Chapter 12
Two Psychosocial Interventions for Complicated Grief: Review of Principles and Evidence Base

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Complicated grief (CG), also known as Persistent Complex Bereavement Disorder (PCBD) in the DSM-5, or Prolonged Grief Disorder (PGD), is a persistent, impairing response to the death of the loved one. While diagnostic criteria sets for CG, PCBD, and PGD slightly differ, in this chapter, we will assume that they refer to essentially the same condition, a bereavement-specific syndrome that reflects poor adjustment

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E. Bui (ed.), *Clinical Handbook of Bereavement and Grief Reactions*, Current Clinical Psychiatry,
https://doi.org/10.1007/978-3-319-65241-2_12

after the loss of a loved one (hereafter referred to as CG). Generally, this syndrome of CG includes core symptoms of yearning or longing for the deceased, emotional pain, sense of disbelief about the death, and preoccupation with the deceased and/or circumstances surrounding the death for more than 6 months [1] or in some criteria sets, 12 months [2], following the loss. Additionally, those with CG may experience bitterness or anger related to the loss, self-blame in relation to the death, excessive avoidance of reminders of the loss, difficulty trusting others, and feelings of loneliness or isolation [1]. Individuals with CG often believe that life is meaningless without their loved one and are reluctant to pursue interests or plan for the future. Frequently, they may desire to die to be with the deceased [1]. CG is distinct from major depression and post-traumatic stress disorder (PTSD) [3] and contributes to impairment above and beyond the effect of PTSD and depression [4]. Fortunately, CG is a treatable condition, with evidence-based treatments developed to specifically target its underlying symptoms and improve the well-being and clinical management of those who suffer from it. In this chapter, we will briefly review three cognitive and/or behavioral models of CG, describe two psychosocial interventions designed to target symptoms of CG, and review the evidence base for these interventions.

Theories of Complicated Grief

Three prominent theories—cognitive behavioral theory, dual-processing model of adaptive coping, and the attachment theory—have emerged to explain the phenomenology of CG.

Cognitive Behavioral Theory

From the perspective of cognitive behavioral theory, CG arises from an individual's inability to accept the loss of the loved

one, in tandem with maladaptive grief- and death-related interpretations and avoidant coping strategies [5]. Central to a cognitive behavioral framework is that psychopathology persists because of distorted, maladaptive interpretations of ambiguous or personally meaningful information and problematic behavior stemming from these biased appraisals, which are mutually reinforcing. In the case of CG, bereaved individuals make biased grief-related appraisals about themselves, the future, and their own reaction to the loss; and engage in avoidance behavior that impedes healthy coping with the loss. For example, individuals may feel they are to blame for the loss (e.g., *I could have stopped it if I had been there*), they have no purpose or sense of meaning without that person, or that they are not reacting normally to the loss (e.g., *If my grief diminishes that means I don't care about the person*). The loss of a loved one can also violate previously held beliefs about an individual's sense of self, their purpose, and their future [5, 6]. Consequently, loss may make the bereaved feel that their lives are meaningless without their loved one. They may also believe that experiencing any positive emotionality after the death is disrespectful to the memory of the deceased or renders the loss less significant. Thus, faulty global, negative, and internal cognitions about the self and their situation prevent those with CG from seeking out support or engaging in previously meaningful and often pleasurable behaviors (e.g., social activities, places, or hobbies associated with the deceased) that foster adjustment to the loss.

One specific model, Boelen's cognitive behavioral model of CG, further posits that bereaved individuals fail to adequately integrate information about the loss with existing, prior knowledge. A bereaved individual's initial schema of the deceased is that of a living individual characterized by elements of both a unique and shared past, and of possibilities of future interaction. While this schema is updated after the loss in most bereaved individuals, Boelen hypothesized that for those with CG information about the permanence of separation is not sufficiently integrated with older information about the relationship with the deceased [5, 6]. Essentially, for the individual with CG,

factual knowledge that separation is permanent does not get linked with information about the relationship with the deceased. Consequently, bereaved individuals with CG continue to experience grief as distinct (i.e., not integrated with other memories) and emotionally painful [5, 6]. From this cognitive behavioral perspective, this explains why bereaved individuals have difficulty accepting the loss as final, experience "*unrealness*" about the death, and continue to feel shock when they are reminded of the loss [5, 6]. Each reminder of the finality of the situation (e.g., that their loved one is permanently gone) is thus at odds with the cognitive framework of individuals with CG and consequently induces distress.

