REBT and Complicated Grief

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Introduction: From Decathexis to Continuing Bonds with the Deceased

In our lifetime we may experience the loss through death of a significant other, with grief being a normal and universal human reaction to the loss.

How do we adapt to the loss? What is an adaptive response? When is grief considered complicated? When is it appropriate to intervene?

The answers to some of these questions have undergone remarkable changes in the last few decades, and one such change has taken place in the field of grief and bereavement in our understandings of grief process, its aims and outcomes (Malkinson, 2007, 2017; Rubin, Malkinson, & Witztum, 2012). A major shift has been that from Freud's (1917/1956) conceptualization of grief as a normal process leading to breaking the bond with the deceased (i.e., *decathexis*), to viewing bereavement as a process of reorganizing of one's life and world view without the deceased, where bonds will remain intact and unbroken. Klass, Silverman, and Nickman (1996) proposed the term "continuing bonds" which has since been accepted and is widely used. Similarly, new models of grief have been proposed, and notably the Two Track Model of Bereavement (TTMOB) (Rubin et al., 2012), and the Dual Process of Mourning (DPM) (Stroebe & Schut, 1999). Both emphasize the complexity and the multidimensional nature of the grief process as well as its being a life-long developmental process.

The Two-Track Model of Bereavement developed by Rubin et al. (2012) views response to loss with two lenses, as its name suggests—continuing with life and con-

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W. Dryden and M. E. Bernard (eds.), *REBT with Diverse Client Problems and Populations*, https://doi.org/10.1007/978-3-030-02723-0_9

Table 1 What affects the grief process and outcomes: circumstantial and personal variables

Mode of death: expected/sudden, traumatic (suicide, homicide, terror, war, natural disasters)
Who died? (parent, child, sibling, partner, close family member, close friend)
Age and gender of the bereaved
Personality variables (spiritual and religion) and attachment style (secure/insecure) resilience and view of self
Perceived relationship to the deceased
Previous experiences with loss
Availability of support system
Socio-cultural context within which grief is experienced

tinuing bonds with the person who died. The model examines both biopsychosocial functioning and the nature of the ongoing relationship with the deceased and the death story in working with the bereaved. It is particularly suited to identify adaptive and maladaptive responses to loss and to optimally focus on interventions where needed. Track I of the model addresses the biopsychosocial functioning; how do the bereaved find a way to continue with life, while Track II addresses the way the bereaved construct an ongoing, inner relationship with the deceased. An adaptive grief response is the balance between attending to life challenges with a flexible connection to the deceased, and when difficulties in this response, they typically reflect some interdependence of the two tracks.

More recently, studies have focused on the long-term outcome of the grief process, suggesting that throughout the years the process becomes less intense but never really ends. The implications of these conceptual changes on defining adaptive and maladaptive[1] course and outcomes of grief and on therapeutic intervention will be examined.

Different forms and circumstances surrounding the death event apparently affect the process, its duration, intensity and outcome as shown in Table 1.

Factors identified as affecting the normative course include the circumstances of the death, sudden and unexpected death events such as suicide, homicide, and terror attacks, man-made or natural disasters—also termed "violent death" (Malkinson, Rubin, & Witztum, 2000), or "powerful situations" (Janoff-Bulman, 1992), that are outside the range of usual human experience and hence more likely to have a markedly distressing, traumatic, or overwhelming effect (American Psychiatric Association, 1994); types of lost relationships, e.g., loss of a child, that are known to impose additional stress on survivors and are associated with higher risks, social-cultural context within which grief is experienced (Witztum, Malkinson, & Rubin, 2001); gender, age at time of the loss, previous experiences with loss, and personality variables such as spiritual and religious world view, past experiences with adverse events, resilience and availability of adequate support networks (Bonanno & Kaltman, 2001).

[1]Maladaptive and complicated grief signifies when grief goes awry; prolonged grief is a term suggested for diagnostic purposes.

How is normative (adaptive) grief defined? What constitutes normal grief varies greatly from culture to culture. Different cultures have different views and customs on the mourning process that follow a death event, but all view it as one necessitating some kind of adjustment which takes place over time. In many cases the society or culture provides a set of mourning guidelines specifying what is expected of the bereaved and the community (Malkinson, 2007).

In line with Rubin's (Rubin et al., 2012) Two Track Model of Bereavement (TTMoB) bereavement is a response to a stressful event (Track I), and reorganizing the now inner relationship with the deceased (Track II). Klass et al. (1996) coined the term "Continuing Bond" stressing negotiation and renegotiation of the meaning of the loss over time. While death is permanent and unchanging, the process of bereavement does change, affecting the mourner differently at different times over the rest of his or her life.

