Utrecht University

15-7-2020

# *Emotional Problems After Traumatic Bereavement: Nature, correlates, and treatment*

**Paul Boelen**

Webinar

Australian Centre for Grief and Bereavement

July 15, 2020

## Content

- What is traumatic bereavement?
- Nature and prevalence of psychopathology
- Risk-factors for emotional distress
- Cognitive behavioural variables maintaining emotional problems
- Cognitive behavioural interventions

# Traumatic loss

*Tsunami, 2004, 230000 deaths*
*9/11 attacks, 2001, 3000 deaths*
*Utoya attacks, 2011, 77 deaths*
*MH17, 2014, 298 deaths*



*2018:*
*1829 deaths, suicide*
*129 deaths, homicide*
*678 deaths, traffic accidents*
*(Dutch population = 17 mljn)*

# Traumatic loss → Traumatic grief

Loss/
Losses

×


Acute disruption

Danger

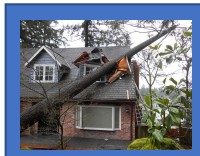
Helplesness

Randomness

Confrontation with “evil” people

Guilt/responsibi-lity

×



Stressful events in aftermath of loss(es)

- Legal consequences
- Responses from environment

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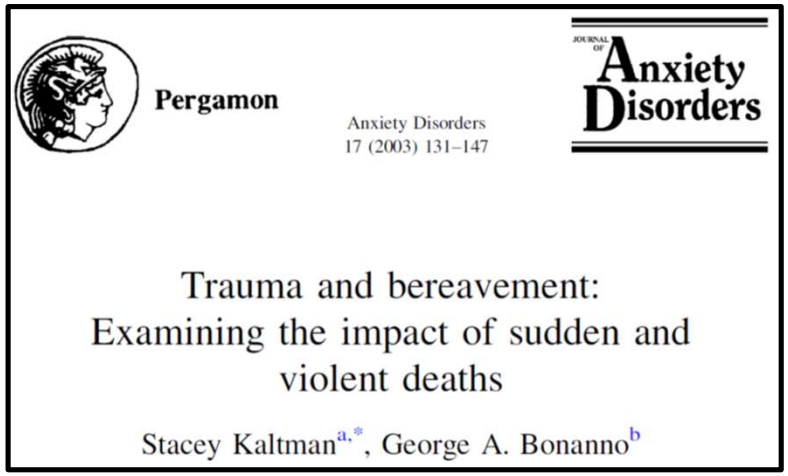
Prolonged grief disorder

Posttraumatic stress

Depression

# Violence or suddeness?



Pergamon

Anxiety Disorders
17 (2003) 131–147

Journal of Anxiety Disorders

Trauma and bereavement:
Examining the impact of sudden and violent deaths

Stacey Kaltman[a,*], George A. Bonanno[b]

PTSD and depression:

- More severe after suicide, homicide, accident then after illness

In people suffering loss to illness:

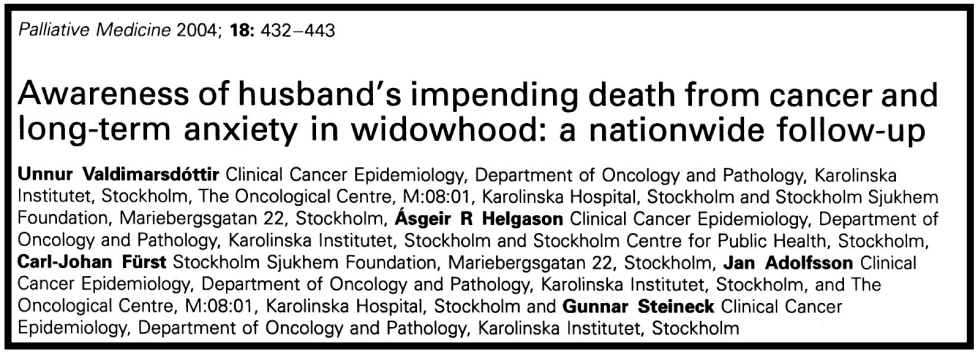
- Equal levels PTSD among those aware of loss on day of the death vs. those who anticipated the death

Women who lost partners due to cancer, diagnosed 2-4 years earlier

*"When did you realize that your husband/partner would die of the disease?"*

Result:

The shorter the "awareness time" the stronger the emotional distress following the death



*Palliative Medicine* 2004; **18:** 432–443

**Awareness of husband's impending death from cancer and long-term anxiety in widowhood: a nationwide follow-up**

**Unnur Valdimarsdóttir** Clinical Cancer Epidemiology, Department of Oncology and Pathology, Karolinska Institutet, Stockholm, The Oncological Centre, M:08:01, Karolinska Hospital, Stockholm and Stockholm Sjukhem Foundation, Mariebergsgatan 22, Stockholm, **Ásgeir R Helgason** Clinical Cancer Epidemiology, Department of Oncology and Pathology, Karolinska Institutet, Stockholm and Stockholm Centre for Public Health, Stockholm, **Carl-Johan Fürst** Stockholm Sjukhem Foundation, Mariebergsgatan 22, Stockholm, **Jan Adolfsson** Clinical Cancer Epidemiology, Department of Oncology and Pathology, Karolinska Institutet, Stockholm, and The Oncological Centre, M:08:01, Karolinska Hospital, Stockholm and **Gunnar Steineck** Clinical Cancer Epidemiology, Department of Oncology and Pathology, Karolinska Institutet, Stockholm

## Conclusions

- Violence is important feature of traumatic losses
- Subjective “suddenness” is important too (at least according to *some* studies)
- Implications: Important to increase cognitive, emotional, behavioural “preparedness” in terminally ill people and their family
- What is traumatic about traumatic loss differs from person to person.

