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# Complicated Grief Treatment: An Evidence-Based Approach to Grief Therapy

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**Abstract** Complicated grief is a condition that occurs when something impedes the process of adapting to a loss. The core symptoms include intense and prolonged yearning, longing and sorrow, frequent insistent thoughts of the deceased and difficulty accepting the painful reality of the death or imagining a future with purpose and meaning. Complicated grief can cause substantial distress and impairment and it is important that clinicians learn to recognize and treat this condition. Complicated grief treatment is a 16-session evidence-based psychotherapy developed to release and facilitate a bereaved person's natural adaptive response. The current paper clarifies the conceptual underpinnings of this approach, provides a description of the major treatment components, structure of each session, and suggestions for how clinicians can use the treatment to help clients suffering from complicated grief. A case example is also included to illustrate this discussion.

**Keywords** Bereavement · Loss · Complicated grief · Psychotherapy · Treatment

## Introduction

Bereavement is one of life's most difficult experiences yet most people find ways to adapt to even the most painful loss. Research over the past few decades indicates that the adaptation process can sometimes go awry. However because grief-related distress and impairment in functioning can continue over a prolonged period there is continuing debate about when and how to identify maladaptive grief reactions.

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Holly Prigerson has led an effort to define a syndrome characterized by grief that is inordinately prolonged and intense (Prigerson et al. 1995). Based on her valid reliable method for identifying this syndrome, our group developed and tested a treatment that we named complicated grief treatment (CGT). This paper describes CGT and suggests a clinical approach to recognizing people who might benefit from this approach. A case example is included to illustrate this discussion.

Complicated grief treatment (CGT) has now been tested under 5 NIMH-funded grants including an initial study published in 2005, a second study targeting older adults published in 2014 and a third, multicenter collaborative study recently completed and submitted for publication (Shear et al. 2001, 2005, 2014). Dr. Julie Wetherell, an experienced CBT researcher, served as a therapist and supervisor for the collaborative study. She independently published a useful outline of our CGT manual with comments from her perspective (Wetherell 2012). The current paper builds on her excellent publication and is structured similarly. In addition it clarifies conceptual underpinnings of CGT, provides a description of the treatment model and aims, a summary of major treatment components and suggestions about how these can be used by clinicians. These additional elements as well as further clarification of treatment procedures should be helpful to therapists.

## Background

The central premise of CGT is that bereavement is a universal life event and that grief and adaptation to loss are natural inborn responses. Notwithstanding this universality each close relationship is unique and correspondingly, so is each grief experience. The elements of grief are shaped by who we lost and what that relationship meant to us. We grieve differently for each person we lose. Grief is also shaped by who we are, by our prior experiences and by the world in which we live. The common dictum "we all grieve in our own way" is clearly true. Nevertheless there are commonalities in grief including its core components and its eventual transformation. More specifically, grief almost always contains elements of yearning, longing and sorrow and thoughts and memories of the person who died and the quality and intensity of these thoughts and feelings change as we adapt to the world without our loved one (Shear 2015).

Acute grief is often intense and highly emotional, dominating our minds and disrupting our lives. Over time the intensity usually attenuates as we come to accept the unwanted reality, reorganize our internal relationship to the person who died and envision ways to live a fulfilling life in a world without them. Acclimating to a loss is facilitated by effective emotion regulation, commonly achieved by finding a balance between confronting the painful reality and setting it aside, by practicing self-compassion and by attending to self-determination needs of autonomy, competence and relatedness. A balance of solitude and openness to comfort from others also facilitates coming to terms with a loss. Adaptation goes on both in and out of awareness, fueled by ever increasing understanding of our loved one's absence. Adapting to a loss does not change the reality of the loss but it does change the quality of grief. The permanence of death is mirrored by the permanence of

grief. We never forget our loved ones nor do we fully stop wanting them or feeling sorrow that they are gone. However the form and intensity of our yearning and sorrow usually evolves and matures over time as grief seeks its rightful place in our lives. This usually means that thoughts and feelings about the loss decrease in frequency and intensity.

Complicated grief is a condition in which manifestations of grief continue to dominate a person's life because something impedes the process of adapting to the loss (Shear 2012). Complicating thoughts, feelings and/or behaviors (Eisma et al. 2013; Boelen et al. 2015) interfere with the process of accepting the reality of the loss, redefining the relationship with the deceased person or envisioning a meaningful future (Maccallum and Bryant 2011). This kind of interference commonly occurs when a bereaved person gets caught up in counter-factual, self-questioning second-guessing thoughts, or spends n excessive amount of time in efforts to escape from the painful reality, such as daydreaming or excessive focus on hearing, seeing, touching or smelling things to feel close to the deceased can make it difficult to revise the relationship to the deceased. Excessive avoidance of reminders of the loss can also do this. The central premise of CGT is that a natural adaptive process is present in people with complicated grief but is being blocked. The overarching goal of the treatment is to release and facilitate the bereaved person's natural adaptive process (Shear 2015).