Adaptive or uncomplicated grief reactions, as it is referred to, are those that, though painful, move the survivor towards an acceptance of the loss and the ability to carry on with his or her life and investing in new relationships and maintaining a sense of self-efficacy. Uncomplicated grief is characterized by feeling very saddened by the death of an intimate, but nevertheless, the ability to feel that life still holds meaning and the potential for fulfillment exists. In uncomplicated grief one's ability to trust others, maintain one's positive attitudes alien to those with complicated grief.

An important aspect of uncomplicated grief is the will to reinvest in an interpersonal relationship and activities, and willingness to explore new relationships and roles despite the pain of the loss, a component missing from complicated forms of grief.

In contrast, in complicated grief bereaved persons view their lives as having stopped, with no future. They don't believe that life holds anything worth investing in. Prigerson and colleagues (1995) conceptualized complicated grief distinct from normal, uncomplicated one. In complicated grief bereaved persons feel acute separation distress and traumatic distress—a sense of emptiness that do not decrease over time (Shear, & Frank, 2017).

Most bereaved individuals find ways to continue life without the deceased, but for others, bereavement increases the risk of developing complications (Table 2).

Concurrently, the bereavement process is viewed as a process which includes coping with the distress evoked by the death event on the one hand, and ongoing relationships with the deceased on the other (Rubin et al., 2012; Stroebe & Schut, 1999). Traumatic bereavement is yet another concept that has been discussed in the literature to convey the linkage between trauma and bereavement as components each requiring an assessment prior to planning intervention (Rubin et al., 2017). With the publication of the 5th edition of the DSM, a debate aroused as to whether complications in the process and outcome of grief justify diagnostic criteria in the Diagnostic Criteria Manual (DSM) (American Psychiatric Association, 2013). Those opposing it expressed a concern of pathologizing a normal and human response to loss, whereas those supporting the inclusion emphasized the need to diagnose and treat the bereaved when their process goes awry. They stressed the unique symptomatology of complicated or prolonged grief rather than giving it a diagnosis of depression or

Table 2 Assessing grief

Uncomplicated grief	Complicated grief
Acceptance of the loss and an ability to carry on with life	A sense that life stopped and lost its meaning—inability to carry on with life
Maintaining a sense of self-efficacy	The sense of self-efficacy is lost while a sense of guilt is maintained
Re-investing in life tasks and new relationships	Difficulties in re-investing in life tasks and new relationships
Pain and yearning are assimilated with ongoing life	Difficulties in assimilating pain and yearning with ongoing life
Positive attitude to life	Negative attitude to life

PTSD (Shear, 2017). Research studies indicated that grief complications may affect 7% of the bereaved population thus supporting the inclusion of criteria that will allow a diagnosis and specific psychotherapeutic interventions (Shear, 2017). The form of prolonged grief or persistent complex bereavement disorder, as it is also referred to appears in DSM-V, (2013) as a set of symptoms identified which impose difficulties in assimilating the reality of the loss in the bereaved person's life (Rubin et al., 2012). This requires a thorough assessment to be followed by specifically tailored interventions (Malkinson, 2012; Shear & Frank, 2017).

Key REBT Theoretical Concepts in Working with Grief

The ABC model of REBT, wherein a distinction is made between healthy and unhealthy, functional and dysfunctional consequences fits perfectly with distinction between "normal" healthy, adaptive grief and maladaptive, complicated grief. Furthermore, the distinction in this model between healthy negative emotions such as sadness and unhealthy negative emotions (depressive response) supports the notion that grief involves negative but healthy emotions. These negative, unhealthy emotions impede the adaptive course and thus make ABC-based assessment and interventions towards a natural grief process, relevant and applicable (Malkinson, 2007, 2017).

Theory of Change: From Irrational to Rational Beliefs

REBT as "…a theory of personality and personality change accepts the importance of emotions and behaviors and particularly emphasizes the role of cognitions in human problems." (Ellis & Bernard, 1986, p. 11).

According to Ellis's ABC formulation, almost always when C consist of emotional disturbance it is the Belief that creates it. However, emotional disturbance

may at time stem from powerful A's. In other words, the powerfulness of the event may affect our tendency to think irrationally. Loss through death is an example of an A that has the potential to increase irrational thinking and consequently lead to emotional disturbance. In Reason and emotion (Ellis, 1994). Ellis's notion about human inborn tendency to think irrationally, along with his emphasis about the ability and motivation to change beliefs into rational ones, is fundamental in applying Rational Emotive Behaviour Grief Therapy.