  *In children? Anticipated deaths more distressing (Kaplow et al, 2014)*
- Clinical practice? Be aware of possible “traumatogenic” elements

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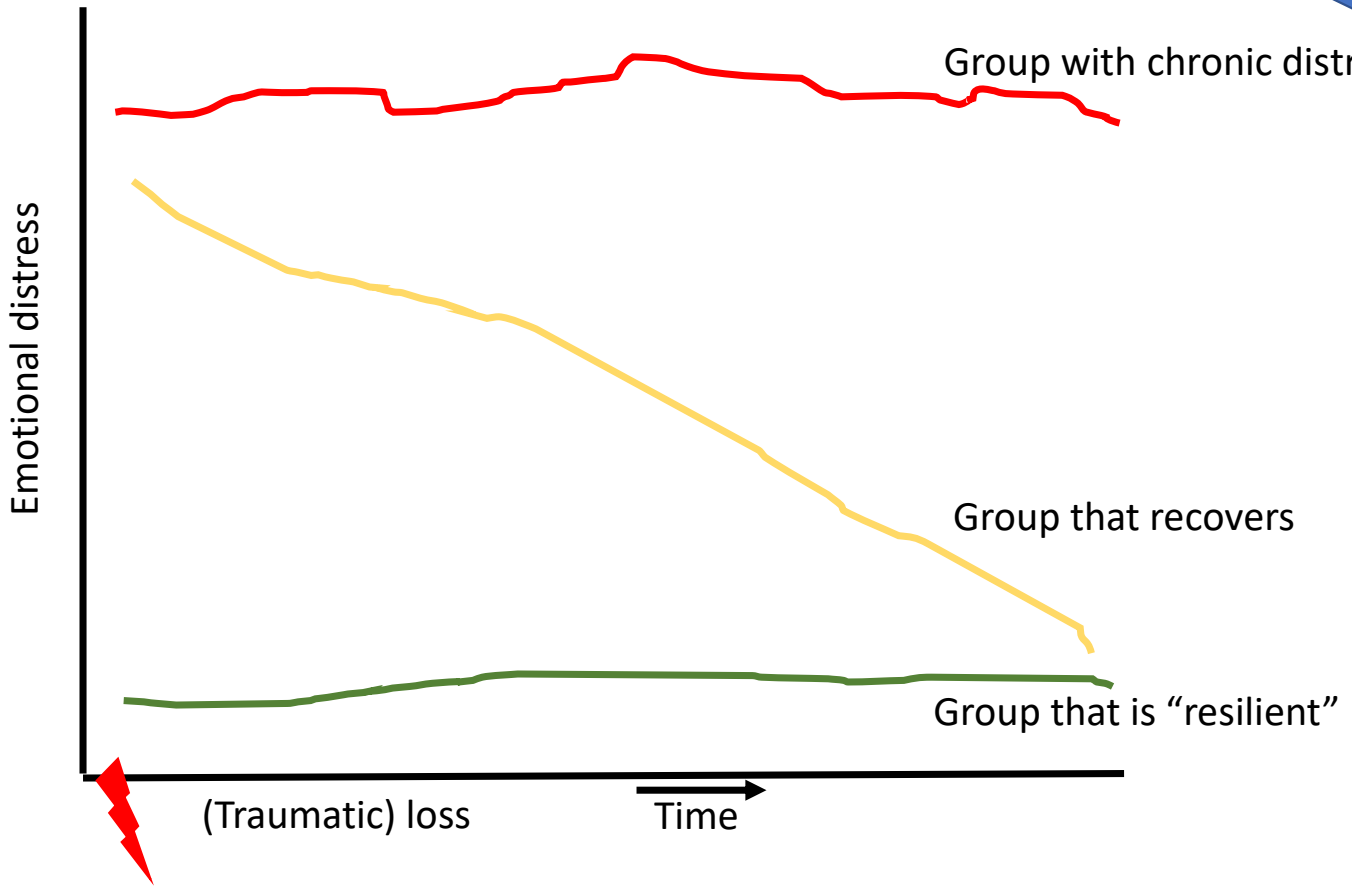
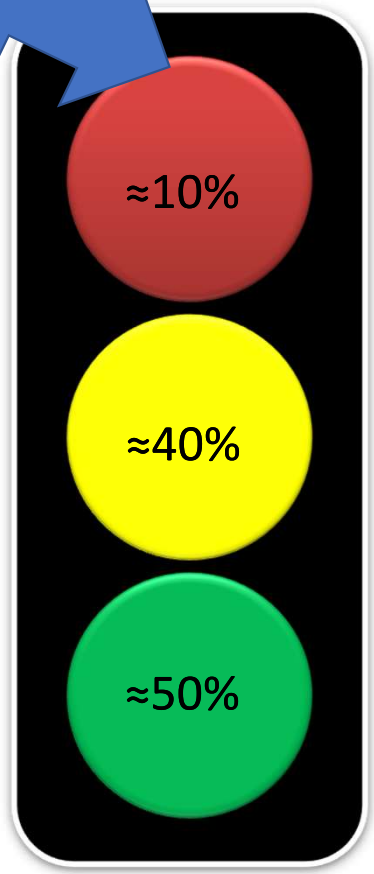
# *Nature and Prevalence of Emotional Distress Following Traumatic Bereavement*