The knowledge base on which CGT is built includes findings from bereavement research (Stroebe and Schut 1999; Bonanno and Kaltman 1999; Bonanno et al. 2005; Neimeyer 2012; Neimeyer et al. 2014) as well as empirically supported principles from attachment theory (Bowlby 1982; Mikulincer and Shaver 1998; Mikulincer et al. 2011), positive psychology, self-determination theory (Ryan and Deci 2000), psychological immunity (Gilbert and Wilson 2000), self-compassion (Neff 2009), self-psychology(Aron et al. 1992; Chen et al. 2011), and learning theory (Tye et al. 2010; Sun et al. 2011). In addition, we use strategies and procedures from other evidence-based psychotherapies (CBT (Malkinson 1996; Foa and Rothbaum 1998), IPT(Weissman et al. 2000), MI (Miller and Rollnick 2002), EFT(Greenberg and Paivio 1997), positive psychology (Aschbacher et al. 2012; Folkman and Moskowitz 2000) modifying them to address the targets of resolving complications and facilitating adaptation.

## Overview of CGT

CGT is a structured intervention that is typically administered in 16 weekly sessions organized in four phases: (1) Getting started, (2) Core revisiting sequence, (3) Midcourse review and (4) Closing sequence. The therapeutic stance in CGT is one in which we acknowledge companionship that derives from the shared human experience of loss and grief. We consider grief to be the form love takes when someone we love dies and we honor its myriad forms and waxing and waning intensity as it seeks its rightful place in a bereaved person's life. The therapist serves as a Sherpa-like guide who accompanies clients as a companion as they grapple with accepting the finality and consequences of the loss, establishing meaningful continuing bonds with the deceased and finding a "new normal" in which happiness

is again possible. The therapist contributes knowledge of the terrain of loss and grief and the ability to design pathways, recognize obstacles and provide tools and resources to aid in the journey. In serving these functions though, the therapist is cognizant of the need for the client to find her or his own ways of moving through the adaptive processes and the therapist intervenes only when necessary. People with CG feel lost, confused and exhausted by unfamiliar and uncontrollable feelings and an inability to imagine a future with any possibility of happiness. They are relieved when they find a therapist who is open and present to their unique story of love and grief, understands the commonalities in grief and provides a sense of hope comforts them. Given this orientation, treatment sessions are designed to be present with clients as they confront the painful reality, to encourage them to spend some time focusing on the future in a positive way, and to monitor and support clients' progress, most of which takes place outside of the session. Planning activities for the upcoming week is an important focus of the session as is motivating the client to do these. Generally what clients do during the interval between sessions is more important than what they do in the sessions.

CGT is a structured approach. We do not sacrifice empathy or the importance of bearing witness to sorrow, but we offer a structure for understanding grief and adaptation to loss. We gently guide and direct the attention of the bereaved person to a series of exercises that can help them move forward. We structure sessions such that each includes a review of the past week, a focus on some aspect of the loss, a focus on some aspect of restoration of a meaningful future, and a summary and plan for the upcoming week. Administration of CGT is intended to be personalized to meet individual needs. The best way to deliver this treatment is to find a middle ground in which you are neither following exactly the highly specified session outlines in the treatment manual nor ignoring session instructions to focus solely on tracking the individual person. The case example provided in this paper includes illustrations of some ways to do this.

There are seven core components of CGT including three thematic components interwoven into four procedural ones. Thematic components include: (1) sharing information, (2) promoting self-observation and self-regulation and (3) rebuilding connection. Procedural components include (1) advancing aspirational goals and rewarding activities, (2) revisiting the story of the death, (3) revisiting a world changed by loss and (4) fostering continuing bonds through living memories.

Thematic components are introduced during the phase we call "Getting Started". Session 1 is focused largely on inviting the bereaved person to talk about her or his own life, relationship with the person who died and grief since the loss. Self-observation is introduced at the end of session one in the form of a grief monitoring diary and this is continued throughout the treatment. Session 2 is largely focused on providing information about love, loss and grief to the client. In Session 3 we begin the process of rebuilding connections by encouraging the client to invite a close friend or family member to join the session and exploring the possibility that this person might serve as a confidant and companion in grief.

Aspirational goals work begins in Session 2 and continues throughout the treatment. Session 4 begins the core revisiting sequence by introducing our imaginal revisiting exercise in which the client and therapist review the story of learning

about the death. Session 5 begins work on avoidance of reminders of the loss that entails plans to confront these in a graded manner. Session 6 begins a discussion of memories of the person who died and Session 11 or 12 includes an imaginal conversation with the deceased. Taken together these procedural components foster acceptance of the finality and consequences of the loss, elaboration of a continuing bond to the person who died and consideration of ways that ongoing life might have possibilities for joy and satisfaction. The remainder of this paper is a session-by-session overview of CGT and a case example.

## Getting Started: Sessions 1–3

The objectives of this introductory phase are to (1) Establish a companionship alliance, (2) Understand the client's loss in the context of their life history, (3) Provide information about CG and CGT, (4) Begin grief monitoring and weekly plans, (5) Begin work on personal aspirational goals and (6) Meet with the client and a significant other

### Session 1

The session begins with introductions, including a brief introduction of the therapist that fosters a sense of companionship. Then the therapist sets an agenda that include an overview of the client's important relationships including a brief discussion of early family relationships and current close relationships. The agenda also includes a brief discussion of important interests and achievements in the client's life and currently. The remainder of the session focuses on the relationship with the deceased, the story of the death, and the client's experience of grief. We suggest using a set of questionnaires available at www.complicatedgrief.columbia.edu as a part of the review of grief. The session ends with a brief summary of highlights by the therapists, feedback from the client and introduction of the grief monitoring diary and the CG handout.

