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COGNITIVE BEHAVIORAL GRIEF THERAPY

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ABSTRACT: From a REBT perspective, loss through death is viewed as an intense negative and traumatic Activating event which effects the Belief system and related emotional and behavioral Consequences. Grief, then, is seen as a normal reaction and the process that follows is a necessary one characterized by the bereaved attempting to reorganize a shattered belief system. In the present paper a distinction between functional and dysfunctional grief is made. Based on Ellis' differentiation between iB's and RB's, typical irrational grief-related beliefs are identified (with specific focus on pain related ones). Various REBT interventions aimed at facilitating a more functional, healthier course of grief are suggested.

LOSS THROUGH DEATH AND GRIEF

Loss through death of a significant person is regarded as a negative event which is followed by intense reactions. The more sudden and unexpected the death event is, the more traumatic its impact and the greater its effect on the bereaved person's ability (and willingness) to come to terms with the loss and reality. All existing schema and assumptions shatter (Janoff-Bulman, 1992; Parkes, 1975).

For the survivor, a death event marks the end of a relationship and the beginning of the painful process of grief, when the individual experiences intense psychophysiological reactions (Lindemann, 1944; Ramsay, 1979).

There is agreement among writers that while it is a painful experience, the process of grief is crucial, necessary and unavoidable for a successful adaptation to the loss (Hodge, 1972; Parkes, 1975; Parkes &

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Weiss, 1983; Rando, 1984, 1992). According to Worden (1991/83), a satisfactory resolution of grief refers to the bereaved person's ability to feel and think about the deceased without intense pain or tears. For grief to be resolved, the bereaved goes through stages (Bowlby, 1980; Parkes, 1972), or components (Bugan, 1977), and according to Worden (1991/83), the bereaved has to complete four tasks which involve cognitive, emotional and behavioral elements. These are: (1) to accept the reality of the loss; (2) to experience the pain of grief; (3) to adjust to an environment in which the deceased is missing; (4) to withdraw emotional energy and reinvest it in another relationship.

Even though individual differences do exist among the bereaved in carrying out these tasks, it is not the order but rather the experience of the tasks which is of great importance (Van der Hart, 1987).

The phenomenology of what constitutes normal versus complicated grief is derived mostly from observations and work done with clients who experienced difficulties in their grief process, thus limiting its generalizibility potential (Stroebe, Stroebe, & Hanson, 1993). Also, the resemblance between grief reactions and the depression episode (i.e. somatic distress, changes in appetite, depressive mood) may result in a different assessment which in turn may lead to a different treatment (Brom et al., 1993). Grief resolution, "positive" and "negative" bereavement outcomes, "completion," "working through," "recovery" are terms that emphasize the dynamic character of the process over time on the one hand; and the difficulty in determining unequivocally what are the preferred composites of the process' outcomes on the other. Of interest is Wortman and Silver's (1989, 1993) review of relevant research literature concerning bereavement. Their analysis of available theoretical and clinical data led them to re-examine accepted and well-established assumptions regarding grief. They suggest that contradictory to existing expectations, grief reactions are not universal, nor are they a necessary response following loss. Accordingly, a variability in response to loss does exist. They examine the assumption of working through of the loss and found that there is no relationship between working through of the loss and grief resolution, nor is there a relationship between positive adaptation following loss and the level of depression. On the contrary, people who experienced depression immediately following the loss and during the bereavement process were likely to be most depressed one or two years later. It seems that although grief is a normal and expected reaction, most bereaved people adapt to the loss in a less intense manner than is assumed (Raphael, 1983).

The present paper will attempt to examine grief reactions, processes

and outcomes from a cognitive perspective. A distinction will be proposed between functional and dysfunctional bereavement processes. It will be recommended that a detailed assessment be conducted of the likely irrational beliefs which may block a healthier course of grief. A special emphasis is given to pain-related irrational beliefs. Two major forms are identified: 1. Avoidance of pain of grief ("It's too painful, it mustn't be so painful"). 2. Overexperiencing the pain of grief ("I must suffer the pain, I deserve the pain," "Suffering the pain is the only way to remember the deceased, therefore, I must keep the pain"). This second form is identified as Excessive Frustration Tolerance (EFT) as distinguished from LFT. Case illustrations are presented.