While death is final and irreversible (A) the cognitive evaluation (B) of the loss is changeable from irrational to rational and thus the emotional consequences (C) as a result. Bereaved individuals are often sceptic of their ability to change their belief system with regard to the loss event and to the deceased for various reasons, some are related to the circumstances of the loss while others are related to the relationship with the deceased. The irrational beliefs that "I must not forget my loved one", or "It's too painful to think that my loved is dead", are beliefs that create fear of either forgetting the deceased or avoidance of being overwhelmed by memories of him or her. Thus, basic understanding of grief process and its outcomes integrated with REBT framework is necessary when working with bereaved clients.

Negative Healthy Emotions and Negative Unhealthy Emotions

A major element in REBT refers to the distinction between healthy (adaptive) and unhealthy (maladaptive) negative emotions and their relatedness to rational and irrational thinking. The difference between disturbed emotions and non-disturbed emotions is the quality, the intensity and frequency of unhealthy negative emotions (DiGiuseppe, Doyle, Dryden, & Backx, 2014). This distinction between Negative Healthy Emotions (NHE), and Negative Unhealthy Emotions (NUE) (Ellis & Dryden, 1997) is particularly relevant to grief. Grieving (healthy negative emotions) as distinct from depressive response is the "heart" of the process. Therapeutic interventions REBT-based include psychoeducation towards normalizing, legitimizing and providing thinking alternatives to facilitate an adaptive process.

Secondary Symptoms—Avoidance or Sustaining the Pain in Grief

Pain in grief is unavoidable. The thought of experiencing pain is often too stressful, and frequently bereaved persons will tend to find ways to avoid or bypass it only to realize that this is almost impossible ("It's too painful"). At other times bereaved will sustain the pain for fear of forgetting the deceased or as a way to punish themselves for not saving him or her ("I deserve the pain"). In REBT terms the loss (A) is followed by an emotional consequence of pain (C) related to the belief (B) that "I will

never see her again, and my life is not worth any longer". According to Ellis (1976, 1994) humans have a pronounced biosocial tendency, particularly following adverse events like death, to evaluate emotions in a dysfunctional way which often creates a disturbance about disturbance. In the case of pain following a loss through death, the appraisals of the primary emotion i.e., pain, as too painful or that "I must keep the pain" are dysfunctional because they create a secondary symptom of pain or anxiety about pain. Meta-cognition or cognitive attentional syndrome (CAS) are terms used to describe dysfunctional evaluation related to human nature of thinking about thinking (Kassinove & Taftre, 2002; Wells, 2005). It is a cyclical dysfunctional evaluation about the harmful consequences (cognitive, emotional, physical or behavioral) that frequently result in efforts to avoid the undesired or feared consequences. Therapeutic help of bereaved clients not to evaluate pain as dreadful but to accept it as a normal part of grieving, and to teach them functional ways to manage the pain in a balanced way in order to facilitate a more adaptive process.

Key Best-Practice REBT-Based Assessment and Treatment Strategies and Techniques in Working with Grief

REBT Studies Showing Positive Effects on Problem/Population

There is no REBT reported research targeted at working with bereaved population or detailing positive effects specifically tailored to working with bereaved. There are however, studies on the efficacy of REBT for various population and problems. When applying a psychoeducational program in a graduate-level practicum on stress management, the ABC model of REBT was used. The aim was to reduce irrational/dysfunctional thinking patterns. The practicum included introducing the ABC model of REBT, identifying rational and irrational beliefs and their emotional consequences, disputing irrational beliefs and changing them into rational ones, and homework assignments (reading, written and experiential exercises). Results indicated reduction in irrational beliefs in the treatment group, and a significant reduction in LFT scores (Kushnir, Malkinson & Ribak, 1998). Similarly, in a training workshop for blue-collar female workers, the Rational Emotive Behavior training was applied including psychoeducation and homework strategies focusing on health promotion and stress-reduction related to work-home conflict experienced by female workers. Results showed reduction on all measures, indicating that use of REBT principles is an effective model for blue-collar females (Malkinson et al., 1996). In a study by Daniel, Szentagoi and colleagues (2008) a comparison between REBT, CT and medication in Major Depressive Disorder was carried. Demandingness and self-downing and the relationship between dysfunctional negative emotions and irrational beliefs were hypothesized as mediators in depression, and strategies applied aimed at reducing secondary symptoms and increasing unconditional self-acceptance, the two central strategies in REBT (Daniel et al., 2008). Secondary symptoms, demand-

ingness and self-downing are frequently assessed among bereaved individuals and the application of these strategies in grief therapy is effective (Malkinson, 2007).

REBT Special Practices with Grief

Psychoeducation: The ABC of Rational Emotive Grief Therapy

The ABCDE framework applied to working with the bereaved offers a humanistic approach to facilitate the natural healing process of grief following loss. The ABC model of Grief: Adverse event (A) of death over which I had no control, and what do I tell myself (Belief)? What are the emotional behavioural and somatic Consequences?