# Emotional distress




-Prolonged Grief Disorder
-Posttraumatic Stress Disorder
-Depression



# What is Prolonged Grief Disorder?

1997

## Diagnostic Criteria for Complicated Grief Disorder

Mardi J. Horowitz, M.D., Bryna Siegel, Ph.D., Are Holen, M.D.,
George A. Bonanno, Ph.D., Constance Milbrath, Ph.D., and Charles H. Stinson, M.D.

**APPENDIX 1. Proposed Diagnostic Criteria for Complicated Grief Disorder**

*A. Event criterion/prolonged response criterion*

Bereavement (loss of a spouse, other relative, or intimate partner) at least 14 months ago (12 months is avoided because of possible intense turbulence from an anniversary reaction)

*B. Signs and symptoms criteria*

In the last month, any three of the following seven symptoms with a severity that interferes with daily functioning

Intrusive symptoms

1. Unbidden memories or intrusive fantasies related to the lost relationship
2. Strong spells or pangs of severe emotion related to the lost relationship
3. Distressingly strong yearnings or wishes that the deceased were there

Signs of avoidance and failure to adapt

4. Feelings of being far too much alone or personally empty
5. Excessively staying away from people, places, or activities that remind the subject of the deceased
6. Unusual levels of sleep interference
7. Loss of interest in work, social, caretaking, or recreational activities to a maladaptive degree

# What is Prolonged Grief Disorder?

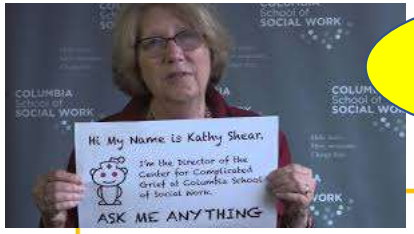
2009

Prolonged Grief Disorder

OPEN ACCESS Freely available online PLOS MEDICINE

**Prolonged Grief Disorder: Psychometric Validation of Criteria Proposed for *DSM-V* and *ICD-11***

Holly G. Prigerson[1,2,3]*, Mardi J. Horowitz[4], Selby C. Jacobs[5], Colin M. Parkes[6], Mihaela Aslan[7], Karl Goodkin[8,9], Beverley Raphael[10], Samuel J. Marwit[11], Camille Wortman[12], Robert A. Neimeyer[13], George Bonanno[14], Susan D. Block[1,2,3], David Kissane[15], Paul Boelen[16], Andreas Maercker[17], Brett T. Litz[18,19,20], Jeffrey G. Johnson[21], Michael B. First[21], Paul K. Maciejewski[1,2]




2011

Complicated Grief

*Review*

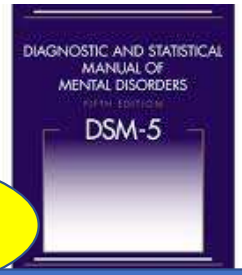
**COMPLICATED GRIEF AND RELATED BEREAVEMENT ISSUES FOR DSM-5**

M. Katherine Shear, M.D.,[1,2*] Naomi Simon, M.D.,[3] Melanie Wall, Ph.D.,[4,5] Sidney Zisook, M.D.,[6] Robert Neimeyer, M.D.,[7] Naihua Duan, Ph.D.,[4,5] Charles Reynolds, M.D.,[8,9] Barry Lebowitz, Ph.D.,[10] Sharon Sung, Ph.D.,[11] Angela Ghesquiere, M.S.W.,[12] Bonnie Gorscak, Ph.D.,[13] Paula Clayton, M.D.,[14] Masaya Ito, Ph.D.,[15] Satomi Nakajima, M.D. Ph.D.,[15] Takako Konishi, M.D. Ph.D.,[16] Nadine Melhem, Ph.D.,[17] Kathleen Meert, M.D.,[18] Miriam Schiff, Ph.D.,[19] Mary-Frances O'Connor, Ph.D.,[20] Michael First, M.D.,[21] Jitender Sareen, M.D.,[22] James Bolton, M.D.,[22] Natalia Skritskaya, Ph.D.,[23] Anthony D. Mancini, Ph.D.,[24] and Aparna Keshaviah, Sc.M.[25]