Accordingly, cognitive behavioral theories explain why individuals with CG engage in cognitive and behavioral avoidance of loss reminders that provoke this affective distress. Individuals with CG may avoid any objects, situations, or thoughts that may cause them to experience distress or confront the finality of the loss [5, 6]. In the context of grief, this behavioral avoidance includes avoiding people, places, situations, or things that are associated with the deceased. Additionally, individuals may also engage in cognitive avoidance, attempting not to think about the events surrounding the loss, which is negatively reinforcing and perpetuates the cycle of nonacceptance. Thus, cognitive behavioral theory-informed interventions may address an individual's reluctance to accept the loss, the faulty cognitions, and avoidance behaviors that prolong grief symptoms and perpetuate the syndrome.

Dual-Processing Model of Adaptive Coping

The dual-processing model of adaptive coping also emerged as a theory to understand the maladaptive patterns of prolonged grief that arise after the loss of a loved one [7]. Similar to the cognitive behavioral framework, the dual-processing model of adaptive coping acknowledges that persistent grief arises when bereaved individuals have difficulty accepting the loss of their loved ones, and develop maladaptive cognitive and behavioral

coping patterns. As with cognitive behavioral theory, avoidance of loss-related stressors is central to the dual-processing model of adaptive coping. Additionally, bereaved individuals are prone to avoid engaging in positive behaviors so that they may remain connected to the deceased [7, 8]. However, the theories diverge somewhat to the extent that the dual-processing model emphasizes the failure of coping mechanisms. The theory posits that typically, bereaved individuals experience an oscillation between two orientations: loss-orientation and restoration-orientation [7]. Most bereaved individuals spend time acknowledging the loss (e.g., attending a funeral, talking about the deceased with others, mourning the loss while looking at photos) and re-engaging in life without the deceased (e.g., attending a social gathering without the deceased, going to a restaurant that used to be enjoyed together, discarding items that belonged to the deceased). According to dual-processing model, CG develops due to a failure to alternate and find balance between these two orientations, such that bereaved individuals with CG spend their time focusing solely on the loss and fail to re-engage in positive life activities, which is thought to be motivated by a desire to remain connected to their lost loved one [7].

Attachment Theory

The attachment theory of CG emphasizes the attachment quality and style of the relationship between the bereaved and the deceased. Attachment theory developed from research on infant–mother attachment styles that were broadly characterized as either secure or insecure, depending on the infant's response to the caregiver's absence and subsequent ability of the caregiver to soothe the infant following a period of absence [9–11]. Adults, not just infants, are motivated to attach and adult attachments are also characterized by sexuality and caregiving systems, or the need to both care for others and be cared for [12]. Attachment is considered an intrinsic biological motivation

that when disrupted, either through separation or death of a loved one, leads to significant distress [10–12]. Hofer [13] theorized that loss of an attachment figure leads to a dysregulation of an individual's biological regulatory system, since that attachment figure plays a central role in their affective, attentional, and motivational processes [12]. Stated another way, when separation occurs (e.g., a mother temporarily leaves a toddler alone, or individual loses his/her spouse), the regulatory system becomes disrupted and is associated with emotional distress such as crying (affective process), difficulty attending to or concentrating on other stimuli (attentional process), and decreased or aimless involvement in other activity (motivational process). A basic premise of the theory is that loved ones (initially caregivers, but later intimate partners and even children) are viewed as "*safe havens*" or secure bases from which an individual explores and interacts with the world. That is to say, individuals with secure attachments function in the world autonomously, but return to the attachment figure as a source of support and comfort. As children age (and become capable of symbolic, cognitive processing), they develop mental representations of the attachment figure that can be a source of comfort even when physically separated.

