

**Complicated grief as a psychological disorder and implications to  
Psychotherapy**

**Timea Konya**

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**Supervisor: Mary Bartley**

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Department of Counselling and Psychotherapy  
Dublin Business School  
School of Arts  
Dublin**

## **Declaration**

I hereby certify that this thesis is entirely my own work and has not been submitted as an exercise for a degree at any other university. I agree that the library may lend or copy the thesis request.

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Timea Konya

## **Abstract**

*The main concept of this thesis is complicated grief as a disorder. Complicated grief is a pathological grieving process that needs attention. The research focuses on the high risk group of family carers who are involved in long term care of a member of their family. There is a possible need in change of perspective from Patient Centred Care to a care that involves the whole family in the caring process, so that the development of complicated grief can be prevented.*

*Psychotherapy treatment is widely available for the mourners seeking help, but many of the affected still remain untreated. The recent inclusion of the disorder in the DSM-5 and the current research efforts are perhaps going to change the level of awareness and will offer more provision not only in treatment but also in prevention of the disorder.*

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# **Chapter 1**

## **Introduction**

In today's increasingly ageing society more and more families choose to take on the role of the caretaker of a terminally ill family member. These caretakers are exposed to different stressors and might be at a risk to develop mental health issues. While most people cope well with losing a family member, there is a minority of bereaved who will exhibit signs of mental health problems even 12 months after the death occurs.

The central concept of this thesis is a pathological grieving process that was first introduced as "complicated grief" by two groups of researchers: Prigerson et al (Prigerson et al., 1996) and Horowitz et al. (Horowitz et al., 1997). After years of research work, today this condition is included in the DSM-5 under Persistent Complex Bereavement Related Disorder, although it is in the section of the manual that is for conditions in need of further study.

This study will examine the risk factors that family carers are exposed to in relation to developing complicated grief. Since a qualitative research in Ireland has not been conducted yet, this literature review will be based on data retrieved from studies carried out in the United States.

The hypothesis of this work is that there is a need for psychological support for people experiencing prolonged and elevated levels of distress in the grieving process. Therefore this work will attempt to describe some of the available psychotherapies and examine their efficacy.

During the writing of this thesis it was evident that some research has been carried out but there is a need for further studies in the area.

This study aims to explore complicated grief as a proposed disorder. As a trainee Psychotherapist, the author of this work believes that there is a need to understand that the grieving process does not necessarily start with the death of a person and it can turn pathological; and most importantly the field of psychotherapy can offer support for those who suffer from it. This research will have a special focus on late life bereavement and risk for complicated grief among family member who take on the carer role. This study may be useful for psychotherapists who wish to work with elderly and in grief counselling.

## **Chapter 2**

### **Grief and grieving**

#### **2.1 Grief, loss, bereavement**

The words ‘grief’, ‘loss’ and ‘bereavement’ are heard frequently when talking about somebody’s death. Even in the field of psychotherapy these words are often used interchangeably, but there is a minor difference in their meaning. (Butler, 2012)

Grief is a natural response to the loss of somebody significant, and it lasts till the person creates new meaning and routine to their life without the other.

Loss happens when something important to the person ceased to exist, such as a divorce, lost job or health, not necessarily another person. Bereavement is the grief exhibited when someone is lost due to death. (Butler, 2012)

The process of grief, mourning is profoundly individual, however it has been seen as going through different stages (Bowlby, 1980). Although contemporary views agree with stages of mourning, there are diverse views on the goal of grieving. Neimeyer (2000) argues that no scientific evidence has been found to support the idea of a ‘clear finish line’ as a recovery from grieving. According to Worden (2009) there is adaptation instead of recovery, where Klass et al believe that the bond that was present between the deceased and the survival will never break. The notion of ‘letting go’ or breaking the bond with the departed can be a result of society and culture where individualism and separation is encouraged. (Butler, 2012)

Majority of people are able to cope with a life changing event, such as death, but research has shown that 10-15% of people who are not able to cope and are in need an intervention of a care provider.

## **2.2 Psychodynamic views on grieving and pathological grieving**

Psychodynamic theories suggest the grief and mourning is multifaceted and influenced by the nature of the loss, the person's coping strategies, the meaning of loss and the social constructions of death and loss.

Freud (1917) believed that mourning is very much like exhaustion, where the mourner disengages from the external world with withdrawing psychic energy. The person who experiences grieving tries to keep the person alive with holding onto memories about the deceased. This behaviour takes energy and that is the reason why the person seems withdrawn. In Freud's view the withdrawn libidinal energy would return with time and then it offers energy for creating new attachments. Freud agreed with the view that the love for someone may never be diminished, but he explains that the lost object becomes internalized as the part of the person's ego.