In working with bereaved clients, the component of psychoeducation is very powerful as it provides information and emphasizes the relationship between adversity event of loss through death, beliefs and emotional consequences (Table 3). It details the ABC of grief-related rational and irrational evaluations and their functional and dysfunctional emotional consequences.

Psychoeducation about grief process and the ABC of REBT also includes normalizing grief process through stressing and teaching the difference between healthy and unhealthy belief-consequence connection. Provision of information about grief process, its components, intensity and duration are an important element of the psychoeducation.

Homework Assignments: Practicing Between Sessions to Facilitate Adaptive Grief

In a workshop in Israel in 1989, Ellis introduced the ABC model of REBT, and presented three related insights: (1) People have a choice whether to become disturbed. They become disturbed when they make their preference into a demand. (2) Emotional disturbance is not necessarily related to people's past but to their demandingness about themselves, others and the universe. (3) And the third and most important insight is: Practice, practice, practice… In other words, in order for clients to achieve cognitive, emotional and behavioural adjustment clients need to actively practice rational thinking (and emotional, behavioural and physical as well). Between-sessions practice is therefore a "must" in order to gain the desired change. DiGiuseppe and colleagues (2014) explain the rational for homework as an integral part of therapy detailing a variety of cognitive, emotional and behavioural homework assignments to assist clients learn and maintain cognitive changes. The relevancy of between-sessions practice in grief therapy is two-fold: Practicing the ABC of the model, and normalizing negative healthy emotions as part of natural grieving process.

Table 3 The ABC of grief: rational and irrational evaluations and healthy functional negative and unhealthy dysfunctional negative emotional consequences

A	Rational evaluation: flexible, non-rigid		Irrational evaluation: rigid, extreme	
Adverse event Loss through death	B	C Functional emotional	B	C Dysfunctional emotional
	Rational belief	Consequence	Irrational belief	Consequence
	I remember her everyday but life goes on	Yearning	Life without her is killing me, I will never get over the loss	Depressive response
	My life without her has changed forever	Sadness	Since the death my life is worthless	Depressive response
	I realize that since her death pain is part of my life	Frustration and experiencing pain	When I think about his death I can't stand the pain	Discomfort anxiety and avoidance
	I asked him to stay at home but he refused and got killed in a road accident. There was nothing else I could have done	Moderated anger	I should have insisted on him staying at home. I will never forgive myself. It's my fault	Intensified anger and guilt

D: Disputation in Grief Therapy

Within the REBT framework the D—disputation is the core of therapy towards the change of dysfunctional cognitions and related emotional consequences: B-C connection, using cognitive emotional and behavioural strategies some of which are most pertinent to be applied in grief therapy with a focus to facilitate a healthy grief process. In grief therapy, cognitive restructuring, emotional and behavioural strategies are more suitable types of disputations to be applied in working with the bereaved especially during the acute phase. An expanded version of Rational Emotive Imagery, letter-writing "as if" to the deceased, visiting the grave will be elaborated as examples of strategies adopted to grief therapy (Malkinson, 1996, 2007).

Rational Emotive Body Imagery (REBI)

Rational Emotive Body Imagery is an expanded version of the REI first developed by Maultsby (1971) as a technique to assist clients feel less disturbed by imagining the stressful event (A) and the emotional consequence (C). Ellis (1993) modified the REI to be applied "in a more emotive-evocative and less dysfunctional way" instructing the client to imagine the worst that can happen (A), and feel the inappropriate emotional consequence as vividly as possible, and "then work on your dysfunctional feeling until you truly change it to appropriate or self-helping negative feeling" (pp. II.8–II.9). Ellis postulated that the change in intensity of emotions enables a self-prescribing of a rational belief or a coping statement emphasizing nonjudgmental self-acceptance (Ellis, 2006). In other words, concentrating on the dysfunctional emotion and changing it to a functional one evidently signifies a change into a rational belief. It is a self-change strategy carried by the client through imagery.

The emotional consequences in grief such as pain, anger shame and depressive response, are frequently very intense and overwhelming. The flooding effect of emotions and body sensation can lead to an evaluation (a secondary symptom) by the bereaved person as too painful and therefore be avoided. A more adaptive way however, would include awareness and acknowledgment of the emotions and body sensation and accepting them in a non-judgmental way as part of healthy grief can help in experiencing an adaptive process.

