral individual therapies have shown efficacy for PGD. The first of these was developed by Shear, Frank, Houck, and Reynolds (2005) and consists of several components delivered over 16 weekly one-hour sessions. After an introductory phase of education about grief, review of the patient's history, and elaboration of the patient's current life goals, the therapy proceeds with exercises intended to encourage the patient to more fully process and accept the reality of his or her loss. These include repeated, detailed narration of the story of the death, an imagined conversation with the deceased, and writing about memories of the loved one. Next, the therapy asks the patient to brainstorm plans for moving toward life goals and restoring valued activities, including those that may currently be avoided because they serve as reminders of the loss. The patient makes concrete behavior changes each week, outside

sessions, in accordance with the plans they develop. Throughout all phases of the therapy, the therapist challenges maladaptive grief-related thoughts that may arise in session, such as inappropriate self-blame for the death or the belief that forming new relationships would trivialize the relationship that was shared with the deceased. Shear and colleagues (2005) found in a randomized controlled trial (RCT) that this treatment package, compared to interpersonal therapy (an effective treatment for depression), reduced grief symptoms for a greater proportion of patients with PGD and produced faster reductions in these symptoms.

A second, similarly effective individual therapy for PGD was developed by Boelen, de Keijser, van den Hout, and van den Bout (2007) and shares some features with Shear et al.'s (2005) treatment. In this therapy, six weekly sessions are devoted to repeated narration of the story of the loss; for homework, the patient is encouraged to confront situations that have been avoided because they serve as loss reminders. Another six weeks are devoted to noticing and challenging unhelpful negative thoughts that the patient may entertain. Regardless of the order in which these two segments of the therapy are conducted, this treatment was found in an RCT to be more effective than 12 weeks of supportive counseling for reducing PGD symptoms (Boelen et al., 2007).

Further paring down the many components of Shear et al.'s (2005) PGD therapy, recent investigators tested a therapy approach for PGD that focuses exclusively on instructing patients to increase the frequency and breadth of their engagement with pleasurable and meaningful activities in their daily lives (Papa, Sewall, Garrison-Diehn, & Rummel, 2013). This therapy is a modified version of behavioral activation, an effective treatment for depression. Patients carefully track how their daily behavioral choices affect their moods, and vice versa, and they gradually incorporate more rewarding activities into their routines and extract themselves from

dysfunctional behavioral patterns. The therapy includes no explicit focus on emotionally processing the loss of the loved one, or on changing unhelpful thought patterns that may be related to the loss. In a randomized open-label trial, this simple therapy, conducted over 12 to 14 weeks, produced large reductions in grief symptoms compared to a waitlist control condition

Internet-Based Psychotherapy

Internet-based therapy is increasingly recognized as a cost-effective, widely accessible, low-stigma means of mental health care. A five-week email-based therapy for PGD produced large symptom improvements compared to a waitlist control condition, and these gains were maintained for at least 18 months following the therapy (Wagner, Knaevelsrud, & Maercker, 2006; Wagner & Maercker, 2007). In this treatment, the patient completes a series of three types of writing exercises, and he or she shares these exercises and otherwise communicates with a therapist via email twice per week. The therapist provides detailed feedback and guidance. The first phase of writing entails vivid accounts of the death of the loved one, similar to the loss narration exercise employed by Shear et al. (2005) and Boelen et al. (2007). The second phase involves writing supportive letters to a hypothetical friend who is also bereaved, encouraging the friend to move toward a positive resolution to the mourning; this is intended to increase the patient's self-compassion and build motivation for change. The third phase asks the patient to incorporate their memories of the deceased into a narrative about the meaning of the loss and how they will cope as they continue to move forward with their lives.

Group Psychotherapy

A nine-session group therapy for PGD produced large reductions in grief symptoms compared to treatment as usual in patients who were receiving an intensive array of services in inpatient settings, where they were being treated for primary problems other than PGD (Rosner,

Lumbeck, & Geissner, 2011). This group therapy, delivered twice weekly, shares much in common with the individual therapies that have shown efficacy for PGD (e.g., Shear et al., 2005). Among other therapeutic tasks, group members learn about grief, complete a written exercise involving confrontation with the loss, learn to identify and reduce avoidance of loss reminders, and practice challenging their unhelpful or irrational thoughts. Supiano and Luptak (in press) developed and tested an even more comprehensive 16-week group therapy targeting PGD, again modeled after efficacious individual treatments, and found that it produced benefits superior to those of a general support group for the bereaved.

Medications

Evidence for the efficacy of medications for PGD is currently weak, consisting only of case series and open-label trials suggesting that selective serotonin reuptake inhibitor antidepressants may reduce grief symptoms (Bui, Nadal-Vicens, & Simon, 2012; Simon, 2013). Until RCTs showing the efficacy of medications for PGD are completed and published, antidepressants should be seen as an adjunctive treatment that may supplement proven psychotherapies (Simon, 2013). Some evidence suggests that the use of antidepressant medications may reduce dropout from psychotherapy for PGD, perhaps by bolstering patients' tolerance of the uncomfortable emotions that may arise within the therapy (Simon et al., 2008).

Summary and Recommendations

People's psychological responses to the loss of a loved one are highly variable. Although most bereaved individuals experience only manageable levels of grief that decline naturally with time, some people develop severe symptoms that persist indefinitely. When disabling or daily yearning for the deceased persists for more than six months after the death of a loved one, and several other grief symptoms are present, the diagnosis of PGD should be considered; the

Inventory of Complicated Grief can be helpful for gauging symptom severity. PGD often co-occurs with depression or PTSD but is distinct from these disorders, and is associated with functional impairment, reduced quality of life, and increased morbidity and mortality.

Most individuals with PGD do not seek mental health services for their grief (Lichtenthal et al., 2011), but RCTs have demonstrated the efficacy of several individual, internet-based, and group psychotherapies specifically targeting PGD symptoms. Mental health clinicians and primary care providers should be trained to recognize PGD symptoms and should consider referring patients with the disorder for appropriate psychotherapy. The PGD treatments used in research studies have tended to be complex, with many separate components (e.g., Shear et al., 2005); however, some research suggests that dramatically simpler therapies may be similarly effective (e.g., Acierno et al., 2012; Papa et al., 2013). In the absence of evidence that extended emotional engagement with the death of a loved one is necessary for recovery in bereavement (see Wortman & Silver, 1989), clinicians should consider beginning PGD treatment with therapy focused on restoring to the bereaved individual's life positive emotions and engagement with new sources of social support.

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