Freud suggests that mourning and melancholia feel similar, but the melancholic feels something distinctive. He experiences confusion about his own self-regard. The melancholic feels something that we refer to pathological grief. This exhibits symptoms like problem with appetite and sleep, feeling worthless and self-critical.

Freud believed that there is an unconscious conflict between the mourner and the deceased and that is the cause of prolonged grief process. Curing melancholia can prove to be problematic due to possible unconscious unresolved conflicts.

Melanie Klein (1940) was investigating mourning and grieving influenced by the mourner's developmental process. Klein discusses two different anxieties that infants would experience: annihilation anxiety and abandonment anxiety. In her view introjection is a defence mechanism that helps the baby to cope with the anxieties. In the case of a death, introjection

helps the mourner to cope with their anxieties. Klein also posits that in a grieving situation sometimes anxieties are unbearable for the person and he/she may deny the need or the dependency of the deceased; and this can result in manic activity. Klein illustrates that the baby or the mourner can not see the world or the other as a whole and they can take up two different positions: paranoid-schizoid and the depressive position. The depressive position refers to the developmental stage where the infant recognizes that oneself and the other are neither all good nor all bad. If a mourner in their early life experienced excessive loss and deprivation, when a new loss occurs they will experience it as all bad. Klein suggests that in a case of death of a beloved the mourner regresses to the stage where the other can be all bad and he loses all the good objects. Sometime the mourner is unable to rebuild a sense of internal goodness, this is when he remains in the paranoid-schizoid position. The mourner needs to achieve the depressive position in order to be able to experience the mourning in a non-pathological form.

Winnicott refers to a holding environment in the infant's life created by the mother where the infant feels safe. The infant later will be able to create this space for himself (transitional space) where he feels safe and where he can soothe himself with a transitional object. This object will help them to deal with separation and loss. Winnicott describes that an inner representation of the deceased have to be maintained otherwise the person will not be able to sooth themselves. The transitional objects in this case are the photographs, diaries and other object that can maintain the tie between the mourner and the deceased. With time this objects can be internalised and the mourner can return to the normal everyday life.

Bowlby believed that mourning is influenced by the child's relationship to the mother. When this tie with the primary caretaker is lost, ego disintegration takes place and the child experiences separation anxiety. Bowlby found that there are 4 responses to loss and grief:

1. Numbing
2. Yearning and searching
3. Disorganisation and despair
4. Reorganisation

He found that depending on the relationship to the mother the person is not always able to move forward from one response to another. Critics believe that grieving is not a linear process as Bowlby thought.

Most of the psychodynamic theorist would reach back to early childhood experiences when seeking for answers in the grieving process and the reason for pathological mourning.

## 2.2 Complicated Grief

It is part of everyone's life to experience losing somebody. The severity of grieving can vary greatly depending on the individual. It is difficult to define 'normal grief' but it is certain that in some cases grieving can turn pathological.

The term complicated grief refers to a form of grief that is long lasting and has a substantial effect on someone's everyday life. Generally the acute grief slowly loses its strength and the bereaved person is able to return to their normal daily routine, as it was before the death happened, although with the knowledge that the deceased is not with them anymore.

Piper et al (2011) posit that the general healing process can be blocked by several different factors and this might result in complicated grief. These factors are:

- Bereaved person's coping style and flexibility
- The way the death occurred (accident, homicide, suicide, illness)
- Personal demographics of the person (age, gender, religion)
- Attachment style and relationship with the deceased
- Available social support

Prevalence of complicated grief is between 6-18% among those who experience bereavement, although the term itself variably defined. (Prigerson et al, 2009)

Symptoms need to be examined within the context of the individual social and cultural environment, in order to establish a possible diagnosis of complicated or prolonged grief. These symptoms include persistent elevated distress, separation distress, functional impairment and increase for suicide. (Simon et al, 2012)

Distinguishing complicated grief from uncomplicated grief is a central question among clinicians and mental health practitioners. Many people exhibiting the symptoms of

pathological grieving remain undiagnosed and untreated in spite of the debilitating nature of their condition. The need of clear diagnostic criteria and complicated grief screening and treatment is more and more important to avoid negative consequences such as suicide. (Simon et al, 2012)

### **2.3 Diagnostic Criteria in the DSM- 5**

As this work discussed before grief is a natural part of life but it is a severe stressor. The majority of people who experience bereavement go through pain and other disabling symptoms for a while; however they usually are not in the need of clinical intervention. Complicated or prolonged grief is different and may cause the onset of other physical and mental illnesses and conditions. These conditions might be mood disorders, post-traumatic stress disorder or sleeping disorder, just to mention a few. Therefore clinicians believe that there is a need for diagnosis and treatment of complicated grief.