*Weekly plans* Activities for the week include daily grief monitoring (diary available through the center for complicated grief) and reading and reflecting on the CG handout.

### Session 2

The session begins with a review of the past week and setting of an agenda. Review of the grief monitoring diary (GMD) is brief and entails only noticing when grief was high and low. The main purpose of this instrument is to encourage self-observation and reflection and to help clients observe the natural ebb and flow of grief intensity. The therapist then initiates a discussion of love, loss and grief and describes the idea of CG as the condition that results when something impedes the natural adaptation to loss. This discussion is conducted in a collaborative and

companioning manner that includes provision of a personalized formulation (see Fig. 1 for an example of the formulation for Grace). The session moves to a discussion of the goals, procedures and rationale for CGT. About 10 min before the session ends, the therapist shifts gears and asks the client to imagine what s/he would want for herself if her grief was at a manageable level. They discuss this for a few minutes and end the session with summary highlights, feedback and plans for the upcoming week.

*Weekly plans* Activities for the week include daily grief monitoring and continued work on aspirational goals.

## Session 3

This session is held with a significant other. The goals are to get another perspective on the client's situation, to be sure that the visitor understands how we see CG and what the treatment entails and has a chance to ask questions and to begin the process of increasing a sense of connectedness to important people in the client's life. After welcoming the visitor and setting the agenda, the therapist asks the client and her friend or family member to discuss their relationship. Then the therapist asks about any observations the visitor might have about the client before and after the death. The therapist summarizes what s/he learns and then shifts to provide a brief version of information about CG and CGT in order for the client's friend to understand how we see the client's grief and how we are going to try to help, including a consideration of some ways the visitor might be helpful. The therapist summarizes and thanks the visitor and then asks to meet alone with the client. In a brief follow-

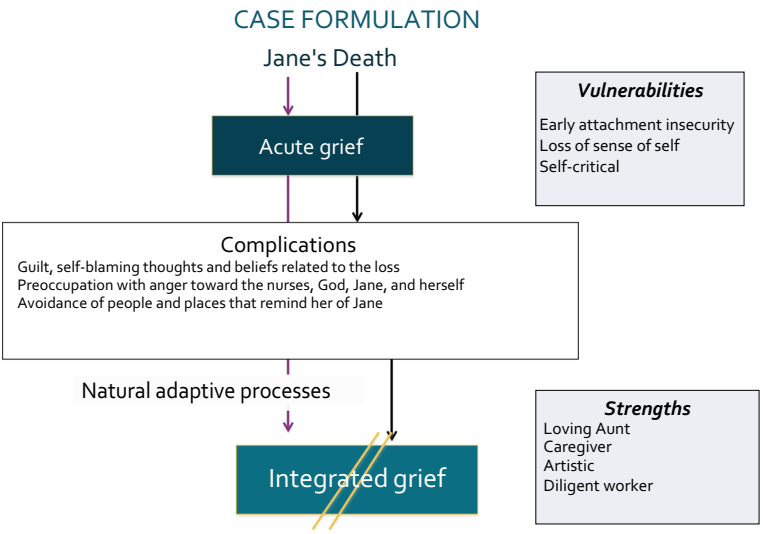


**Fig. 1** The CG formulation as it applies to Jane

up meeting the therapist thanks the client for bringing this person and asks the client how they thought the session went. The discuss this very briefly and then briefly review GMD and aspirational goals work and make plans for the upcoming week.

*Weekly plans* Activities for the week include daily grief monitoring and continued work on aspirational goals and making notes about things they want to mention about the session with the visitor.

## Core Revisiting Sequence: Sessions 4–9

The core revisiting sequence includes focused work on accepting the loss, introduction of work with continuing bonds and continued work on finding a satisfying "new normal." Sharing information, self-observation and self-regulation and rebuilding connection are continued throughout this phase as is aspirational goals. Imaginal and situational revisiting and memories work are introduced. The revisiting exercises are designed to bolster capacity to reflect on the death and to help integrate this focal event into the past and future relationship with the deceased. People with complicated grief, like the rest of us, need to come to terms with the fact that all life ends with death, and in this sense, death is an integral part of life. As such, unwanted as it is, death is as much to be honored as are the many human faults we come to accept and even treasure in those we love.

When revisiting is successful, clients begin to find a way to think about the death of their loved ones while continuing to live their own lives fully. However reflection is never completed after a loved one's death. We all grapple with the meaning of death throughout our lives. As we do so, we naturally revisit and revise our understanding of the death of our loved ones. The goal of CGT is to release this natural process from the stranglehold of complicating thoughts, feelings, and behaviors.

In summary, goals of the core revisiting sequence are to (1) Reduce behavioral and experiential avoidance of reminders of the loss, (2) Decrease the emotional impact of the story of the death and help the patient comprehend the painful reality, (3) Reflect on and resolve troubling aspects of the death, (4) Continue work to define and plan how to meet long-term aspirational goals and facilitate the experience of genuine positive emotions, and (5) Encourage re-engagement in ongoing daily life and relationships.