GRIEF AND BEREAVEMENT: COGNITIVE EMOTIONAL AND BEHAVIORAL EXPERIENCE

Most therapies dealing with bereavement and grief focus on the emotional dimension of the process: anger, depression, shame, guilt, and use these reactions or their absence as crucial indicators to understand and evaluate short and long term outcomes. Moreover, most models describe pathological forms of bereavement in emotional terms: the symptoms listed include excessive anger, guilt, anxiety, depression and apply mostly cathartic intervention in order to help the bereaved person alleviate the intensity of these emotions (Marshall & Guithier, 1977; Beck, 1976). Most models also assume that emotional reactions such as anger, guilt and anxiety are essential, and propose that for the process to take its normal and desirable course these emotions have to be experienced and overtly expressed. According to traditional models, the absence of these emotions or the avoidance of their expression are an indication of complicated grief. As well, cognitions are seen as the by-products of emotional disturbance. Hence, emotional aspects of the grieving process are the foci of therapy, and catharsis is a major strategy helping the bereaved to express emotions. The therapist's tendency to emphasize emotions as central to the process of grieving has led them to neglect the cognitive aspect of grieving (Rando, 1984).

In contrast, cognitive therapies emphasize the centrality of cognitive processes in understanding emotional disturbance. They assume the interaction between cognitions and emotions and refer to distorted or irrational thinking (Back, 1976; Ellis, 1962, 1993). According to cognitive therapies, there is a relationship between distorted thinking and emotional disturbance. Overreactions or lack of reactions are not in

themselves "right" or "wrong," preferred or not (undesirable), but are related to a specific set of beliefs (cognitions) which are functional or dysfunctional (adaptive or maladaptive).

Because of the traumatic nature of the death event, emotions seem to be more dominant than are cognitions, especially during the acute crisis.

Moreover, because of the overt nature of emotions, as opposed to cognitions which are more covert, as well as the fact that emotions have a flooding effect especially during acute crisis such as a death event, cognitions are regarded as less central. In contrast, from a cognitive perspective, a death event has an impact on a persons's assumptive world (Parkes, 1975), schema (Beck, 1976; Horowitz, 1988; Janoff-Bulman, 1992) or belief system (Ellis, 1962, 1994) and grief, then, is a process of reorganizing what has been shattered.

Beck (1976) concluded that emotions and behaviors are related to a person's evaluations (schemes) about him/herself, the world and the future. Accordingly, psychopathology is related to distorted thinking, and depression is a negative evaluation (automatic thought) of a person's self, the world and the future. According to Beck (1983) bereaved persons with distorted thinking may be likely to interpret loss as an intended rejection.

Horowitz (1993), who has extensively researched the relationship between thoughts and emotions in traumatic states, suggests that following a death event the bereaved person's schema have to be modified accordingly: the cognition-emotion state changes sharply with news of the death, and grief is the painful process of giving up old meanings to one's life and forming new ones. Horowitz (1986) described the phenomenology of the responses to include feelings of helplessness and a sharp detachment from life as existing prior to the traumatic event. The working through of a traumatic event involves reexperiencing the event (in full or in parts) on the one hand and avoiding it and its related memories on the other.

Ellis (1980, 1984) emphasizes, like Beck and other cognitive theoreticians, the cognitive dimension as central to understanding emotional disturbance. Like other cognitive theoreticians he too holds ". . . that almost all people who experience serious traumas—such as rape, physical abuse, terrorism, continued incest, and harrowing war experiences—suffer severe stress and shock from these experiences, especially when they are unexpected, unfair, and senseless." (Ellis, 1994, p. 12). In other words an intense traumatic and unexpected Activating event affects the person's response—i.e. belief system, as well as the

emotional-behavioral (and physical) consequences. A loss through death and specifically a sudden and unexpected one is one such event (Holmes & Rahe, 1963). Thus, for the grieving process to take an adequate course towards functional and satisfying outcomes, grief-related cognitions (appropriate and inappropriate alike) should be identified, included and treated as an equal part of intrapsychic processes (Gluhosky, 1995; Kavanagh, 1990; Rando, 1988).