It was proposed that complicated grief to be classified as a disorder and be included in the DSM-5, as it was not included on its own in the DSM-IV.

Horovitz et al led an initiative supported by evidence that complicated grief be included in the DSM – IV. That time the evidence that was produced seemed insufficient. Since then more research has been conducted and more supporting evidence was available through results of rating scales. These scales include the Inventory of Complicated Grief and the Core Bereavement Items. See Inventory of Complicated Grief Assessment tool on Appendix 2. (Shear, 2011)

The recently released DSM-5 includes a diagnostic code that refers to prolonged grief problems; it was placed in the chapter that is devoted to conditions needing further research.

The list of proposed diagnostic criteria for Persistent Complex Bereavement Related Disorder can be viewed in Appendix 1.

## **Chapter 3**

### **Complicated grief and risk factors in family carers**

Family caregivers of the terminally ill face higher risks for developing complicated grief as there are unique pre-death stressors during the caring process. It is a completely different stress environment that cannot be compared to situations where the death occurs suddenly.

This section of the thesis will review the risk factors that occur when a family member becomes a caretaker.

According to the available data from the U.S. Centres for Disease Control approximately 70% of death resulted from chronic illnesses such as cancer, cardio-vascular diseases, Alzheimer's disease, Parkinson's and other respiratory illnesses. Because of the nature of these chronic illnesses the patient will need substantial care at some stage during the course of the condition. According to the article (Ghesquiere, 2011) in the U.S. family members who take up the caretaker role is a sizeable percentage of the caregivers, as the healthcare system is limited in capacity.

A survey of end of life care in the US found that caregivers were on average 62 years of age and almost 80% of them were female. In half of the studied cases the caretakers were caring for a spouse. (Ghesquiere, 2011)

According to Ghesquiere's review (2011) there have been several studies that report a negative impact on the caregivers during the caring process, especially before the ill person dies. Research has shown that taking care of an ill person has impact on both mental and physical health.

After the ill person's death the caregiver can experience negative psychological consequences and may develop mental health issues. These could be depression, decreased quality of life, and anxiety. Complicated grief can be one of the negative psychological outcomes.

Ghesquiere suggests that there is no evidence that would support that family caretakers exhibit different complicated grief symptoms than any other grieving person; but she believes that the unique experience of caretaking present specific risk factors for developing complicated grief.

Reviewing the research in relation to family caregivers and complicated grief, it is found that there are numerous variables that can be accounted for developing complicated grief after someone dies.

The location of the care and the death is considered to impact of the grieving experience. Studies have found that caregivers had a higher grief score on Grief Experience Inventory when the terminally ill person died in a hospice setting rather than at home. (Bernard and Guarnaccia, 2002)

Shuter, Edwards and Sacre (2008) proposed that the type of illness can influence the development of complicated grief. They suggest that caregivers of dementia patients would be more at risk of prolonged grief as opposed to other chronic illnesses. They believe that the uncertain path and timeline of dementia can be accounted for this. Other difficulties with caring for someone with dementia lie in the erosive nature of the disease, ie. the caretaker has to witness the cognitive deterioration of the person. (Ghesquiere, 2011)

Another risk factor that was found by Shuter et al (2008) is the intensity of the care provided. They found that caregivers who were greatly committed were more likely to develop symptoms of complicated grief. Schultz et al (2006) found in their research conducted with

dementia caregiver that they felt caretaking as an exhausting burden. They also reported that these caretakers would have feelings of guilt of not having done enough which is a symptom of complicated grief. (Ghesquiere, 2011)

Shuter et al (2008) suggest that not satisfactory interaction with healthcare professionals can play a role in complicated grief post-loss. Feelings of being ignored or left alone were reported by dementia caregiver, which is thought to be a risk factor for complicated grief.

Demographics appear to correlate with development of complicated grief after death. Schutz et al documented that younger the caregiver was higher the complicated grief symptoms were presented among dementia caretakers. They also found that the likelihood of complicated grief was higher among people with lower incomes and educational levels. (Ghesquiere, 2011)

Siegel et al (2008) identified that complicated grief was more prevalent in spouses of the departed than any other family member. The gender of the caregiver appears to be a risk factor. Rudd, Viney, and Preston (1999) reported that female caregivers are more likely to experience symptoms of complicated grief.