Thus, whereas infant relationships require close physical proximity between mother and child, adult relationships rely more heavily on internalized representations (i.e., cognitive symbols, ideas, or images) of the attachment figure (e.g., parent, spouse, child) informed by the quality and functioning of the relationship [12, 13]. According to attachment theory of grief, the loss of an important attachment figure consequently changes an individual's sense of a security in the world and impacts interpersonal functioning [12]. From this perspective, the loss creates a mismatch between mental representations of the loved one and the sudden change in the bereaved person's relationship with the deceased, leaving the bereaved with a strong sense of yearning for the loved one and sense of disbelief over the loss [14]. Importantly, the loss of a close relationship impedes one's ability to construct a meaningful sense of

self without that person [8]. Thus, according to the attachment theory, the death of a loved one usually produces a state of traumatic loss and symptoms of acute grief that will evolve into a state of CG if an individual is unable to accept the reality of the death or reestablish their identity without that person [12].

In summary, three psychological theories of CG, cognitive behavioral theory, the dual-processing model of adaptive coping, and attachment theory, have emerged to describe the underpinnings and phenomenology of CG. Central to all three theories is the inability to accept the reality of the death, which consequently disrupts bereaved individuals with CG from maintaining a meaningful sense of self and purpose. Additionally, across all three theories, bereaved individuals with CG develop maladaptive coping strategies as a result of the loss, which has led researchers to develop evidence-based cognitive behavioral therapeutic interventions that directly target grief-related behavioral and cognitive avoidance and help individuals to re-engage in their life in meaningful ways. In the following section, we will review the principles and empirical evidence for two specific approaches based on these theories: cognitive behavioral therapy (CBT) and complicated grief treatment (CGT). Other therapeutic approaches, such as narrative therapy, similarly based on dual processing theory, is described in a separate chapter (Chap. 8).

Cognitive Behavioral Therapy Approaches

Principles

Guided by theory, cognitive behavioral therapy (CBT) for grief incorporates specific techniques to encourage acceptance of loss, modify maladaptive grief-related appraisals, and reduce avoidance. CBT has been delivered in group and individual settings and typically consists of 12 sessions. CBT consists of four core treatment interventions including psychoeducation, cognitive restructuring, exposure, and behavioral activation.

Psychoeducation

First, bereaved individuals receive psychoeducation about loss and the nature and symptoms of CG. The therapist reviews symptoms of CG, discusses the differences between acute and prolonged grief, and helps the patient understand the cognitive and behavioral factors that maintain grief. As with other CBT interventions, this phase allows patients to understand the nature and history of their distress and enables therapists to build credibility for the rationale for treatment while normalizing the patient's experience. In the context of grief, psychoeducation is an early step in helping patients begin to accept the loss as final [1].

Cognitive Restructuring

Cognitive restructuring is a series of techniques that includes identification, labeling, review of evidence, and reappraisal to directly target the faulty and negative cognitions that arise over the course of bereavement. The patient and therapist work collaboratively to identify the global, internal, and stable negative feelings about themselves and their situations that impede resolution of prolonged grief [1, 15, 16]. Commonly targeted thoughts in CBT for grief include inappropriate self-blame surrounding the death or deceased, belief that re-engaging in life or diminished acuity of grief would dishonor the deceased, or feelings of worthlessness or meaninglessness in life without the loved one [1].

Exposure Therapy

Another critical component of CBT for grief is the incorporation of exposure therapy into treatment sessions. A highly efficacious treatment for anxiety disorders and related conditions like PTSD, exposure therapies help individuals experience reductions in distress and disconfirm faulty beliefs about a situation (e.g., "I *can tolerate this feeling without going crazy*") [17]. In the case of grief, the therapist works to

help the patient confront affectively salient reminders of the loss. This may include approaching situations that remind the patient of the deceased (e.g., looking at pictures of the deceased, discarding items of the deceased, visiting the cemetery) or completing written or spoken exposure narratives, in which patients are asked to repeatedly describe the loss of the loved one and recount circumstances of the death [1, 15, 18]. Through repetition, exposures help patients to accept the reality of the loss and reduce grief-related distress [1].