REBT AND GRIEF AND BEREAVEMENT

The following are assumptions relevant to grief from a REBT prospective:

1. Death is regarded as a traumatic event which affects the belief system and, consequently, emotions and behaviors.
2. Grief is a process of experiencing the pain of the loss and searching for new meaning of life without the dead person. Grief, then, is a normal and necessary reaction to a stressful event. The human tendency to think irrationally (Ellis, 1976) probably reaches its peak following a death event. Unlike other life situations, a death event is a traumatic (in nature) one and as such effects people's responses—cognitively, emotionally and behavioral. As Ellis and DiGiuseppe (1993) note, people have a choice of responding to events with functional emotional consequences (C's) . . . . . or responding with dysfunctional emotional consequences (C,s) (p. 472). It seems as though that following a traumatic event the awareness of one's choice of response is temporarily affected and an irrational pattern of response is more dominant than the rational one.

   Interviews with men and women who experienced a loss of a spouse lend support for this assumption: There was a correlation between the death event and irrational beliefs. Sudden death of a spouse was found to be associated with more irrational beliefs (as compared to an expected one ($r = .42$; $p < .048$; $n = 23$) (Malkinson & Kushnir, in press).
3. Within the REBT conceptual framework, grief process is a necessary one to help the bereaved organize the shattered belief system following a death event into one wherein the event is not avoided nor constantly remembered but is rather a part of the rearranged system.
4. REBT distinguishes between appropriate and inappropriate reactions to loss. Grief which has a healing effect in the process of adapting to a reality which no longer includes the deceased involves negative emotions such as sadness, guilt, shame and pain.

The aim of therapy is to identify irrational thoughts and change them into more rational ones so that a more functional process of grief can take its course.

COGNITIVE ASSESSMENT AND INTERVENTION FOLLOWING LOSS THROUGH DEATH: THE CASE OF THE DETAILED-A

A common procedure in cognitive therapies is the application of two types of assessments during the intake sessions:

1. general demographic assessment;
2. assessment of the person's cognitive maps (DiGiuseppe, 1991).

Cognitive assessment aims at assisting the therapist to formulate a hypothesis regarding the clients' thinking constructions and their interaction with emotions and behaviors (DiGiuseppe, 1991; Kavanagh, 1991; Beck, 1976).

The interaction $A \times B = C$ suggested by Ellis and Dryden (1987) indicates that the more traumatic the Activating event is, the greater the effect of thoughts on the emotional and behavioral consequences. The crisis events (like loss through death) and the emotional consequences that follow tend to be intense, acute, profound and pervasive (Ellis, 1994), and resemble emotional disturbance although they may in fact be appropriate grief reactions. For purposes of determining the appropriateness of the response, it is important to understand the bereaved person's evaluation of the circumstances of the loss event which are likely to be interwoven into his/her account of the event itself.

For this reason, unlike other types of REBT interventions where too many details about the A are redundant, the therapist will seek to explore details concerning the Activating event (Malkinson, 1993).

Eliciting a detailed-A regarding the loss often:

1. Gives the therapist a clue about the client's irrational beliefs underlying specific emotional consequences.
2. Enables the therapist to use the details to help the client make a distinction between functional and dysfunctional responses regarding the event.
3. May have a cathartic effect in that it is an opportunity to express irrational thoughts the client has about the event itself or thoughts about self, others or the circumstances, with regard to the loss.

The following is an example of a detailed-A assessment which focuses on grief reactions of a father whose son got killed during a military action. U. in his late fifties lost his youngest son in a road accident during his military service. U. introduced himself as one who had survived a few wars. He said that a few years earlier he lost his wife and was left to care for their three children. Following his son's death, U. said he sought therapy because it was suggested to him by his relatives although he himself was rather sceptical about how effective it would be for himself. U. was sad and grieving painfully over the loss but also was very upset over his reaction, especially the crying.

> Therapist: Tell me what brought you here.
> Client: It's difficult for me to tell you. My only son was killed during a military action. He was the youngest of three. He was a very sensitive child and difficult to discipline. He didn't like school and had few friends. Only recently upon his joining the forces he grew out of many of his insecurities. He matured and we became closer, enjoying each other—real friends. Only recently, I began to enjoy him, his personality and his company. It's very painful and sad. Since his death I am crying and unable to stop crying. What worries me most is when bereaved parents warn me that it is going to get worse. That thought frightens me more than anything else. I must be rational. Tears and crying have no rational explanation and that is why I am terrified.