The caregiver social network is another predictor of complicated grief. Shuter et al (2008) found that people caring for a dementia patient with no or minimal support and substantial family conflicts are more likely to present with prolonged grief symptoms.

Boerner, Schultz and Horowitz (2004) posit that existing mental distress among caregivers before the bereavement increase the chances of developing complicated grief symptoms. These mental distresses can be depression or anxiety, or other underlying conditions.

Boerner et al (2004) also found that the caregiving relationship can affect the caregiver prospect for complicated grief. Those who perceived the caregiving as a positive experience

were more likely in presenting symptoms post-loss. Schultz et al (2006) explains this with the caregiver perceives the role as very important or there is a very strong attachment between the caregiver and the care recipient or there is a dependency between them. (Ghesquiere, 2011)

Prigerson (2007) reported that those who claimed very close marital life or dependency were exceptionally at high risk of complicated grief.

This summary of risk factors suggests that there is a need for support services from healthcare provider pre-bereavement, during the caring process. Although not all the risk factors can be modified, such as age and gender, the intensity of some factors could be decreased with professional intervention. (Ghesquiere, 2011)

## Chapter 4 Treatment

### 4.1 Treatment - Different approaches

Since the recent inclusion of Prolonged Grief Disorder in the DSM – 5, it is likely that practitioners are seeking to give diagnosis to clients and offer a treatment.

The two main categories of treatment are Pharmacotherapy and Psychotherapy.

#### *Pharmacotherapy*

According to studies carried out by Simon et al (2012, 2013) selective serotonin reuptake inhibitor antidepressants may reduce symptoms of prolonged grief disorder. Other trial stage studies found tricyclic antidepressants are not very effective in treating grief, even while they were found to be very effective in the treatment of major depressive disorder. (Reynolds et al, 1999) Simon (2013) suggests that until further research is undertaken, there is no evidence to support that pharmacotherapy on its own is effective. Some experts in the field propose that pharmacotherapy may produce results in conjunction with Psychotherapy. Studies to prove this theory are ongoing. (Jordan, 2014)

#### *Psychotherapy*

*Individual psychotherapy* is found to be successful in alleviating symptoms of complicated grief. Different approaches offer different therapy, but evidence shows that Cognitive Behavioural Therapy is effective. Whereas CBT is focused on reducing symptoms, the Psychodynamic approach builds on the therapeutic relationship, transference and countertransference in understanding past, present and future. (Butler 2012).

Research suggests that *group psychotherapy* can address symptoms of prolonged grief disorder. Rosner et al (2011) found in a clinical trial in Germany that clients who took part in a total of nine group psychotherapy sessions as an addition to their treatment experienced a great reduction of their symptoms compared to the treatment as usual. This type of group therapy focused on Psychoeducation of clients, understanding and reducing avoidance and challenging disturbing thoughts.

Two additional trials have produced evidence to support the efficacy of group therapy in treating complicated grief.

The first clinical trial was carried out by Supiano and Luptak (2014) and was based on Shear et al's (2005) individual therapy. The therapy included Psychoeducation, cognitive restructuring, emotional processing of loss.

The second therapy trials have departed from the cognitive behavioural approach and compared integrative psychodynamic group therapy to supportive group therapy (Piper et al, 2001). In their randomized controlled trial of 12-week group therapy, they focused on raising patient's awareness into their own patterns of conflict and loss. The supportive group therapy was based on a more person centred approach, where the current coping strategies of the clients were praised to help them adapt to the new life situation. Piper et al found that participants of both clinical trials showed equivalent improvement in reducing symptoms of prolonged grief disorder.

Innovations of recent years have made it possible for clients to seek psychological help on the internet. *Internet based intervention* in complicated grief can be another modality that breaks away from traditional individual or group therapy. To support this idea a study by Wagner et al (2006) carried out with parents grieving the loss of a child. The 5-week email based therapy showed success in reducing symptoms of prolonged grief disorder compared to the