Characteristic to grief is rumination over the loss event with "why" questions repeatedly being asked thus maintaining unhealthy negative emotions of anger, guilt and shame—a loop that blocks the natural healthy process. Imagery is an effective strategy to assist the bereaved change the intensity of emotions, a central element in an adaptive grief. Indeed, it marks the difference between a healthy functional feeling and unhealthy dysfunctional one, enabling the bereaved to cognitively increase self-control over what seems to be overwhelming emotionally and physically, it feels uncontrollable. In line with the third wave CBT, mindfulness-based cognitive therapy in particular (Segal, Williams, & Teasdale, 2002) the body component is incorporated in the imagery: Rational Emotive Body Imagery (REBI) (Malkinson, 2012).

A basic assumption underlying Rational Emotive Body Imagery within the ABC of REBT framework is that the client links his/her emotional distress as well as the accompanying body sensation (Consequence-C) to the loss event (Activating event), and not to his or her appraisal (B) of it. The aim of REBI is through constructing a safe setting for the client, to reduce the emotional distress by introducing the understanding that beliefs about the event act as mediators between the event and the consequences—a Belief-Consequence connection. In other words, the client is helped to understand that despite not having a control over highly negative events, the right to choose one's belief and interpretive framework remains (Malkinson, 2007, 2012).

Three stages to applying the strategy:

The first step is preparation: explaining to the client what rational–emotive-body imagery is and its usefulness in treatment along with an introduction to the SUDS

scale (subjective units of distress scale). The second: The therapist guides the client to re-live the event and directs her efforts to do so especially with regards to non-verbal expressions. The third step is the follow up after completing the imagery exercise and preparing its practicing between sessions.

In cases where verbal communication by client is not present, the therapist may encourage nonverbal communication such as suggesting they nod their head to signal progress.

The REBI intervention
1. Constructing the image (A)
2. Identifying the emotion and/or body sensation (C)
3. Measuring the intensity of the response (SUDS)
4. Reducing the intensity of the response (that the client is experiencing in the moment at his or her own pace)
5. Measuring the change of intensity of the emotion and/or body (physical) response (SUDS)
6. Evaluating the cognitive change (B)
7. Discussing the cognitive change and its new emotional and body consequences
(B-Connection)

Letter Writing, "as if", to the Deceased

The healing potential of writing is well established (Pennebaker, 1997; Rubin et al., 2012). The act of writing puts into words thoughts and feelings about the writer's past present and future life. Because writing involves cognitions and emotions and has psychological as well as physical benefits it is frequently applied in cases of complicated grief in a number of ways. In some cases, it is one-time letter writing; at times it is done over a limited number of consecutive days, while in other cases this technique can be carried out daily as a continuous letter writing for a period of time. Whatever the chosen structure or setting, writing is believed to help he bereaved individual express the often time avoided pain in "private" way with the writer choosing the words the pace, and emotions. Put it differently, it allows the bereaved writer to experiment with alternative reconstructions of the loss narrative in a more organized way. Letter-writing "as if" (Ellis & Dryden, 1997) allows the bereaved "to talk", write; think as if the deceased were present. In line with REBT tenet of normalizing grief responses, the application of "as if" letter writing provides means to legitimately let the bereaved to express otherwise unexpressed "crazy" (irrational) thoughts (Malkinson, 2007). Structured treatment of letter writing is based on the four steps of "leave-taking" rituals of preparation, reorganization, finalization and follow-up.

Treatment Guidelines from the Empirically-Supported Therapy Literature that Inform Best Practice in REBT with Grief

While the debate continues with regard to inclusion of a diagnostic criteria for prolonged grief disease (PGD) in the DSM, empirically-based cognitive grief therapy protocols have been developed to assist bereaved who experience difficulties in reorganizing life following a loss. Reported studies applying CBT in complicated grief and PTSD were found to be efficacious: a comparison between exposure therapy cognitive restructuring support therapy (Boelen et al., 2007), PE (Foa & Rothbaum, 1998), Imagery re-scripting (Holmes, Arntz, & Smucker, 2007) and letter-writing (Pennebaker, 1993) are but some examples. In a meta-analysis of studies for the treatment of Prolonged Grief Disorder, cognitive grief therapy, specifically exposure therapy (ET) and cognitive restructuring (CR) were found to be more effective than supportive, nonspecific therapy and waiting list (Boelen, de Keijser, van den Hout, & van den Bout, 2007). In particular, evidenced-based studies indicated CBT as an effective treatment for complicated grief (Malkinson, 1996; Shear, Frank, & Hauck Reynolds, 2005; Boelen et al., 2007). In their study Shear and associates (2005) have modified the standard IPT (Interpersonal Psychotherapy) for complicated grief and included elements of cognitive behavior (Shear et al., 2005) which later was developed as complicated grief therapy (CGT) addressing both separate anxiety and traumatic anxiety elements (Shear & Gribbin, 2017).