U.'s account is an example of how rational and irrational beliefs coexist under what is obviously regarded as a traumatic and sad sudden loss. The therapist will aim at explaining the appropriateness of sadness—normalizing pain and grief and by the same token the inappropriateness of the client's self-damnation over his crying. A distinction between the two will be made and discussed through therapy. As can be seen, a detailed-A does not necessarily have to focus on the event itself, rather it is the client's personal account of the event, its circumstances and background—the story.

The above therapist's hypothesis was that the bereaved father had an irrational belief about himself and his grief: "If I cry I am a weak person."

Being terrified over his crying is an example of a secondary symptom. It is the stress that U. is creating over his being upset following his son's death. As Ellis (1994) notes secondary symptom is the stress

or disturbance about the disturbance . . . especially when people are very upset about their original Activating Experience or Adversity (A) (p. 5). The above therapist distinguished between self-downing and self-acceptance so as to give legitimization to a normal and appropriate response like crying.

Another example of a detailed-A assessment for purposes of forming a hypothesis regarding the grief response is as follows. M., in his late twenties, lost his girl friend in a road accident just a few months before their already planned wedding. He sought therapy a few months after the accident because he felt he "was going crazy."

Here is his response to the question concerning the circumstances of the accident: "My girlfriend and I were planning to get married. In fact it was supposed to take place this month. We already made arrangements for the wedding. On the day of the accident we took the bus to go home for the evening after spending a wonderful week together. We had booked for a later bus but as we were ready, I thought an earlier bus will give us extra time at home. We left earlier as a result of me changing the tickets."

(Hypothesis: the client feels guilty for his girlfriend's death because he was responsible for changing the bus tickets.)

"The bus turned over and I saw my girlfriend was hurt, I insisted that she should be attended but other passengers were attended to by the first aid team. I understood later that she was unattended because she was already dead but I should have insisted."

(Hypothesis: I am guilty for her death.)

It is possible to hypothesize "I"—related irrational beliefs over a traumatic loss: "I" shouldn't have changed the tickets. "I" should have insisted that the first aid people should have attended her. The irrational beliefs identified in the detailed-A will be used throughout the therapy to assist the client to take an appropriate and functional course of grief. Also, information regarding the appropriateness of the reactions, normalizing the feelings of sadness and, at times, "going crazy" will be given and repeated as therapy progresses.

INTERVENTIONS

In general, the aim of psychological interventions immediately following a death event is to enable grief to take a functional course, focusing on its cognitive, emotional, behavioral and physiological components. Because of their acute nature immediately following the loss,

the following interventions are suggested for channeling the pain of loss into a more effective grieving process:

A. Providing information about (1) the A×B=C relationships, (2) rational (functional) vs. irrational (dysfunctional) ways of grieving, (3) the grief process and its painful nature, its components, intensity and normalcy.
B. Focusing on self-acceptance rather then self-downing pattern which is a frequent thought among the bereaved, especially during the acute phase.
C. Thought stopping, to help the bereaved gain a cognitive control over an uncontrolled external event.
D. Thought reconstructing and self talk (Ellis, 1981; Lazarus, 1976; Seligman, 1990).
E. Teaching the bereaved a repertoire of skills and behaviors congruent with the new life situations.
F. Progressive relaxation and breathing to help with body stress and sleep disturbance.

During the acute phase of grieving, disputation if used, preferably should be empirical, focusing on distorted perceptions of reality. The bereaved person is less able at this stage to logically challenge irrational beliefs because of the overwhelming effect of the event (Horowitz, 1986, 1993).

Following a detailed-A assessment of U. the therapist's initial hypothesis formulated related to the secondary symptom: "I should not cry over the death of my son. It's a sign of weakness which worries me because other bereaved parents tell me that things get worse as time goes by. If this is so, what would I do and what will life look like for me."

The intervention that followed included information about grief following loss and the normalization of the pain and crying as human universal reactions. Also, the interaction between the Activating event (A), the Belief (B) and the Consequences was explained.

Therapist: The loss of your son is very tragic and unexpected. Your grief is normal but are telling yourself something about your reaction. What are you telling yourself?
Client: . . . That I am weak and worthless if I cry and can't stop it.

(Hypothesis regarding the possible irrational Belief: I must be strong even now).