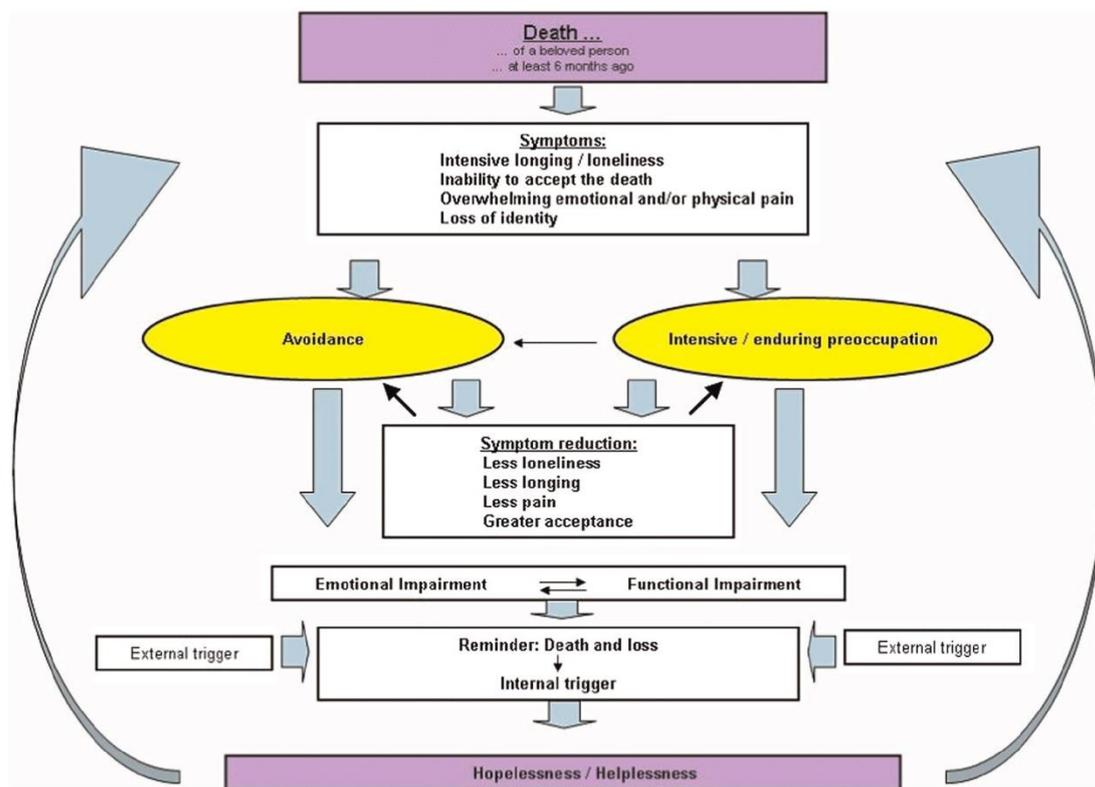
control group. Similar results were found by Kersting et al (2013) whose sample consisted from parents grieving a miscarriage. In this treatment client were taking part in a three phase exercise and they kept in contact with the therapist by email. The three phases included exposure of the death, self-compassion and new view of the future, their new life.

In the following part of this chapter this study will explore, in greater detail, two types of therapies that are commonly offered to clients experiencing complicated grief: Integrative Cognitive Behavioural Treatment and the enhancement of Psychodynamic Therapy with elements of Cognitive Behavioural Therapy.

## 4.2 Integrative Cognitive Behavioural Treatment approach

As prolonged grief disorder is different from depression and post-traumatic stress disorder. it is sometimes comorbid with them. It cannot be naturally assumed that therapies that offered solution for depression or PTSD will do the same with prolonged grief disorder. In this part of the study an integrative approach, integrative cognitive behavioural treatment for complicated grief (CG-CBT), is going to be explored and described in details.

This approach offers a model of Complicated Grief Disorder.



Source: Rosner et al (2011)

The treatment is designed to include 20-25 sessions of individual therapy. The rationale for the set number of therapy session is that this would be the usual number of a CBT therapy and this is the typical health insurance standard in Germany, where the study was carried out.

Before the treatments client were invited to 3-5 sessions, where an assessment would take place, using the aforementioned assessment tools, to offer a diagnosis.

Out of the 25 sessions five are optional and usually used to explore special circumstances or occasions, such as family holidays or anniversaries. The other 20 sessions of the therapy are divided into three phases, each with their own therapeutic strategies.

Every session of the treatment, except the first one, starts with a question: What has changed? This sets a tone of expected change, and the repetition creates a structure for the treatment. A list of typical content and strategies within the therapy can be viewed in Appendix 3.