Behavioral Activation

Finally, some models of CBT for grief use components of behavioral activation modified for grief, to help patients reengage in previously meaningful activities and enhance quality of life. In the context of grief, behavioral activation helps patients increase the frequency and breadth of their engagement in enjoyable and meaningful activities in everyday life [1, 19]. In addition to increasing engagement in pleasurable activities, previously enjoyed hobbies, and social activities, some CBT practitioners may facilitate behavioral activation for grief in the form of writing exercises, in which patients are asked to write a letter to a bereaved friend, to offer support, encouragement, and positive resolutions in the healing process [18].

Although there is not one universally adapted or published CBT treatment manual for acute grief or CG at the present time, and providers may vary their emphasis on particular strategies, CBT interventions are similar in their use of these techniques and shared the primary treatment goals of targeting faulty cognitions and behavioral avoidance that maintain pathological grief reactions and prolong nonacceptance of the loss.

Review of Outcome Studies

CBT has shown efficacy in reducing CG symptoms in comparison to waitlist controls or general supportive counseling.

In a randomized control trial (RCT) of an Internet-based CBT for CG, 55 bereaved individuals with CG were randomly assigned to either a waitlist control or CBT treatment group [18]. Wagner et al. [18] incorporated three CBT modules into the 5-week intervention, addressing core components of the cognitive behavioral model tailored to bereavement: exposure to bereavement cues, cognitive reappraisal, and restoration of goals. The treatment group improved significantly in comparison to the waitlist control, demonstrating reduced intrusive thoughts, avoidance, maladaptive behavior, and general psychopathology [18]. In a follow-up to this study, gains from CBT were maintained at 18-month follow-up [20].

In a stratified RCT, based on relationship to the deceased and type of death, Rosner et al. [21] compared CBT to a waitlist control. Fifty-one individuals with CG were randomly assigned to a waitlist control or integrative CBT. The treatment group received 20–25 sessions, which were divided into three parts: seven sessions that focused on stabilizing and motivating the patient to explore their individual grief situation; nine sessions devoted to teaching relaxation techniques and cognitive restructuring to address maladaptive views of self, the deceased, and the circumstances surrounding the loss; and four sessions focused on creating future goals while maintaining a healthy relationship to the deceased. Although this study did not incorporate exposure into the CBT intervention, the CBT treatment group had greater reductions in grief severity and depression symptoms relative to the waitlist control group [21]. In a follow-up study performed 1.5 years after treatment completion, Rosner et al. [22] found the treatment effects were stable over time and the general mental health improvements seen post-treatment were maintained among those in the CBT group.

In contrast to the two studies above, in which CBT was compared to inactive treatment groups (i.e., waitlist conditions), Boelen et al. [15] compared CBT to a nonspecific, but active treatment for CG to understand how a targeted

treatment, such as CBT, may perform relative to a general, supportive therapy. Fifty-four bereaved individuals with CG were randomly assigned to one of three conditions, two CBT conditions and one supportive counseling condition. Across all conditions, individuals completed 12 sessions of treatment. Both CBT conditions incorporated exposure therapy (ET) and cognitive restructuring (CR) into their sessions, but differed in the order in which the interventions were provided. One CBT condition led with 6 sessions of CR followed by 6 sessions of ET (CR + ET) and the other CBT condition led with 6 sessions of ET followed by 6 sessions of CR (ET + CR). Individuals in the third treatment group received 12 sessions of supportive counseling. Results from both completer and intent-to-treat analyses demonstrated that both CBT conditions led to greater reductions in psychopathology and CG symptoms than the SC condition [15]. Comparisons of the two CBT conditions suggested superiority of exposure relative to cognitive restructuring, such that ET+CR was more effective than CR+ET and that adding ET to CR led to greater improvement than adding CR to ET [15]. Another RCT further investigated how grief-focused exposure improves CBT in a randomized control trial of 80 bereaved individuals with CG [23]. All 80 individuals received 10 weekly, 2-h sessions of group CBT without exposure and then were randomized to receive four, additional 1-h individual sessions of exposure therapy to memories of the death (CBT + exposure) or four, additional 1-h supportive counseling sessions (CBT alone). Compared to CBT alone, CBT + exposure was more effective at reducing depressive symptoms, negative appraisals, and cognitive impairment [23]. Additionally, fewer patients met CG criteria at 6-month follow-up in the grief-focused CBT + exposure condition [23]. Together, these findings demonstrate efficacy of CBT and exposure therapy in particular for the treatment of CG. Although it is common for providers to be concerned that grief-focused exposures may lead to unnecessary provocation of distress, these findings underscore the importance of including exposure therapy to grief- and death-related cues.