### Session 4

This session begins the core revisiting sequence. The session begins with agenda setting. The therapist encourages the client to reflect briefly on Session 3 and then move to a review of the grief monitoring diary and acknowledgment of continued goals work. Then the therapist shifts and introduces the imaginal revisiting exercise, describing the rationale and providing a detailed description of the procedure. The therapist describes the SUDS (Subjective Units of Distress) rating procedure, checks

the client's understanding of this as well as the rest of the procedure, and asks for any questions. Then the therapist starts an audio recording, checks SUDS level and invites the client to close her eyes and visualize herself at the time she first learned of her loved one's death. Continuing to visualize herself, she tells the story of what happened next. The therapist asks for SUDS level about every 2 min, without any further comments or discussion. After about 10 min the therapist stops the recording and asks the client to open her eyes and report her SUDS level. The therapist invites the client to reflect on the experience of telling this story. The therapist's own reflections are not included in the discussion at this point. After about 10 min the therapist concludes this exercise by checking SUDS level and doing another visualization exercise to put the story away. We ask the client to imagine that the story she just told is on a videorecording. We ask her to visualize herself putting the recorder into the machine, pushing the rewind button, listening to the tape rewind, then stopping, ejecting and putting the cassette away in a safe place. The session moves to a discussion of rewarding activities and aspirational goals work and concludes with a brief therapist summary of the session, client feedback and discussion of interval plans.

*Weekly plans* Activities for the week include continued daily grief monitoring, aspirational goals and plans for listening to the recording of the revisiting exercise followed by doing a rewarding activity.

## Session 5

Session 5 goals are to (1) Review grief monitoring, (2) Continue imaginal revisiting, (3) Introduce the situational revisiting list, (4) Discuss aspirational goals and (5) Continue weekly activities. The session begins by setting the agenda followed by a brief discussion of grief monitoring, a review of the client's experience listening to the imaginal revisiting tape, doing a second imaginal revisiting exercise, introducing situational revisiting, discussing aspirational goals and planning for the upcoming week. The therapist problem solves any difficulties with the imaginal revisiting exercise and aspirational goals work in a way that feels safe and supportive.

The second revisiting exercise is a simple repetition of the first and often illustrates how the story changes with repetition. Some things are emphasized, fleshed out or clarified, while others are mentioned less. Strong emotions typically lessen sometimes replaced by spikes in other places in the story. The period of reflection may also be different as the client begins to notice and process different aspects of the experience. While such change is common, it is not necessary for the exercises to be effective.

In this session therapist re-introduces situational revisiting, repeating the rationale explaining that the desire to avoid is understandable when a situation triggers painful reminders that the deceased is gone. However, extensive avoidance undermines the ability to come to terms with the death and its consequences and restricts the possibilities for finding fulfillment in ongoing life. It is more difficult to restore interest in other people and situations if a person is focused on not going to

certain places, doing certain things or being with certain people. The therapist explains that we start by listing people, places or situations the client is avoiding and rating the degree to which each would trigger grief using a 0–100 scale. The Grief Related Avoidance Questionnaire can be used to facilitate this discussion. The client rates an example situation and the therapist discusses this. The session moves to a discussion of aspirational goals followed by a summary of session highlights, feedback from the client and discussion of weekly plans.

*Weekly plans* Activities for the week include continued daily grief monitoring, aspirational goals, plans for listening to the recording of the week 5 revisiting exercise followed by doing a rewarding activity and generating a situational avoidance list.

## Session 6–9

Goals for these sessions are to similar to session 5 and include, discussion of grief monitoring, continued work on imaginal and situational revisiting, aspirational goals and weekly plans. Memories work is also added beginning with session 6. Specific work in any of these areas is dictated by the client's interest and progress.

Imaginal revisiting continues to focus on the same story. If distress levels remain high after 4 repetitions (by session 7) one of two possible modifications can be helpful. If there is a particular place in the story that remains highly activating (sometimes called a "hot spot") the client visualizes and describes just that moment of the story and without opening her or his eyes, repeats this 3 or 4 times in rapid succession. Doing the exercise in this way usually brings distress levels down pretty dramatically and this can be disconcerting to people so this procedure should be used judiciously. The other modification is used when distress levels are not coming down between sessions, the client is not listening to the recording or is not reflecting on the story. In this case, it can be helpful to do the imaginal revisiting exercise procedure just focused on reflection or problem solving, omitting the visualization and telling of the story. When this is done, the therapist needs to return to a full revisiting exercise in a subsequent session.

Situational revisiting progresses during these sessions by reviewing the hierarchy list and selecting an activity or situation that is feasible to do repeatedly and getting the client's agreement to do this multiple times during the week—ideally every day. The activity chosen is one in which the distress level is in the range of 40–60. The experience with situational revisiting is discussed in each session and a new exercise is planned for the upcoming week.

Aspirational goals work ideally focuses on a specific long term project or activity that is usually not achievable before the end of the treatment. The first few sessions focus on helping the client decide on such a project. The focus then shifts to a discussion of how the client will know they are making progress on this goal, how committed they are to achieving it, what might stand in their way and who can help them. Each week progress on the project is discussed and new plans made.