Shear and associate's is a 16-sessions evidence-based protocol based on CBT and strategies and procedures from other evidenced-base psychotherapies (Shear & Gribbin, 2017). Sessions are structured and combine cognitive behavioral and imaginal strategies to facilitate the natural course of grief. The sessions are organized in four phases: Getting started, core revisiting sequence, midcourse review and closing sequence. Therapy is designed based on the Dual Process Model (Stroebe & Schut, 1999) viewing grief process as oscillation between loss orientation and restoration orientation. Strategies include among others grief monitoring dairy, imaginal and situational revisiting exercises (Shear & Gribbin, 2017).

Imaginary exposure and imagery re-scripting are forceful strategies used in the service of recollection of painful memories or processing of feared emotional outcomes and introducing a new meaning to them. These procedures are reported as effective in reducing distress following trauma and loss (Holmes et al., 2007; Shear & Gribbin, 2017). From REBT perspective, each of these strategies can be modified to include the central elements of rational and irrational beliefs and the distinction between NUE and NHE. For example, focusing on irrational beliefs preventing the bereaved to approach reminders of the deceased because of the pain it entails ("its' too painful") strategies such as letter-writing, visiting the grave, imagery exposure can be easily incorporated to assist the bereaved overcoming avoidance.

Brief Case Example

The framework of treatment utilized in the case example with Nora included establishing a therapeutic alliance; joint evaluation of the problem, provision of social support, cognitive assessment of the B-C belief-emotional framework, and assessment of the potential for change and potential obstacles to change.

Nora married in her late 30s requested therapy following still birth she experienced 12 months earlier and was 12 weeks pregnant. Therapy was once a week and continued throughout her pregnancy.

She was suffering from anxiety symptoms (heart palpitation, sleep difficulties, loss of appetite) as pregnancy was progressing she was agitated and restful of the upcoming delivery (fearing she will have to experience once more the nightmare she went through in the first delivery), and depressive response with images of the unborn baby, symptoms of traumatic grief. The ABC of Rational Emotive Behavior Grief Therapy was applied to help Nora experience an adaptive healing process but firstly attending to the traumatic circumstances of the loss that hindered the natural course of grief (Track I of the TTMoB). Subsequently, focusing on grief elements of remembering the unborn baby and the pain and yearning these involve (Track II of the TTMoB). The first few sessions included providing Nora with information about grief over the loss of the baby and its traumatic circumstances, normalizing and legitimizing the flooding effect of her experience. The ABC of adaptive grief was explained, teaching Nora the Beliefs-Consequences connection and the distinction between HNE and UNE. Between session assignments included reading material about REBT and grief, breathing exercises and to record in writing her irrational thoughts when she felt distressed. When Nora reported a relief in the symptoms (slept better, regained her appetite), therapy focused on the relationship with the unborn baby (Track II in the TTMoB).

Can I Tolerate and Control My Pain?

Nora's description of the recurrent and persistent image of the time of delivery when there was no pulse on the monitor followed by a still delivery and the intolerable pain that accompanied the recollection led to apply REBI strategy and one-time letter writing to facilitate a healthy grief process. I described REBI to Nora and explained its usefulness in her treatment along with introducing the Subjective Units of Distress (SUDS) scale and how to apply it during the REBI. Nora was prepared to reconstruct the image and apply SUDS. When feeling distress at any stage, she was to signal the therapist and would be assisted. Nora was instructed to recreate the image or a picture of the event of the delivery and was given a choice to keep her eyes open or shut. With her eyes closed she was asked to recall as closely as possible the feeling she experienced when it happened and signal when she had done so (*Constructing the Imagery*). Tension in her body and tears were the consequences of the reliving

the experience. She was guided to attend to the emotion and the body sensation and be aware of them (*Identifying the emotion and the body sensation*) and measure its intensity on the SUDS scale. With her hand on her chest, and concentrating, Nora answered 10 (*Measuring the intensity of the response*). Having measured the degree of the emotion, she was asked to concentrate on the intensity of the response and try to do something in any way she thought would help her reduce its intensity, taking her time to do so. With her eyes closed she was asked to make a sign when she accomplished this. As Nora continued to hold her hand on her chest, I encouraged her "to listen" to her body while doing something to reduce the intensity of her distress as a way to empower her and giving her a degree of control over her distress. Nora concentrated and at a certain moment there was a look of relief in her face and her body seemed relaxed somewhat (*Reducing the intensity of the response*). Nora was told she could open her eyes and was asked whether there was a change in the intensity of her pain and to report on its level. Nora answered 9 and opened her eyes (*Measuring the change of intensity and/or physical response*). Nora was praised for her efforts to do the imagery and change the intensity and was asked what she did and what she said to herself to lower the intensity from 10 to 9, and also assess the difference (*Evaluating the cognitive change*). Nora answered that she said to herself: "I can stand the pain, I have the strength to tolerate the pain and remember my angel, and then I felt a relief". To the question what was the difference between 10 and 9 she said: "I could breathe". The change of cognitive evaluation in her statement and the emotional and physical consequences were noticeable. Nora was supported and encouraged to re-experience the difference in the change of the emotional and body sensation, to give it validity in a way of practicing between sessions. Being aware and mindful of her emotions and body sensation and changing her belief and telling herself, "I can stand the pain, I have the strength to tolerate the pain and remember my angel" decreased the tension. Being aware of the tension and "listening to it" made Nora feel she has more control over her body and while focusing in a mindful way she was able to accept the pain of grief.