Therapist: That could very well be the reaction to the death of your son whom you loved so much.
Client: . . . (Crying) Yes, only now I am aware how much I miss him. As a child who grew up without a mother he was very sensitive and touchy. I spent many hours and energy to comfort him. Becoming a soldier changed him greatly . . . and now he has gone . . .
Therapist: So that's the pain of bringing him up and the pain of losing him. (functional pain).
Client: Yes, exactly, and the shame that it is so painful.
Therapist: Yes, it's very painful but you are damning yourself for not being able to overcome the pain when pain is part of the reaction. You are telling yourself: "I must not cry," when in fact it's very normal to cry when one loses a son. Can you see the appropriateness of your reaction?
Client: I haven't thought about it that way.
Therapist: And when you think about it, what is your reaction?
Client: Less critical of myself.
Therapist: And when you are less critical of yourself, how do you feel?
Client: . . . Less shame.
Therapist: Could you tell yourself to stop criticizing yourself?
Client: Is it possible?
Therapist: Let's try: What is it that you can say to yourself?
Client: I can tell myself to stop thinking these thoughts.
Therapist: That's right. You can tell yourself to stop those irrational thoughts; and then you will allow yourself to be sad and cry without damning yourself. Can you try it now?
Client: (Hesitates) ... Stop criticizing yourself. . .
Therapist: Good, now you want to practice saying it.

The therapist then gives information about grief, its process and components, normalizing and legitimizing reactions like crying. Interventions also included rehearsing with the client self-talk statements, and the teaching of relaxation.

DYSFUNCTIONAL GRIEF

As mentioned previously, some forms of grief are identified as complicated ones. Duration of grief, its intensity and persistence of emo-

tional components over time are variables used to assess the various forms of grief, its course and outcomes (Rando, 1993). Although grief as a process is a universal experience and its course is generally identifiable and predictable it is also a highly individual one and there is difficulty in accurately defining its outcomes. The commonly referred to phase of competition (also known as reorganization, acceptance or resolution) describes positive outcomes as opposed to negative ones—complicated or pathological forms of grief. But because grief as a psychophysiological intrapersonal process is always experienced in a socio-cultural context—the question as to what constitutes complicated and/or uncomplicated grief can be socially defined (Kleber & Brom, 1992). By the same token, Rubin and Dichterman-Katz's (1993) findings indicate a continuous emotional bond with the dead son (loss during wars) among bereaved parents long over what is regarded as normal duration. Zissok and Shucter (1985) identified a similar pattern among widows and widowers: Persistence of a number of symptoms for over 10 years, suggesting that grief-related feelings, symptoms and behaviors, as well as many aspects of grief-work, continue indefinitely in a significant proportion of otherwise normal individuals (Rando, 1993, p. 146). Rando (1993) indicated that chronic grief (also termed prolonged or protracted) resembles clinically acute grief with intense reactions like crying, anger and protest over time. From a cognitive perspective, crying, anger and protest are related to the bereaved belief system and if these emotions persist over time they indicate a dominant irrational belief system. Or in terms of constructivism, it is a difficulty or a failure to reconstruct one's alternative "assumptive world." Variables such as the circumstances of the loss, the nature of the relationship with the deceased, past experiences with loss (Rubin, 1993) are associated with barriers in the process of reconstructing a "new model," as well as an increased tendency to think irrationally (Ellis, 1995). A tendency to view the loss consciously or unconsciously as reversible (Bowlby, 1980) is an example of irrational thinking. Typically, in such cases there is a cognitive awareness of the occurrence of the death but at the same time there is a belief that the loss is not final in the sense that the dead person is still here. It is as though the bereaved is maintaining a non-existent relationship with the deceased in an effort to retain the "old model" which no longer exists.

Thus, from a cognitive perspective, bereavement outcomes will refer to changes or lack of them with regard to the construction of a different assumptive world.

DYSFUNCTIONAL GRIEF AND REBT

In REBT, dysfunctional grief is defined as persistence over time of dominant irrational beliefs regarding the loss event, the deceased and the self. Ellis (1986) distinguishes between two major types of anxiety: Ego Anxiety (EA) and Discomfort Anxiety (DA). Each one may, according to Ellis, be experienced as a primary or a secondary symptom. Both forms of anxiety are frequently identified among the bereaved. Cognitions of an ego anxiety type can include: "I should have prevented his/her death and if I didn't—I am worthless."