Session 6 introduces a discussion of specific memories of the deceased using a series of 5 memories worksheets that are introduced sequentially over sessions 6–10. These worksheets include stimulus questions to elicit warm and favorite memories as well as memories of difficulties. The therapist works with these in the session by simply reading through the responses and commenting briefly.

*Weekly plans* Activities for the weeks between sessions 6-10 include continued daily grief monitoring, aspirational goals, plans for listening to the recording of the revisiting exercise done in that session followed by doing a rewarding activity, situational revisiting exercises and completing memories worksheets. This is a significant time commitment on the part of the client that is intended to be so, following the principle that interference in ongoing life is an important motivator for adaptation.

## Midcourse Review: Session 10

The third phase of CGT consists of taking reviewing progress to date and planning the closing sequence. This usually means finishing up work that has been ongoing. Sometimes though it makes sense to shift to work on a second loss or to shift to a current interpersonal conflict or role transition using a brief IPT approach. For example, the therapist might complete an interpersonal inventory and stage an interpersonal dispute. Additional details about procedures used to address these interpersonal issues can be found in Markowitz and Weissman (2004). The remainder of this paper focuses only on the situation in which the closing sequence continues ongoing work.

To facilitate the midcourse review, the therapist returns to the formulation developed in session 2, revises this if necessary and estimates progress in reaching the overall objectives of resolving grief complications and facilitating adaptation. The review is guided by the following questions: what are the complications (thoughts, feelings or behavior) that have impeded adaptation? How well have these been addressed so far? What has helped? What has changed? What work remains to be done? How successful has work with aspirational goals been? What about imaginal and situational revisiting? The answers to these questions are developed by both a discussion with the client and a review of questionnaires.

Based on the review the therapist and client work together to decide how best to spend the remaining sessions. The work usually includes a continued focus on both goals and situational revisiting. In some cases imaginal revisiting is continued or possibly just reflection on problems that remain in coming to terms with the loss. An imaginal conversation is planned for the final phase. Grief monitoring and other interval plans continue as before.

*Weekly plans* Activities planned at week 10 include continued daily grief monitoring, aspirational goals, situational revisiting exercises and completing the final memories worksheet.

## Closing Sequence: Sessions 11–16

Strategies and procedures for these sessions are more flexible than for earlier ones with plans based upon results of the session 10 review. Each of the loss-focused exercises from sessions 4–9 can be used in this phase. The choice of which to employ is based on the decision about the focus of treatment. The closing sequence includes Memories Form-5 in which the patient is asked to recall both positive and negative memories. Session 11 and/or one of the later sessions also entails an imaginal conversation with the deceased person. Under some circumstances, when clinically indicated, the imaginal revisiting is continued into this phase and the conversation is delayed. Another variation is to repeat the imaginal conversation in more than one session in the closing sequences. Each session in the closing sequence also includes a discussion of ending the treatment.

### Sessions 11–15

Goals for the closing phase sessions are to (1) discuss the Grief Monitoring Diary, (2) discuss thoughts and feelings about ending treatment, (3) do an imaginal exercise as indicated (revisiting or imaginal conversation), (4) discuss situational revisiting, (5) discuss aspirational goals work and (6) discuss weekly plans. In addition the final memories worksheet, including positive and negative memories, is reviewed in session 11.

The approach to discussion of termination in CGT follows an IPT role-transition approach. The discussion centers around: (1) ways in which the therapy has been supportive and helpful and feelings about losing this helpful support, (2) what has been difficult, e.g. time required, travel and other inconveniences, ways that the therapy has been difficult and time consuming, other things that may have been distressing or problematic, (3) problems the person foresees in the future, including managing difficult times and other problems that the patient may anticipate and (4) opportunities and positive aspects of ending the treatment, including having more time, having the opportunity to test new learning and develop a sense of confidence in having assimilated something new that remains even when the meetings with the therapist are over. The discussion follows the patient's lead, but generally proceeds from (1) and (2) above to (3) and (4). Positive aspects of the future without the therapy is generally introduced at session 15 and discussed at session 16.

Calendar dates that trigger surges in grief intensity are difficult times for bereaved people. Discussion of difficulties the patient foresees in upcoming months and years includes anticipation and planning for difficult times. The patient is given the Difficult Times handout in session 12 so that this can be discussed in sessions 13 and following.

The imaginal conversation is the final core CGT procedure. The therapist invites the client to imagine that s/he is with her or his loved one not long after the death. The client imagines that s/he knows the person has died, but that s/he can speak to the deceased person and s/he can respond. The client tells or asks their deceased loved one anything s/he wants. After speaking for about 5 min, the client pretends

s/he is the loved one and answers. Then, s/he can become her or himself again and respond to that answer. This "back and forth" conversation, conducted entirely by the patient, should go on for about 15–20 min. Tell the client that just as with the Revisiting exercise, you want her or him to try to visualize their loved one in the room. You want them to imagine that they are really talking with them and imagine how their loved one would really respond, even though this exercise is imaginary. After completing the exercise the therapist invites the client to reflect on this experience.

Each session in the closing sequence has a similar structure to the rest of the treatment, beginning with setting an agenda and reviewing the grief monitoring diary. There is generally some loss-focused activity followed by a restoration-focused activity and ending with a summary of highlights, feedback and planning for the upcoming week.