2013

**Diagnosis and classification of disorders specifically associated with stress: proposals for ICD-11**

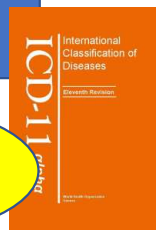
Andreas Maercker[1], Chris R. Brewin[2], Richard A. Bryant[3], Marylene Cloitre[4], Mark van Ommeren[5], Lynne M. Jones[6], Asma Humayan[7], Ashraf Kagee[8], Augusto E. Llosa[9], Cécile Rousseau[10], Daya J. Somasundaram[11,12], Renato Souza[13], Yuriko Suzuki[14], Inka Weissbecker[15], Simon C. Wessely[16], Michael B. First[17], Geoffrey M. Reed[5]




2013

Persistent Complex Bereavement Disorder

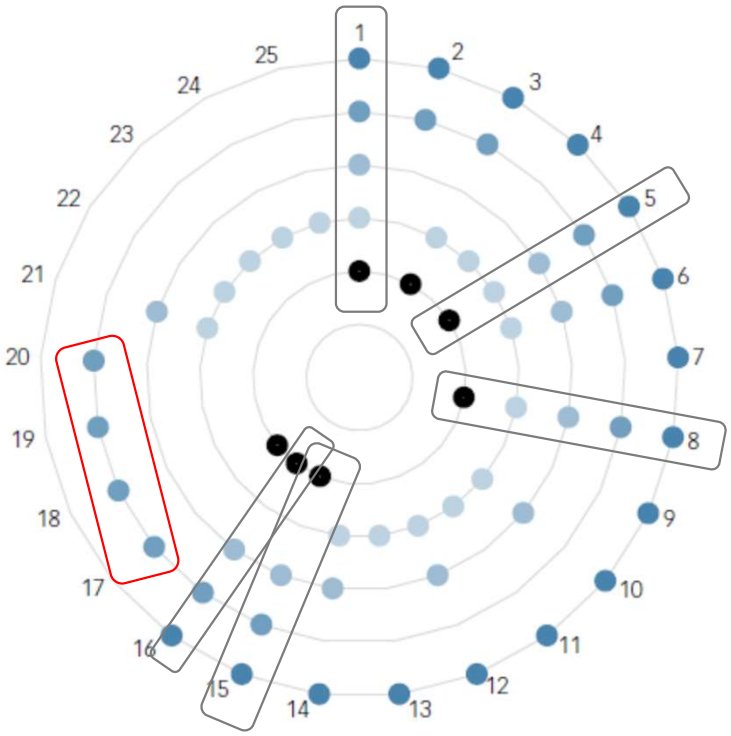
Prolonged Grief Disorder *as per* ICD




2018




● PCBD (DSM-5; APA, 2013) ● PGD (ICD-11; WHO, 2019) ● PGD (Prigerson *et al* 2009) ● Complicated grief (Shear *et al* 2011) ● beta-draft ICD-11




**Brief symptom description**

1. Persistent yearning/longing for the deceased
2. Intense sorrow and emotional pain
3. Preoccupation with the deceased
4. Preoccupation with the circumstances of the death
5. Marked difficulty accepting the death
6. Experiencing disbelief/emotional numbness over the loss
7. Difficulty with positive reminiscing about the deceased
8. Bitterness or anger related to the loss
9. Maladaptive appraisals about oneself (e.g. self-blame)
10. Excessive avoidance of reminders of the loss
11. A desire to die in order to be with the deceased
12. Difficulty trusting other individuals since the death
13. Feeling alone or detached from others
14. Feeling that life is meaningless or empty without deceased
15. Confusion about one's role in life (e.g. feeling that a part of oneself died)
16. Difficulty to pursue interests or to plan for the future
17. Guilt
18. Denial
19. Blame
20. An inability to experience positive mood
21. Feeling stunned, dazed or shocked by the loss
22. Feeling envious of others who have not experienced a loss
23. Frequently experiencing pain or other symptoms that the deceased person had, or hearing the voice or seeing the deceased person
24. Experiencing intense emotional or physiological reactivity to memories of the person who died or to reminders of the loss
25. Change in behavior due to excessive proximity seeking (e.g. doing things that are reminders of the loss)

With distress and disability?

>6 mos. after loss?

PGD

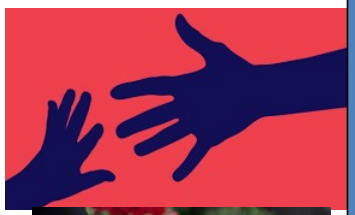
**Lenferink et al. (2019) Br J Psychiatry**

# PGD is different from other disorders

| | Prolonged Grief Disorder (PGD) | Posttraumatic Stress Disorder (PTSD) | Major Depressive Disorder (MDD) |
|---|---|---|---|
| **Feelings** | Longing<br>Yearning<br>Despair | Anxiety<br>Fear | Depressed mood<br>Lack of positive affect |
| **behaviour** | Searching<br>Proximity seeking behaviour | Avoidance of feared situations / stimuli<br>Hypervigilance | Passivity<br>Anhedonia |
| **Thoughts** | "I cannot stand that s/he is not there"<br>"Life is meaningless" | "The world is dangerous"<br>"People cannot be trusted"<br>"I cannot control things that happen" | "I am worthless"<br>"The world is unfair"<br>"The future is hopeless" |
| ***Intrusive images about:*** | Lost person<br>(positive and negative) | Lost person<br>(positive) | Poor performance of self – hopeless future |
| **Timing** | ***≥12 months*** | ***≥1 months*** | ***≥2 weeks*** |