Complicated Grief Treatment

Principles

Developed from the dual-processing model of adaptive coping and attachment theory, in which grief resolves optimally when attention is balanced between loss- and restoration-orientations, Complicated Grief Treatment (CGT) is a manualized bereavement-focused individual therapy that consists of 16 sessions designed specifically to treat the composite factors of CG [7, 24–26]. The rationale for treatment is that individuals with CG should receive both loss-focused (e.g., confrontation with reminders of the death) and restoration-focused (e.g., engagement in activities and goal setting) interventions. Additionally, informed by attachment and cognitive behavioral theories, a goal of the treatment is to simultaneously identify the patient's history and relationship with the deceased while addressing the complex emotions, and targeting maladaptive cognitive and behavioral patterns [1, 24]. As noted earlier, there is overlap between CG and other disorders, namely PTSD and major depressive disorder. Thus, CGT combines techniques derived from other treatment packages including prolonged exposure and interpersonal therapy (IPT) to treat symptoms such as intrusions, sadness, and social withdrawal [24]. CGT includes three phases of treatment, each of which uses different strategies to help individuals address their loss-focused distress and restoration-focused future goals [1].

Introductory Treatment Phase

In the introductory phase of treatment, there is emphasis on developing a companionship alliance between therapist and patient. Within this working alliance, individuals receive psychoeducation about CG and come to understand the differences between normal and complicated grief trajectories. In the first few sessions, patients learn about the rationale for the treatment strategies, such as the need to manage avoidance,

rumination, and excessively negative appraisals, the importance of creating positive memories, as well as the value of developing new goals [1, 24]. By learning about the rationale for the treatment strategies in tandem with this psychoeducation about CG, patients can begin to understand how specific aspects of the treatment target the foundations of their CG symptoms. With the therapist, patients also share details about their relationship with the deceased. During these first sessions, patients are taught the importance of processing the loss as well as restoring life functioning and purposeful engagement that may have halted after the death [1, 24]. Patients are also encouraged to bring a loved one into an early session to enable the therapist to learn more about the patient's grief and also facilitate grief-related social support for the patient.

Middle Treatment Phase

In the second phase of treatment, individuals address the maladaptive avoidance patterns and faulty cognitions surrounding the death, by participating in both situational and imaginal revisiting of the events surrounding the death and reminders of their loved one. Situational revisiting exercises take place outside of therapy sessions, in which bereaved individuals are asked to return to places they may have gone with their loved one or visit places that they may have avoided, like the cemetery. Imaginal revisiting is completed during therapy sessions, in which the patient describes in detail when they first learned about the death. The revisiting exercise is audiotaped, and then patients are asked to listen to the exercise at home to develop a new relationship with their experience surrounding the death [24].

Final Treatment Phase

The final phase is comprised of personalized goal-setting and plans for the future in order for the individual to lead a happy and healthy life during the final therapy sessions.

The therapist helps the patient to generate plans for moving toward the goals they want to achieve, and to develop concrete behavior changes each week to obtain those goals [1, 24]. At the end of a successful course of treatment, individuals have accepted the loss of their loved one, acknowledged the finality of loss, revised their life goals without the deceased, and re-engaged in meaningful activities.

Review of Outcome Studies

CGT has consistently shown efficacy reducing CG symptom severity across three RCTs. In the first study, Shear et al. [24] compared their novel grief-focused therapy, CGT to interpersonal therapy (IPT), to test their hypothesis that CGT leads to greater treatment response in bereaved individuals with CG than, non-grief-targeted psychotherapies. In this study, 95 bereaved individuals were recruited through a university-based research clinic as well as a satellite clinic in a low-income African-American community. Participants were randomly assigned to either 16 weekly sessions of CGT or IPT delivered over a 16–20-week period. Across treatment sites, randomization was stratified by type of death (e.g., violent or nonviolent). Although both IPT and CGT led to improvements in CG symptoms, CGT had both a higher response rate and a shorter response time when compared to IPT [24]. The first study to assess CGT, the authors concluded that although general therapies such as IPT may relieve some of the distress associated with the death of a loved one, CGT, a grief-targeted therapy, is an improved treatment model with greater and faster treatment response.