### Session 16

The final session is a wrap up of the treatment that includes a summary of CGT principles, goals and procedures, and discussion of how the client understood and used these. There is a discussion of what has been accomplished and what remains, as well as any thoughts and feelings about ending treatment and plans for the future. Grief Monitoring and Goals work are continued in session 15 and reviewed for the last time in session 16. Situational revisiting may be continued in session 15 and reviewed for the last time in session 16.

The therapist reviews with the client what she has learned in the treatment and notes progress on loss-related and restoration-related issues. The therapist also helps the client identify and deal with any feelings, both positive and negative, about ending the treatment and about the future. Plans for using and managing these feelings are discussed. Plans are also discussed for continued work on personal goals and on any other component of the treatment that is not fully completed. Termination can sometimes evoke feelings of loss that can trigger grief. This usually emerges on the Grief Monitoring diary. If grief intensity rises in the last few sessions in relation to termination of the treatment, this becomes an opportunity to illustrate how different loss experiences may trigger grief about her lost loved one. Knowing that this is a natural process and that it does not indicate "unfinished business" can be very helpful.

The final session is used as an opportunity for the therapist to summarize and comment on her or his view of the treatment and the progress the client has made. It is useful to summarize again the CGT model and the individual formulation and to discuss how the client has or has not yet come to see things a little differently. It is important to summarize the client's strengths. Plan to give some examples of how the client used her strengths in the treatment and also some concrete ways these could be useful to her in the future. The session ends with a genuine statement of the therapist's positive feelings about working with the client, information about availability in the future, and saying good-bye.

## Case Example

Jane was Grace's older sister and her best friend, for as long as she could remember. As a child, Jane was Grace's idol. Her 5-years older sister always seemed like everything Jane wanted to be. Their mother, repeatedly hospitalized for severe depression, was not very available. Their paternal grandmother, a kind woman who did not live with the family, did her best to fill in. However, as an immigrant who did not speak English, she struggled to contain her energetic grandchildren. Though only Jane married and had children of her own, Grace and Jane remained close, and talked on the phone at least twice a day. Jane had done better in school and had a more successful career, but Grace had better instincts as a mother. She was also more artistic. Jane's children loved their aunt. As a result, it was Grace who helped Jane manage problems she had with her middle child. Grace was the confidant Jane turned to when she learned that her husband was having an affair. They got through that together, difficult though it was. Grace encouraged Jane to stay with her husband Rob for the sake of the children. Then Jane learned that she was HIV positive. Grace was panic-stricken. She said it felt like she couldn't breathe—like her life was slipping away.

Grace went with Jane to every doctor's appointment and watched helplessly as her beloved sister's illness worsened. During her final hospitalization, Jane was heavily medicated, and had episodes of confusion and paranoia. Grace, sleep deprived and distraught herself, finally decided to follow the nurses' advice and use a day bed available to her in Jane's room to get some sleep. When she awoke after about 3 h, they were alone in the room and Jane was sleeping fitfully. Her breathing seemed irregular. Grace thought something didn't look right and decided to go find a nurse. The nurses were in their morning report and could not be interrupted. Grace waited, thinking to herself that she did not know how much more of this she could take. When the nurses finally finished, one of them accompanied Grace into Jane's room. They found her very still. She had stopped breathing. Her eyes were open, and Grace thought there was a look of fear on Jane's face. Grace cried out, "NO" and collapsed on the chair by Jane's bed. She covered her face and began to sob, "No" she said again, "No. No. No." If Jane's life had ended, Grace's own life was over too.

Four years later, her sister's death remained as fresh to Grace as the week after it happened. Her mother convinced her to seek help after Grace again refused to celebrate Thanksgiving with the family. Whenever she thought about Jane's death, she would feel a profound sense of dread and remorse. She had not been at her sister's side during those last moments, and she feared Jane felt abandoned and alone. Grace alternately blamed herself, the nurses, Jane or God for the fact that Jane had died when Grace was out of the room. She still spent hours mulling over the reasons she was not there and telling herself she had a valid excuse, only to find herself besieged with angry self-criticism when she encountered a fresh reminder of her sister. She was similarly preoccupied with trying to rationalize her anger toward the others. She became convinced she would feel very differently about the death if only she had held her beloved sister's hand as she passed. No one could dissuade her

of this idea and her friends and family, feeling helpless and frustrated, had stopped trying. Grace functioned best at her job as the buyer in a children's clothing store. The only time she could distract herself from the longing she felt for Jane and the insistent self-criticism was when she was working. Evenings and weekends she spent isolated at home as it seemed that almost anywhere she went and anyone she socialized with would remind her of Jane. Nothing dissuaded her from what she perceived to be reality—that her life had ended with Jane's. Grace felt badly about letting her friends and family down, but she saw no way to be herself again. She agreed to participate in CGT because her mother begged her to do so. She had little hope that the treatment—or anything else—could possibly help.