Discomfort anxiety cognitions relate to the pain involved in the process of grief and the efforts to avoid the pain: "I don't want to think about him/her as a dead person, it's too painful." Discomfort anxiety is most relevant to dysfunctional grief.

There is a link between the fear of forgetting the decreased (I must not forget him/her or else I am worthless, I can't forget him because I will betray him) and the pain that is involved in the process of grief.

Some bereaved view the pain as a way to remember the deceased (if I have a pain I am faithful to him/her, being faithful helps remembering). Others use the memories as a way to avoid the pain: Keeping the deceased as if he/she is alive, not thinking about him as dead helps decrease the pain.

Unlike other types of anxiety-related to grief, discomfort anxiety is associated with the pain involved in grief (Sanders, 1989) and the interpretation that the pain accompanying loss is unbearable and one can't stand the pain.

Pain is an unavoidable experience following loss through death, especially a sudden one. The natural human response when facing pain is an effort to avoid the pain. In bereavement as in other situations, avoidance of the pain may result in panic attacks (Kleber & Brom, 1992) but has the element of the dead person. Avoidance of accepting the reality of the loss enables "as if" thoughts: as if he/she hasn't died. On the rational level the bereaved knows that the person has died but there is a continuing thinking on another level—irrational one—that the dead is here. Whenever there is an external reminder of his/her death (and usually there are at least a few such reminders) anxiety follows.

The following is a case illustration of the circular chain of thoughts maintaining avoidance and resulting in panic attacks.

A CASE ILLUSTRATION

A woman in her late forties lost her son eight years prior to coming to therapy because of panic attacks. The son was killed during his military service.

She recalled that when the news of his death was brought to her she was given an injection for fear of fainting; as a consequence very few details of the event were remembered by her. Grief process was accompanied by tranquilizers and she has been using them ever since. She tries to cut down the use of pills but whenever she does so she can't fall asleep, sleep is disturbed, she wakes up with pain in her chest and a feeling of choking. Her referral for therapy coincided with the son's memorial day which is a very difficult time for her. For that reason she decided to seek professional help.

The woman described her yearning for her son and when talking about him, she referred to him in the present tense as if he was still alive.

Her family has tried to talk her into reducing her participation every year in the memorial service into just one, but she insisted that she had to go to all three (local, regional and national) because she owed it to her son she couldn't, therefore, betray him.

The therapist's hypothesis was that the loss of the son had been so traumatic and involved fears (those of the woman as well as her relatives) that she wouldn't be able to withstand the pain, thus leading to the efforts to reduce the pain through the use of medication which resulted in increasing efforts to avoid the pain. The pattern of avoidance that developed was threatened each memorial day and the fear of the pain intensified.

The woman said: "When I think of him as dead it's too painful, and that is why I avoid thinking about him as somebody who died. He is here, I talk to him, tell him things. I know he is dead . . . . but I pretend he isn't. When somebody (like you) says that he is dead—I panic."

TRAUMATIC A (death of son) → B1 → SHOCK

COPING/EFFORT

	Dysfunctional		Functional
irB2	It's horrible, it shouldn't feel so painful.	RB2	Pain is normal
C2	More pain		

A3	More pain	C2	Pain frustration
irB3	If I don't admit he is dead it will be less painful.	RB4	I know he is dead and it makes me very sad
C3	Avoidance		
A4	Avoidance	C3	Grief
irB4	I shouldn't forget him but I shouldn't suffer.	RB4	Although I know he is dead I still remember him, it's painful but I can stand it.

CONCLUDING REMARKS

Grief as a normal human response to loss through death has been well documented. A cognitive perspective takes into account the various normal stages of grieving with special emphasis on the bereaved thoughts and cognitions over an event that he/she had no control over, an event that because of its traumatic nature is most likely to increase the human tendency to think irrationally. The interaction between the event, thoughts and emotional consequences in grief was reviewed and related to functional and dysfunctional courses of grief. REBT, like other therapies, emphasizes the healing effect of grief and distinguishes it from depression. REBT with its focus on psychoeducational interventions was demonstrated as effective not only in prolonged dysfunctional grief, but also during the acute phase, with the aim of normalizing the grief process and facilitating a healthier course of an inner "battle" to reconstruct a new meaning to a reality that has changed forever.

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