Between session homework and practicing REBI was given to strengthen Nora's belief in her ability to regulate and control the level of her distress. Nora reported practicing the imagery which she said helped her to identify her irrational thoughts and change them into more rational ones and exercise mindful breathing as a way of regulating the pain. As pregnancy was progressing Nora became very anxious saying she feels disconnected to the fetus: "I keep on thinking about my baby that I lost and I am afraid to think about the one I am carrying." A one-time letter writing to the lost baby was the chosen strategy suggested to Nora to help her express in writing her thoughts and emotions regarding the loss, as she chooses the words, construct the narrative, the pace of writing the emotional tone. Letter writing to the deceased is a technique with a proven therapeutic potential (Pennebaker, 1997; Rubin et al., 2012) that from a REBT perspective enables the bereaved to release "locked in thoughts", many of them are irrational accompanied with distressing emotions. Also, writing a letter "as if" to the deceased provides an opportunity to identify and express these irrational beliefs and change them into more rational ones and explore ways of forgiving oneself, others or the world.

Nora accepted the suggestion and wrote a letter which she brought and read at the following session.

This is an extract from her letter:

"My sweet girl, we were together 9 months, I always talked to you and each time I ate something sweet you were "running wild" and I loved this sensation… even during the most difficult days I knew you were there and everything became dwarfed because I had you…. When they didn't find your pulse in the monitor I felt that blood was coming out of my body…I miss you so much and sometimes I think that perhaps you tried to warn me and I wasn't attentive… I promise you that I did everything I could, and what can I say, not always we manage to be saviors…not everything is in our hands. I know you are in a good place because you are my little angel and always will be".

Nora was crying as she read the letter and added that though it was very difficult to write it she felt relieved upon completing it and felt that she could concentrate on the present pregnancy. Therapy continued until Nora gave birth to a little baby girl. Nora called to update me, said that it wasn't easy but the baby is beautiful and she "told" her about "the angel".

Rational Emotive Imagery with added elements of awareness to physical sensation provides a mind-body experience in which the client is guided in a safe setting to choose a way to reduce the distress associated with the traumatic loss.

Choosing the event experiencing mindfully emotions and body sensation to reduce the intensity and changing cognitions is a way to empower the client to be more self-accepting, and thus increase inner control, and enabling a healthy grief.

What I Have Learned About Using REBT with Grief

Accommodating Individual Differences: Client Gender, Ethnicity, Socio-economic Status, Intelligence and Other Factors

Though mourning is human, normal and universal it always occurs within a socio-cultural context that impacts both process and outcomes. The socio-cultural religious and spiritual lenses are critical to the understanding of the individual's grief. Similarly, mourning customs differ from one culture to another and need to be assessed when intervention is planned. Age, gender, relationship to the deceased (child, parent, sibling etc.) as well as assessment of attachment styles and past experiences with losses are important variables to be assessed because they affect grief process and the structure of the therapy (Rubin et al., 2012). Although grief is an idiosyncratic process based on the unique relationship the bereaved had with the deceased, the bereaved person's belief system is always shaped within socio-cultural context. REBT distinguishes between moral, ethical spiritual and religious values, and the tendency to interpret them in irrational absolutistic way which increases emotional

distress and therefore encourages the adoption of rational beliefs as way to cope with adverse events.

The Do's and Don'ts

The Do's

Remind yourself as a therapist that there are many paths to grieve and remain non-judgmental to different ways of experiencing it.

During the acute phase provide information, normalize the process and explore possible cognitive attitudes alternatives that lead to experiencing an adaptive grief process.

Explore the individual style and preferences towards making the change.

As therapy progresses re-evaluate with the clients the goals and accommodate the tasks and the pace accordingly.

The Don'ts

Don't try to lead the bereaved through "the right way" to grieve. There is no right way one way, and there are no stages to grief. Remember that though grief universal it is an idiosyncratic process. There is no one suit that fits all.