Grace attended her first CGT session reluctantly. A friend had found our website and suggested she might try it. She said she wanted her mother to "get off my case" and also said she knew she needed to get past this loss but in her heart she really felt it was not possible unless the therapist could bring Jane back. The therapist did not dispute this and said only that it was not surprising to her that Grace was feeling so discouraged. She said that she (the therapist) nevertheless felt hopeful for Grace and that one of her jobs was to carry hope for clients until they found that they could take some of it on themselves. They spent the session getting to know one another, primarily talking about Grace, her relationship with Jane and her intense grief. The therapist also made sure she asked Grace to talk about herself and the things she (and Jane) most admired. At the end of the session Grace had the thought that she might have a new friend. Before she left, the therapist introduced the idea of planning activities between the sessions and asked her to start keeping a grief monitoring diary. The therapist also gave Grace a Handout explaining love, loss and grief and asked Grace to consider inviting someone to come to session 3.

Grace had trouble completing the grief monitoring diary. She said she did not like paying attention to grief and also found it hard to put a number on her grief. With an edge in her voice she reminded the therapist that she had because she was paying too much attention to her grief, not too little. However, she also said that she found the Handout fascinating. The part about how grief was related love seemed new to her and very interesting. She thought the description of complicated grief fit her very well. She was not so sure about some of the plans for the treatment. The therapist accepted Grace's comments about the diary and said she understood that doing this might seem a little counter-intuitive. She also said that its not unusual to be uncomfortable with the diary but in her experience once people get used to doing this monitoring they often find it very interesting and helpful. Grace agreed to keep trying to do it. Then they talked about the CG model of acute and integrated grief and the kinds of things that complicate grief. The therapist showed Grace a picture of the model and identified her grief complications as "if only" thoughts—blaming herself and others for how and when Jane died and her isolation and avoidance of reminders of her loss. These issues were also making it much more difficult to regulate the very natural feelings of yearning, sorrow and anxiety that kept surging and making Grace feel so out of control. Then the therapist explained that the treatment is designed to help activate and strengthen her own healing processes. She told Grace about the core CGT procedures and discussed Grace's reservations about these. Then she asked to shift gears and invited Grace to do an exercise in which she

imagined that the therapist could wave a magic wand and her grief was at a manageable level and to think about what she would want for herself. Grace was silent for a few minutes. Then she said she really wasn't sure but when Jane was so sick and Grace would sit with her while Jane slept, she had started to think about making jewelry. In fact she had gone as far as buying some beads and silver. Now she was thinking she would like to take some classes and start making jewelry. She said her real dream would be to get good enough to sell it. The therapist said this sounded very interesting. She asked Grace to think about how she would know if she was making progress toward achieving this goal, how committed she was to this idea, what could stand in her way and who could help her with it.

Grace's mother Audrey came to the third session. She was a quiet person who seemed sad and hesitant, but she also conveyed a feeling of warmth and there was no question about her love for daughter. She talked openly about her own struggles with depression when Grace and Jane were children and said that things have been much better for her in the last 10 years. She expressed regret that she was not more available to her daughters, but said that they had grown up to be lovely young women in spite of that. She said she was very proud of them. She also said she was very worried about Grace. Then she surprised them both by telling a story that Grace had never heard. When Audrey was 25 and Jane was a baby, Audrey had a best friend, Betsy, who was like a sister to her. Betsy had a brother who she loved very much. Her brother had broken up with a girl friend and Betsy had arranged a date with a girl she knew. Her brother died in a car accident on that date. Betsy was devastated and could not stop blaming herself. She wouldn't talk to Audrey about anything else and eventually stopped coming over. Three years after her brother died, Betsy took her own life. Grace was born shortly after this and Audrey became severely depressed. Audrey and her doctor had talked about this when she was hospitalized years ago and he had told her she needed to accept the fact that Betsy was gone and move on. He said she had two beautiful children and she needed to focus on them. Audrey had tried very hard to do this and so she never talked about it. Now, with Jane's death, it all came back. She said she thought she could understand how Grace was feeling but she didn't really know what to do to help. She did not feel that her doctor helped her deal with Betsy's death. She was thankful that Grace was getting the help she needed and very grateful that she was invited to come to the session and that she could finally tell Grace this story. Grace and her mother hugged as her mother left the session. She was tearful as she reflected on the session with the therapist and she thanked the therapist for encouraging her to invite her mother to come.

Grace was 10 min late for session 4. She wasn't sure if she was ready to talk about Jane's death. The therapist gently encouraged her to give this a try and Grace agreed. Her distress level was at a 9 as she began and quickly escalated to "100 on a scale of 1-10". She sobbed through much of the story but when she finished she said she felt relieved. She had been very worried about this session. Her grief level was still high, but she had a sense of accomplishment. She agreed to listen to the recording at home. She was able to get herself to listen twice during the first week. As planned, she and the therapist talked briefly after she listened the first time. Grace repeated the revisiting exercise weekly for three more weeks and her distress

levels fell noticeably. Without any direction from the therapist, she began to think differently about her sister's death. Her self-blaming thoughts diminished as did her thoughts of blaming the medical staff. She began to think about how sad it was that her sister became ill. For awhile she focused on her brother-in-law as the culprit but eventually started to think that what was really sad was the AIDS epidemic and all the beautiful people it had taken. After about 3 weeks she started reporting that her sadness had a different quality. In some ways it was stronger but it was also "sweeter" and at the same time she felt lighter. She began to feel some hope for the future.