Shear et al. [26] again compared CGT to IPT in a second RCT, in which they examine CGT efficacy in an elderly bereaved population, a unique group with the highest prevalence of CG. Geriatric populations are more commonly exposed to loss of loved ones (see Chap. 6), yet many

clinicians are reluctant to implement exposure-based therapies with older individuals [26]. Shear and colleagues recruited 151 bereaved individuals 50 years or older and randomly assigned them to either CGT or IPT, an evidence-based treatment for depression. Bereaved individuals in both conditions received 16 individual weekly sessions, over the course of a 16–20-week period. Similar to findings of the previous study, both CGT and IPT produced reductions in CG symptoms. However, relative to IPT, CGT was associated with greater reductions in CG symptoms and functional improvements. Additionally impressive was that the response rate in the CGT condition was twice the rate in IPT [26]. Secondary analyses also supported that CGT led to a significantly greater reduction in illness severity, while bereaved individuals in IPT were still moderately ill at the end of treatment. This study further supported CGT as an effective treatment for CG relative to non-targeted treatments. Furthermore, this study highlighted that although CG and depression are commonly comorbid and share overlapping features, CG is a distinct disorder that requires implementation of specialized treatment.

More recently, a placebo-controlled RCT tested the efficacy of CGT with and without antidepressant pharmacotherapy. Shear et al. [25] examined whether CGT could be enhanced with the addition of the antidepressant, citalopram (CIT; [25]). A multisite RCT included 395 bereaved individuals who met criteria for CG. Individuals were recruited nationally and treated at medical centers in four, large urban areas [25]. Bereaved individuals across the four sites were randomized into four conditions: CIT, placebo (PLA), CGT + CIT, or CGT + PLA, and were stratified by presence of major depressive disorder. CGT was delivered in 16 sessions over a 16–20-week treatment period. Across all four conditions, individuals received pharmacotherapy with flexible dosing, psychoeducation, grief monitoring, and encouragement to engage in activities [25]. When comparing CGT + CIT to CGT + PLA, the addition of an antidepressant, CIT, did not significantly improve treatment outcomes. However, results indicated that

enhancing CGT with CIT (CGT + CIT vs. CGT + PLA) did optimize the treatment of depressive symptoms associated with CG [25]. When comparing within the CIT medication conditions, (CIT alone vs. CIT + CGT), results indicated that enhancing medication treatment with CGT did improve treatment outcomes [25]. The authors concluded that although addition of antidepressant medication to CGT did not appear to enhance reductions in CG symptoms, for individuals with comorbid depression, supplementing CGT with antidepressant medication was effective in targeting associated depressive symptoms [25]. Furthermore, these findings suggest that a combination of CGT with citalopram is more effective than medication alone. In sum, CGT is an efficacious treatment for CG and superior to supportive psychotherapies, non-grief-specific treatments (i.e., IPT), and pharmacotherapy alone.

Summary

Bereavement is one of the most stressful experiences individuals face in a lifetime. Approximately 7% of bereaved individuals and 2–3% of the overall population will develop CG [27]. CG is hypothesized to develop because of maladaptive cognitions about the death, avoidance behavior, insufficient integration of the death into one's autobiographical memory, poor coping responses, and disruption of biobehavioral systems that regulate attachment. Although impairing, CG is a treatable condition. Two evidence-based psychotherapy treatments—cognitive behavior therapy and complicated grief treatment—are effective for the treatment of CG. The treatments have many similarities with respect to the nature of interventions delivered. For example, psychoeducation is a core component of both treatments and revisiting and exposure share many similarities. However, the treatments differ somewhat with respect to their emphasis on other strategies (e.g., cognitive restructuring, understanding the nature of the relationship to the deceased), which is due to the theories that inform their interventions. Further

research should identify mechanisms of action in CBT and CGT to increase efficiency of treatments targeting CG symptoms. Additionally, dissemination of knowledge about grief and evidence-based treatments for CG should be prioritized to increase access to care and enhance treatability of this condition.

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