The first phase of the therapy focuses on establishing the therapeutic alliance, stabilization, exploration and motivation. The key activities are designed to provide safety for the client, not only in the therapeutic environment but outside of it too. This can happen in forms of writing a list of important phone numbers etc... As stabilization is very important for the client to go on to the next phase of therapy, the therapist encourages the client to redefine roles in their new environment. This activity should not be used to encourage avoidance. This stage of the therapy can be very practical, provides a hands on experience for the client. Clients are also taught to refocus to the here and now and orient themselves.

The second stage is referred to as 'exposure and cognitive restructuring'. In this part of the treatment the client is offered Psychoeducation of cognitions, emotions and behaviour. The key step is to raise awareness of dysfunctional thoughts and then to eliminate them.

In the last stage is proposed to be the phase for integration and transformation. It explores the clients' hopes and intentions for the future. In some cases clients can decide on establishing a ritual routine that is dedicated to the deceased.

This therapy manual mainly based on cognitive behavioural techniques and theories, it utilizes other therapy approaches, like relaxation techniques, Gestalt therapy, and Multigenerational Family Therapy. It utilizes genograms from Family therapy to demonstrate patterns of loss and traditions in grieving in the family. Another integrative element is the ‘walking to the grave’ which has its origins in Gestalt Therapy. It is a set a leading questions about the loss to create new responses and thought about it.

As this research is undertaken in a training that is mainly psychodynamic, the next part of this project will focus on how the psychodynamic model can be enhanced with CBT elements.

### **4.3 Psychodynamic approach blended with Cognitive Behavioural Therapy**

Psychodynamic theory has been used broadly in exploring and understanding our experience of relationships and the change or loss of these relationships. In the same way cognitive behavioural therapy has been used extensively to treat grief, especially prolonged and avoided grief.

Both of these therapies have been long established and evolved over time to offer several different strengths. Butler and Northcut propose an integrative approach to a therapeutic model, where the strengths of both psychodynamic therapy and CBT would be incorporated. The psychodynamic view would enhance the therapeutic outcome with exploration of the past and present and the therapist would utilize symptom reducing techniques from the cognitive behavioural view.

CBT can be used to complement psychodynamic therapy in different ways:

- Assess the client's cognitive thinking
- Provide symptom relief
- Promote learning of problem solving in relationships
- Creating therapeutic alliance when the client is not ready for explorative therapy

CBT helps the client to address dysfunctional and distorted cognitions, such as catastrophizing, egocentric thinking all within the framework of psychodynamic views where the developmental influence is recognised. (Butler 2012)

Heller and Northcut (2011) propose ways as to how CBT could be used to enhance psychodynamic therapies. This combination of approaches was trialled in several cases with individuals grieving over a death of a significant other.

Counterfactuals are very common in the grieving process. The notion of counterfactuals is a series of causations that would offer an explanation to an event. For example: if A had not

happened, B would have occurred. According to Psychodynamic views underlying these counterfactuals is a reluctance of acknowledging that we are not always in control of certain event in our lives. These counterfactuals present a defence that helps to cope with anxiety. However counterfactuals can become maladaptive which will eventually lead to severe feelings of guilt, and the grieving person finds it difficult to let go. CBT proposes that since counterfactuals are distorted cognitions they can be eliminated and exchanged to new, rational thoughts.(Butler, 2012)

Unexpressed grief can inhibit the resolution of the grieving process. In Psychodynamic therapy the therapist would encourage the client to explore the reasons of not expressing grief. This could be due to attachment styles, habituated patterns, family beliefs etc... The holding environment (Winnicott, 1969) is a key element of psychodynamic therapy and it is proven to work with clients who needed a safe place and someone who is concerned about their feelings. Irrational thought drawing from family beliefs can be uncovered with psychodynamic investigation and can be resolved with the used of some cognition restructuring techniques provided by CBT.

In her work Butler provides theoretical and clinical evidence to support the success of the integration of these two well establish and very different psychotherapy approaches.

## **Chapter 5**

### **Discussion and recommendations**

This research has focused on one group of the population that is exposed to higher risk in developing Prolonged Grief Disorder. This group consists of family carers who look after a terminally ill member of their family. The current healthcare system primarily revolves around the patient, which is called Patient Centred Care. Ghesquiere et al found that there is very limited provision aimed at prevention in a high risk group such as family carers. Health care providers, including the field of Psychotherapy, will have to recognise the need of this high risk group, as the average life expectancy increases there are going to be more people involved in long term care and end of life care.