Supported by factor analytic studies, latent class analyses and network analyses

## Traumatic loss → Traumatic grief



Separation distress

- Preoccupation with thoughts about lost person
- Everything is a reminder of lost person
- Difficulties to accept that separation is <u>irreversible</u>
- Persistent need for reunion
- Intense yearning, proximity seeking

Traumatic distress

- Re-experiencing of traumatic circumstances
- Difficulties to understand and believe that danger is in the past
- Ongoing "sense of current threat"
- Persistent avoidance of reminders of the trauma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# *Nature and Prevalence of Emotional Distress Following Traumatic Bereavement*

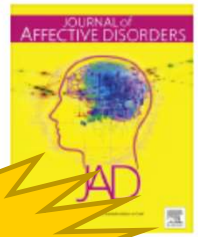
| | | % with probable PGD | % with probable PTSD | Data collection |
|---|---|---|---|---|
| Suicide | Dyregrov et al. (2003) | *78%* | ? | *Self-report* |
| Accident | Dyregrov et al. (2003) | *78%* | ? | *Self-report* |
| Homicide  | Van Denderen et al. (2016) | *83%* | *31%* | *Self-report* |
| Hurricane Katrina | Shear et al. (2011) | 20% | ? | 5 item screening by telephone |
| 9/11 | Bonanno et al. (2006) | ? | 11% (after 6 mos.) | Interview |
| 9/11 | Nerya et al. (2007) | *43%* | ? | *Self-report* |
| Disappearance of relative  | Lenferink et al. (2017) | *47%* | *23%* | *Self-report* |

High prevalence rates of emotional disorders
PGD is more prevalent than PTSD
Self-reported % yield overestimations.

Prevalence of prolonged grief disorder in adult bereavement: A systematic review and meta-analysis

Marie Lundorff[a,*], Helle Holmgren[a], Robert Zachariae[b], Ingeborg Farver-Vestergaard[b], Maja O'Connor[a]

[a] Research Unit for Natural and Complicated Grief, Department of Psychology and Behavioural Sciences, Aarhus Uni
[b] Unit for Psycho-Oncology and Health Psychology, Department of Oncology, Aarhus University Hospital and De
Sciences, Aarhus University, Aarhus, Denmark




9.8% probable PGD

2017

49.5% probable PGD


2020

The prevalence of Prolonged Grief Disorder in bereaved individuals following unnatural losses: Systematic review and meta regression analysis

A.A.A. Manik J. Djelantik MD [a, b, c], Geert E. Smid [b, c], Anna Mroz [a], Rolf J. Kleber [a, b], Paul A. Boelen [a, b, c]

Article

The Burden of Loss: Unexpected Death of a Loved One and Psychiatric Disorders Across the Life Course in a National Study

Katherine M. Keyes, Ph.D.

**Objective:** Unexpected death of a loved one is common and associated with sub- and most likely to be rated a dent's worst, regardless of oth

Age group 60-65yrs:
→ *7 x bigger chance of 1st depression*
→ *8 x bigger chance of 1st period alcohol abuse*
→ *37 x bigger chance 1st PTSD*

*Other ages? About the same*

## Conclusions

- Traumatic loss (vs. non-traumatic loss) is a risk factor for:
  - PGD, PTSD, depression;
  - Additional symptoms, guilt, anger, shame;
  - The onset of other disorders

- Still: resilience is the *rule*, not the exception.

- More research, using clinical interviewing in representative samples is needed.

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# *Risk Factors for Emotional Distress Following Traumatic Bereavement*

# Risk-factors for elevated emotional distress

Socio-demographic variables
- Women; Lower education; Lower social economic status.

Aspects of lost relationship
- Kinship (Loss of child or partner); Closeness; Interdependence

Pre-loss vulnerability
- Neuroticism; Attachment anxiety

Features of the loss-event
- Suddenness, Untimeliness, Suffering of lost person

Aftermath of loss
- Additional stressors (Presence/absence of body; Media attention; Stigmatization; Legal issues); Poor social support