Grace began to work on situational avoidance during the 5th session and she was diligent about doing what she and the therapist planned each week. The first exercise she did was to go shopping with Allyson a good friend who she had not seen much lately. They planned a route that took them past a restaurant where Grace and Jane often met for lunch. Over 3 weeks Allyson made herself available at least 3 days a week and Grace committed to walking past the restaurant the other days either by herself or with someone else. At the end of this time, Allyson and Grace had lunch together in this restaurant and Grace smiled broadly as she reported "I actually enjoyed myself at lunch!" She also started doing a lot of things she had been avoiding, including looking at pictures of Jane, going to the gym where they would work out together and spending time with Jane's family. She found each of these things difficult at first but also found she could do them and she felt better when she did. Her hope for the future continued to grow, especially because she was also making progress in her jewelry making lessons. In session 12 she wore a pair of earrings she had made and proudly showed them to the therapist.

Grace cried when she reviewed the memories worksheet with the therapist in session 7. She said she missed Jane so much, but she continued to work with the memories forms and by the 10 session, when she was asked about not-so-positive memories, she was able to laugh as she recalled how Jane would sometimes trick or bully her into doing something Jane wanted when they were little. Although she had made good progress, Grace felt uneasy about having an imaginal conversation with Jane when the therapist invited her to do this in session 11. Again, the therapist simply encouraged her gently to do this, reiterating that this was definitely Grace's decision. Grace closed her eyes and visualized herself at Jane's bedside right after she died. She told Jane that she was so sorry that she had to suffer in this way and she was especially sorry about not being with her at the moment she died. She hesitated and then said there were so many things she was sorry about. She began recollecting times she thought she had let Jane down. She hesitated again and said, "You know what really bothers me? It's the way I encouraged you to stay with Kevin even though we knew he was cheating on you. Why did I do that? Why didn't I realize I was putting your health at risk? If I had not encouraged you to stay, you might have left him and never gotten AIDS." Grace was crying now. The therapist suggested she take Jane's role and respond. Grace now spoke as Jane and said, "Gracie. Please don't be so hard on yourself. You were always my very best friend and really the person I loved most in the world, after my children. You were with me constantly after I got sick. Sometimes I thought you must be a saint. I don't know how you did it." She hesitated. "Gracie—you can't blame yourself for my

decision to stay with Kevin. For one thing, even if you did encourage me, it was still my decision with whatever risks were involved. Not only that, I could always count on you to help me think about my kids and that was so important. It was mostly because of them that you wanted me to stay with Kevin." She hesitated again. "There is one more thing. I know you had a hard time being around my family after I died. That made me so sad. I really want you to be part of their lives. I always did and not that I am not there, it is even more important. I really hope you will commit to being there for them". "Grace switched back to her own role". She was crying now. "Oh Jane. Of course I will do that. I am so sorry that I was a missing person for so long. I want you to know that I am very committed to being there for your children. I love them very much." The therapist asked her to open her eyes and they reflected on the exercise together.

Grace completed the treatment by finishing several more imaginal revisiting exercises and completing her first jewelry making class. She had signed up for another one and was making some plans to rent a studio with a woman she met in the class. Her mother was very supportive of her jewelry and she had made her mother a bracelet that she was wearing every day. She talked about how different she was feeling. She said her relationship with her mother had changed completely after the joint session when she learned about her mother's terrible loss. They had become closer than they ever were. Grace was also spending time every week with her sister's oldest daughter Lilly and had shared a lot of the CGT ideas and exercises with Lilly. Jane's birthday was coming up a few months after the last CGT session and Grace and Lilly and Audrey were planning to spend the day together. They were thinking of what they could do to honor Jane and take care of each other. Grace ended the treatment feeling enthusiastic about her life and her future. She thanked the therapist, saying she was so grateful. She said she never could have dreamed that things could be so much better.

## Summary and Conclusions

The efficacy of this treatment approach has been demonstrated in three clinical trials as well as several studies using a closely related treatment (Boelen et al. 2007; Wagner and Maercker 2007; Wagner et al. 2006; Asukai et al. 2011; Rosner et al. 2011; Acierno et al. 2012; Kersting et al. 2013; Barbosa et al. 2014; Bryant et al. 2014; Rosner et al. 2014; Supiano and Luptak 2014). In our first study CGT was more effective than standard Interpersonal Psychotherapy in relieving CG symptoms (Shear et al. 2005). In our second trial, we replicated these results in older adults whose mean age was 66 (Shear et al. 2014). In our third trial, results of which have been submitted for publication, CGT was again shown to be efficacious, with an average response rate of 70 % across all studies.

CG is a prevalent condition that has been reported in bereaved individuals worldwide. There is good evidence that it causes substantial distress and impairment. It is important that clinicians learn to recognize and treat this condition. Working with bereaved people can seem sad and hopeless so clinicians sometimes shy away from work with grief and fear burnout. It may seem

paradoxical, but therapists have often told us that learning CGT has been the most rewarding experience of their career. Knowing how to administer a short-term treatment that has a 70 % response rate is very gratifying and a powerful antidote to burnout. This paper has outlined our approach. More detailed instructions for CGT are available by contacting the Center for Complicated Grief www.complicatedgrief.columbia.edu.

**Compliance with Ethical Standards**

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