Several research have been undertaken to identify effective therapies to treat complicated grief. Internet based therapy was one of the modalities that is often offered to people suffering from Prolonged Grief Disorder. There are numerous advantages of internet based therapy, however some qualities of this modality has its drawbacks too. As internet based therapy seems very accessible, it is with the condition of the person is a computer and internet user. This automatically excludes most of the elderly population even though they would be at a higher risk of developing complicated grief. Internet based therapy lacks that special therapeutic relationship that can evolve between client and therapist and is very highly regarded. Another disadvantage of internet based therapy could be that it adds to the loneliness that is already present, however it can help client to open up freely and not face the stigma around mental health.

Many people with Prolonged Grief Disorder do not seek professional help due to different reasons. One of the reasons is the poor public knowledge of the existence of the disorder. The recent inclusion of the complicated grief in the DSM-5 has not allowed the disorder to gain so

much public attention. Raising awareness and providing education in the high risk sectors, such as health care sector, could help bringing complicated grief into the foreground and hopefully more and more people would seek help and treatment.

This study was based on research carried out in the United States and at the present moment there are no relevant studies undertaken in Ireland. This could be a possible direction for further studies for students of the Psychotherapy field who are interested in grief therapy and especially working with elderly.

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# Appendices

## Appendix 1

Table 1.

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DSM-5 Persistent Complex Bereavement-Related Disorder

**A.** Death of a close other

**B.** Since the death, at least one of the following on most days to a clinically significant degree, for at least 12 months after the death:

1. Persistent yearning for the deceased
2. Intense sorrow and emotional pain in response to the death
3. Preoccupation with the deceased
4. Preoccupation with the circumstances of the death

**C.** Since the death, at least six of the following on most days to a clinically significant degree, for at least 12 months after the death:

1. Marked difficulty accepting the death
2. Disbelief or emotional numbness over the loss
3. Difficulty with positive reminiscing about the deceased
4. Bitterness or anger related to the loss
5. Maladaptive appraisals about oneself in relation to the deceased or the death (e.g., self-blame)
6. Excessive avoidance of reminders of the loss
7. A desire to die in order to be with the deceased
8. Difficulty trusting other people since the death
9. Feeling alone or detached from other people since the death
10. Feeling that life is meaningless or empty without the deceased, or the belief that one cannot function without the deceased
11. Confusion about one's role in life or a diminished sense of one's identity
12. Difficulty or reluctance to pursue interests or to plan for the future (e.g., friendships, activities) since the loss

**D.** The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

**E.** The bereavement reaction must be out of proportion or inconsistent with cultural or religious norms.

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American Psychiatric Association (2013)

## Appendix 2

### Complicated Grief Assessment

*Please mark the box next to the answer that best describes how the respondent has been feeling over the past month. The blanks refer to the deceased person over whom the respondent is grieving.*

#### Criterion A:

- A.1a. In the past month, how often have you felt yourself longing and yearning for \_\_\_\_\_?
- Almost never (less than once a month) - 1
  - Rarely (2-6 times/month) - 2
  - Sometimes (more than 7 times/month, but not every day) - 3
  - Every day - 4
  - Several times every day - 5

- A.1b. In the past month has the yearning been distressing to you or disruptive to your daily routine?
- Yes  
No

*A frequency of "every day" or "several times a day" OR distress or disruption caused by the yearning is required for a Complicated Grief diagnosis.*

#### Criteria B:

*Below, 4 of 8 B Criteria must have an intensity of "4" or "5".*

- B1. In the past month, to what extent have you had difficulty accepting the death?
- No difficulty accepting the death - 1
  - A slight sense of difficulty accepting the death - 2
  - Some difficulty accepting the death - 3
  - A marked sense of difficulty accepting the death - 4
  - Extreme difficulty accepting the death - 5
- B2. In the past month, to what extent have you had difficulty trusting people?
- No difficulty trusting others - 1
  - A slight sense of difficulty trusting others - 2
  - Some sense of difficulty trusting others - 3
  - A marked sense of difficulty trusting others - 4
  - An extreme sense of difficulty trusting others - 5