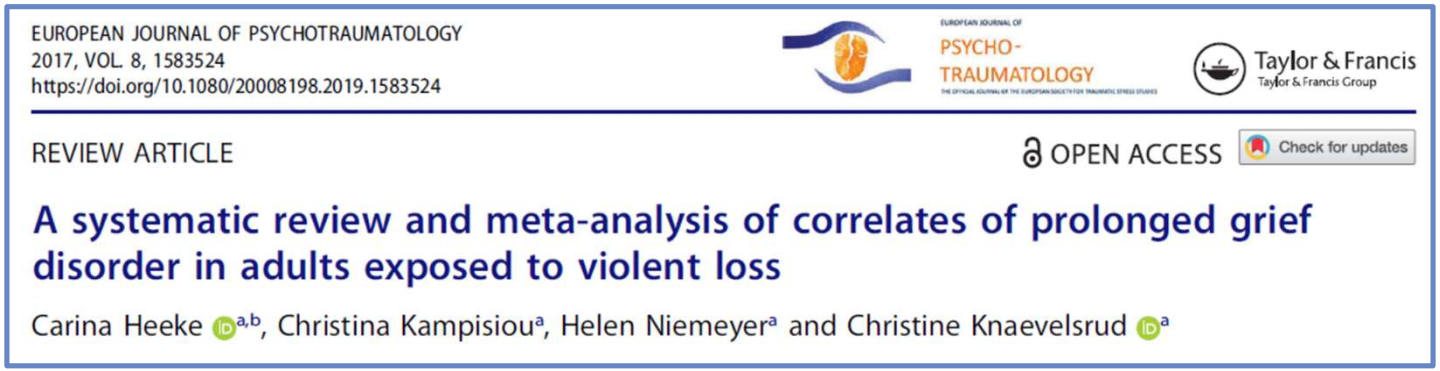
## Risk-factors for elevated emotional distress

Socio-demographics
- Female gender, lower education, being unemployed, no remaining children;

Relationship with deceased
- Loss of partner, child, sibling vs. more distantly related
- (not time since loss)

Personality
- Attachment anxiety (not attachment avoidance, neuroticism)

Cognitive variables
- Rumination


EUROPEAN JOURNAL OF PSYCHOTRAUMATOLOGY
2017, VOL. 8, 1583524
https://doi.org/10.1080/20008198.2019.1583524

EUROPEAN JOURNAL OF PSYCHO-TRAUMATOLOGY

Taylor & Francis
Taylor & Francis Group

REVIEW ARTICLE

OPEN ACCESS Check for updates

A systematic review and meta-analysis of correlates of prolonged grief disorder in adults exposed to violent loss

Carina Heeke [a,b], Christina Kampisiou[a], Helen Niemeyer[a] and Christine Knaevelsrud [a]

# Risk-factors in times of COVID-19


- Limited possibilities for saying goodbye
- Limited options for funeral
- Treatment in ICU
- Feeling responsible for the death (contamination)
- Secundary stressors (fear of corona, financial problems)
- Suffering multiple losses in a short time
- Limited options for social support

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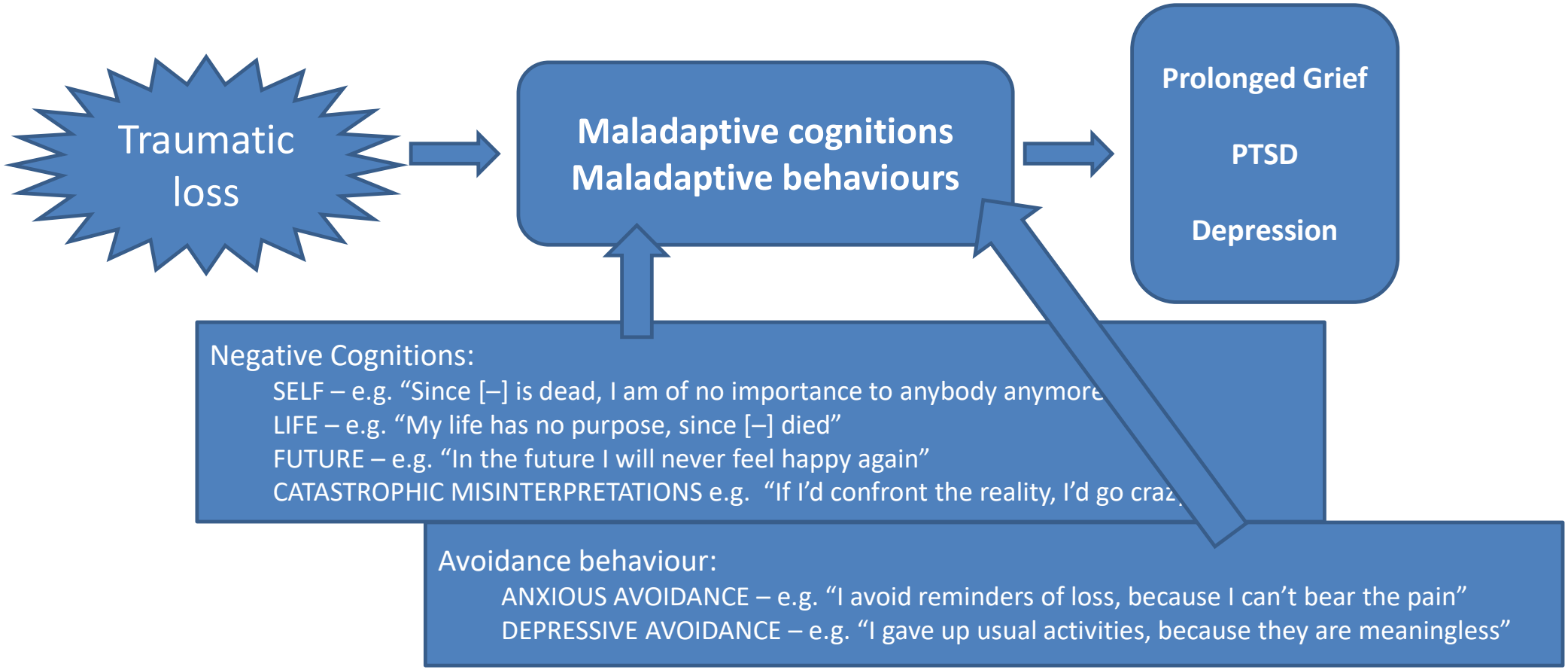
*Boelen, Eisma, Smid, De Keijser, Lenferink (in press) J Loss and Trauma*