Because loss in most cases is unexpected, undesirable and traumatic, and in many ways "illogical" and the grief that follows is a process to reorganize "shattered assumptions". Do not use at this phase rigorous forms of disputation such as logical disputation or empirical disputation (Malkinson, 2007).

Which Aspects of REBT Deliver the Most Benefit for Change and Which Don't

Which Aspects of REBT Deliver the Most Benefit for Change

REBT therapist is active and directive and flexible in forming the therapeutic alliance in accordance with the individual client's style (Dryden, 1991). This is especially relevant in forming therapeutic alliance in REBT with grief that includes the therapist, the client and the deceased. Accurately perceiving the client's cognitive, emotional, behavioral and non-verbal communication is most important to understanding the individual client's grief as well as conveying this understanding. Moreover, REBT's

philosophy of human tendency to think irrationally along with a belief that humans can change their way of thinking and moderate their distress makes REBT most suitable to working with bereaved individuals and families. The therapeutic goal in REBT with grief is to help the bereaved process a painful experience in a healthy adaptive way, using the client's idiosyncratic language and metaphors not only as a way to express empathy but as a way to introduce cognitive emotional behavioral and physical change.

Based on my clinical experience, I view the ABCDE of REBT as a Hungarian Cube; it holds given components that can be arranged and rearranged in so many ways and variations. Both therapist and client have access to the cube and can negotiate changing it. The simplicity of the model (in Hebrew it translates to "EMET"-"truth" which can be questioned upon disputation!) and yet at the same time it allows for many twists and turns accommodating for individual idiosyncratic needs towards a cognitive emotional behavioral and physical change. The ABCDE model consist of a set of principles and at the same time allows flexibility. Therapy with clients who experienced a loss through death is likely to impose strain on therapists as they confront an adverse event that potentially can evoke irrational beliefs. However, the ABCDE of REBT when A is death—an irreversible event—provides an opportunity to apply a model that fits the normal, human and universal phenomena when it goes awry.

Unconditional Acceptance of Self, Others and the Circumstances of the Death Event

Evaluating or rating one's behavior or actions rather than global evaluation of oneself as worthless is in my eyes the "Jewel in the Crown" of REBT. As its psychological and philosophical stance, it emphasizes that it is human to make mistakes, and accepting it involves practicing cognitive, behavioral and emotional flexibility towards acknowledging one's imperfection (DiGuiseppe et al., 2014). Unconditional acceptance of oneself, others and the world (or life) is pertinent to working with bereaved individuals who feel guilty and/or experience unhealthy anger at themselves, the deceased, the world's injustice or God. Changing rigid global rating into unconditional acceptance will help moderate emotional distress and enable an adaptive grief process.

The Belief-Consequence Connection

Cognitions and emotions are central components in general CBT but the emphasis on the connection between the two as a source of distress and the key to reduce it, is characteristic to REBT, and relevant in applying it following loss. The idea rooted in REBT that "it's all in the head" is basically an optimistic one highlighting free-

dom of choice we, as human creatures, have: "All is foreseen but freedom of choice is given". (Ethics of the Fathers, C, 15). Therapy than can be viewed as a psychological and philosophical dialogue between therapist and client about choices and their implementations in distinguishing between healthy functional and unhealthy dysfunctional emotion when death is the adverse activating event. Thus, in working with a bereaved father who feels guilty over not protecting his son who was killed in a road accident, we searched for the belief that increases guilt: "I should have protected him and if I failed, I am a worthless father". Introducing the distinction (D) in the Bible between thinking and acting willfully or unintentionally, enables exploring emotional consequences, and offer a healthy negative emotion such as remorse which is a normal response in grief (B-C connection).

Which Aspects of REBT Do Not Deliver the Most Benefit for Change

As elaborated throughout the chapter the aim of grief therapy is to facilitate an adaptive grief process following an adverse event of a loss through death. In most cases, logical and empirical disputation strategies are unsuitable and ineffective in particular during the acute phase, during which time assumption about the self, others and the world have been shattered. Bereaved, during the acute phase are sensitive to questioning or debating the catastrophe that befell on them, and express resistance which may also affect the therapeutic relationship. Arguing about the "truth" of the evaluation is perceived as insensitivity on behalf of the therapist. Rather, teaching the ABC of adaptive grief, emphasizing negative healthy emotions to normalize grief process towards accepting life without the deceased. D for dialogue is preferable.

Refrain from insisting on the terminology of "should" and "musts" during the acute grief.

Concluding Remarks

Grief is a cognitive, behavioral, emotional and somatic process of accepting the changes enforced on one's life caused by death. Rational Emotive Behavior Therapy with its distinction between NHE (a core element in grief), and UNE (that block the natural course and increased emotional distress) is a most appropriate framework for working with bereaved in assisting them to adaptively experience grief.

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