- B.3. In the past month, to what extent have you felt bitter over \_\_\_\_\_'s death?
- No sense of bitterness - 1
  - A slight sense of bitterness - 2
  - Some sense of bitterness - 3
  - A marked sense of bitterness - 4
  - An extreme sense of bitterness - 5
- B4. Sometimes people who lose a loved one feel uneasy about moving on with their life. In the past month, to what extent do you feel that moving on (for example, making new friends, pursuing new interests) would be difficult for you?
- Moving on would not be difficult - 1
  - Moving on would be a little difficult - 2
  - Moving on would be somewhat difficult - 3
  - Moving on would be very difficult - 4
  - Moving on would be extremely difficult - 5
- B.5. In the past month, to what extent have you felt emotionally numb or had difficulty connecting with others?
- No sense of numbness - 1
  - A slight sense of numbness - 2
  - Some sense of numbness - 3
  - A marked sense of numbness - 4
  - An extreme sense of numbness - 5
- B.6. In the past month, to what extent do you feel that life is empty or meaningless without \_\_\_\_\_?
- No sense of emptiness or meaninglessness - 1
  - A slight sense of emptiness or meaninglessness - 2
  - Some sense of emptiness - 3
  - A marked sense of emptiness - 4
  - An extreme sense of emptiness - 5
- B.7. In the past month, to what extent do you feel that the future holds no meaning or purpose without \_\_\_\_\_?
- No sense that the future holds no purpose - 1
  - A slight sense that the future holds no purpose - 2
  - Some sense that the future holds no purpose - 3
  - A marked sense that the future holds no purpose - 4
  - An extreme sense that the future holds no purpose - 5

B.8. In the past month, to what extent have you felt on edge, jumpy, or easily startled?

- No feelings of being on edge - 1
- A slight sense of feeling on edge - 2
- Some sense of feeling on edge - 3
- A marked sense of feeling on edge - 4
- An extreme sense of feeling on edge - 5

**Criterion C.** Has your grief resulted in impairment in your in your social, occupational, or other areas of functioning? For instance, does your grief make it difficult for you to perform your normal daily activities?

- Yes - 1
- No - 2
- REF - 97
- DK - 98

*If Yes, then Criterion C is met.*

**Criterion D.** Have any of the above symptoms, including yearning and at least one Criterion B symptom, lasted for at least six months?

- Yes - 1
- No - 2

*The symptoms must have persisted for at least six months to be considered "Yes". If the respondent suggests that the symptoms have occurred intermittently, then mark "No".*

*If Yes, then Criterion D is met.*

**Complicated Grief Diagnosis = Criteria A, B, C, and D are met.**

- Yes - 1
- No - 2

## Appendix 3

### Session content and treatment strategies

Session number	Session content	Treatment strategies
A1	Admin. contracting, psychoeducation about treatment	Work sheet on social roles and tasks and symptoms, safety planning
A2	Nodal events: My loss in a bigger perspective, stabilization	Genogram, life line, grounding exercises if necessary
A3	Psychoeducation on normal and complicated grief and introduction of CG-model	Worksheets to prepare psychoeducation and CG model to enable the patient to recognize dysfunctional behavior and personal triggers
A4	—	—
A5	Primary and secondary losses in my life	Introduction of the deceased with pictures, music, etc; worksheet on life changes due to bereavement
A6	Review of information and treatment goals	Four blocker method similar to motivational interviewing; Advantages and disadvantages of change, worksheet on treatment motivation, and treatment goals
A7	—	—
B8 oder	Relaxation	Introduction to relaxation, progressive muscle relaxation
B8	Relaxation and demarcation	Imagery work addressing distressing cognitive stimuli followed by relaxation techniques
B9	Identification of dysfunctional thoughts	Cognitive restructuring, metaphors, psychoeducation regarding thought processes, helpful, and non-helpful thoughts
B10	Rumination and guilt	Socratic dialogue, reframing, metaphors, worksheet
B11	Emotions and perceptions	Worksheet, dialoguing (Gestalt)
B12 & 13	Worst moments: confrontation <i>in sensu</i>	Confrontation of thoughts, emotion, and/ or situations that are avoided
B14	Worst moments and identification of "hot spots"	Identification of "hot spots" and dysfunctional cognitions, cognitive restructuring, reinterpretation; Preparation of "Walk to the Grave"
B15 & 16	Confrontation, cognitive restructuring, and acceptance	Dialogical work "Walk to the Grave"
C17	Heritage and continuing bonds	Presentation/letter/essay, worksheet, home activities
C18	Memento and future	Dialoguing or letter, description of new life, dedication
C19	New life	Describing new status quo and life plan
C20	Termination	Review, relapse prevention, feedback, questions
Optional	Family session—preparation	Identification of topics and tasks (for example, different ways of grieving in the family)
Optional	Family session—implementation	Dealing with different grieving styles; collateral narratives, circular questioning
Optional	Special event planning: Birthday, anniversary, holidays Court appointments	Preparing plan, modify rituals, include social network Identify course of events, elicit information from lawyer, contact social support, carry out plan <i>in sensu</i>

Source: Rosner et al 2011