**A Cognitive-Behavioral Conceptualization of Complicated Grief**

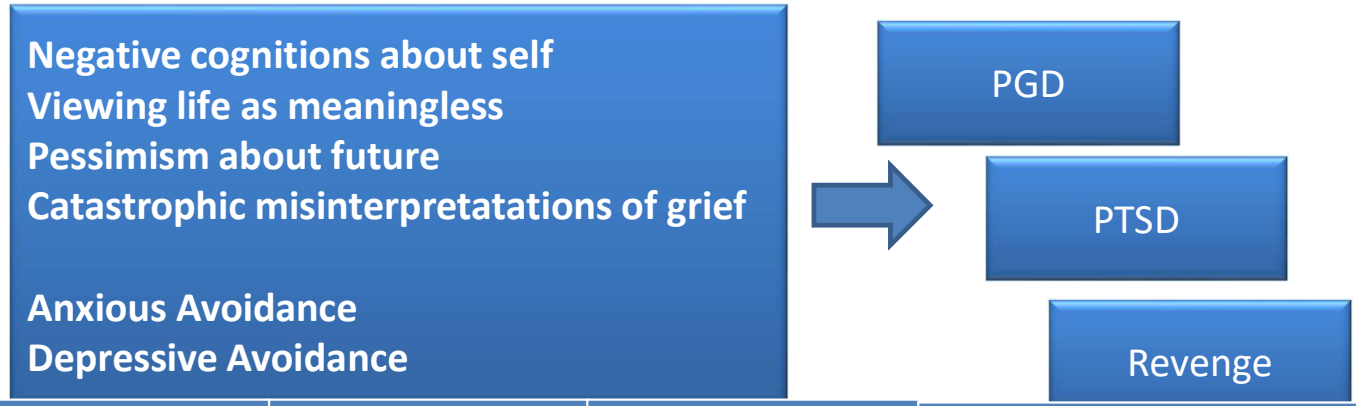
Paul A. Boelen, Marcel A. van den Hout, and Jan van den Bout, Department of Clinical Psychology, Utrecht University

*Clinical Psychology: Science & Practice, 2006*




*Boelen, De Keijser, Smid (2015) Psychological Trauma, Theory, Practice, Policy*

# Groningen Homicide Study




| *Unique correlates of…* | … PGD | … PTSD | … Revenge thoughts and feeling |
|---|---|---|---|
| Negative about self | **β = .22*** | **β = .24 *** | **β = -.18 *** |
| Life is meaningless | β = .01 | β = .03 | β = .04 |
| Pessimism future | β = .06 | β = .09 | **β = .31*** |
| Catastrophic misinterpretations | **β = .35*** | **β = .25*** | β = .11 |
| Anxious avoidance | β = -.02 | β = -.07 | **β = .21 *** |
| Depressive avoidance | **β = .29*** | **β = .30*** | β = .08 |

*Boelen, Van Denderen, De Keijser (2015) Homicide Studies*

## Conclusions

- Negative cognitions and avoidance behaviours are associated with emotional distress after violent/traumatic loss;
- Some cognitions (negative future) are more important than others (life is meaningless)
- Depressive avoidance is more important than anxious, phobic avoidance.
- Revenge thoughts & feelings are associated with a fear to confront the loss

*Preoccupation with anger toward the perpetrator may reflect a way to avoid the pain of the loss.*

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# *Emotional Distress Following Traumatic Bereavement: A Cognitive Behavioural Approach*

# “Cognitive puzzle” of PGD

Preoccupation with loss/lost person

- People think of nothing else but the loss
- Everything reminds them of the loss

Persistent disbelief

- Loss feels like 'something unreal'

Core symptoms:

- Feeling separation is temporary
- Yearning
- Inability to focus on the (near) future

# CBT perspective

- Acute grief becomes chronic because:
  - The (irreversibility of the) loss is insufficiently integrated within the grieving person's **memory**
  - The person develops persistent negative **cognitions**
  - The person engages in **anxious** and **depressive** avoidance behaviour

**A Cognitive-Behavioral Conceptualization of Complicated Grief**

Paul A. Boelen, Marcel A. van den Hout, and Jan van den Bout, Department of Clinical Psychology, Utrecht University

*Clinical Psychology: Science & Practice, 2006*

# CBT perspective

**(Confronting) exposure**
**Writing assignments**
**Therapeutic rituals**

Insufficient 'elaboration' of loss

Insufficient integration of loss with autobio-graphical memory

Loss remains a 'new' event

"Working model" of relationship remains unchanged

Own identity remains unchanged

Traumatic distress
Shock, disbelief

Separation distress
(yearning, searching)

Identity confusion
Focus on past

# Persistent, rigid, negative thought patterns

"I am a useless person now that my child is dead"

*"Life is meaningless and pointless"*

"I will never feel good in the future ever again"

Yearning, Attention focused on past

# Persistent, rigid, negative thought patterns

**Cognitive restructuring**

"I could and should have prevented the death"
"I am responsible and deserve to be punished

Self-blame, guilt

"I will not rest before the people responsible are sentenced!"

Anger, hate revenge

*"If I would fully realise that s/he will never return, I would go crazy"*

Anxiety
Affectphobia

# Anxious, phobic avoidance

**(Confronting) Exposure**

"If I allow myself to be sad, I will go mad"

*"If I'd really let it get to me that she will NEVER, NEVER, NEVER come back, I would go mad and lose control"*

"I cannot bear my sorrow"

Avoidance of situations, objects, people, places

Suppression of thoughts, memories

Rumination
*Why? What if..?*

# Depressive, passive avoidance


**Graded activation**

"I am unable to continue usual activities, hobbys work, friend."

"It will not give me any pleasure to continue usual activities"

"I do not deserve to feel pleasure, joy ..."

Passivity

Stopping work or social, recreational activities

# Therapy goals

Changing the stagnated (“unhealthy”) grieving process into a healing (“healthy”) process:

- *Accepting (not resisting against) the reality of loss and the implications of the loss for the self, life, future*
- *Working through and emotionally processing emotions*
- *Resuming a pleasant, fulfilling social, recreational, and working/education life*

# Cognitive Behavioural Therapy

Mismatch between new reality and existing knowledge

Chronic negative thought patterns

Avoidance behaviour

***PGD***

# Cognitive Behavioural Therapy

*EXPOSURE – COGNITIVE RESTRUCTURING – GRADUAL ACTIVATION*

INTEGRATE new reality WITH existing knowledge

CHANGE negative thought patterns INTO HELPFUL COGNITIONS

CHANGE Avoidance behaviour INTO HELPFUL COPING BEHAVIOUR

***PGD → Normal grief***

# Modifying maladaptive cognitions

| Theme | Example | Consequence |
|---|---|---|
| Self | *I am of no worth anymore now that s/he died* | Yearning, depression |
| Life | *Life is meaningless and pointless* | Yearning, depression |
| Future | *Things will never get any better* | Yearning, depression |
| Catastrophic misinterpretations of grief | *If I would fully realise that s/he will never return, I would go crazy* | Anxiety |


| Themes | Example | Consequence |
|---|---|---|
| Safety | *Nowhere it is safe, the world is a dangerous place* | Anxiety |
| Trust | *Other people cannot be trusted* | Anxiety, anger |
| Self-blame | *I should have prevented the death* | Guilt, blame, anger |
| Control | *I have no control over things happening* | Despair, anger, demoralization |

# Modifying maladaptive cognitions

[1] Address cognitions that can be **falsified**

- Not: "Life is meaningless", "I could have prevented this loss"
- But: "*There is nothing in my life that I feel positive about*", *"The fact that I did not prevent the loss, means that I should be punished - I no longer deserve to be happy"*

[2] Challenge with Socratic questions

- About validity of cognitions: How do you know that ...?
- About usefulness of cognitions: What will happen if you keep thinking ...? Will it help you move on if you keep believing …?

[3] Challenge with behavioural experiments

- Assignments that challenge the truth of specific 'what if?' propositions
  - "If I arrange to meet that friend, I will not enjoy it" ➔ arrange to meet the friend
  - "If I visit the grave, I will feel so sad that I will lose control" ➔ pay a visit to the grave

# Exposure

- Rationale: *Avoidance (of places, objects, memories, thoughts) always plays role in PGD*

- Why do people avoid?
  - *To avoid confrontation with fact that separation is permanent.*
  - *That reality is assumed to be too painful to bear!*

- *Four forms of exposure*
  - *General exposure*
  - *Stimulus exposure*
  - *Imaginal exposure*
  - *Diminishing grieving behaviour*

# General exposure

| | |
|---|---|
| **When?** | In all cases of Prolonged Grief Disorder |
| **What?** | Confronting the reality and irreversibility of the separation |
| **Why?** | To target “a sense of unrealness” about the separation |
| **How?** | Confronting photos, places, people, memories, thoughts to confront irreversibility of separation |

# Imaginal (prolonged) exposure

| | |
|---|---|
| **When?** | When patient has real or ***imagined*** distressing images of specific events |
| **What?** | Reconstructing and repeatedly reliving the events – focusing on **hotspots** |
| **Why?** | To construct a coherent story, with a beginning and end (and to facilitate habituation) |
| **How?** | (Re)living events moving from "observer" perspective to "field" (first person) perspective – zooming in on hotspots |

# Graded activation


Dysphoria accompanying grief takes away motivation and desire to do usual things

↓

People engage in DEPRESSIVE AVOIDANCE

(they become inactive and withdraw)

↓

People have no positive experiences

↓

The low mood persists and gets deeper

# Graded activation


Step 1: Explaining rationale

"If you become more active, then your mood will gradually improve"

Step 2: Search for valued activities

What did patient do before the loss?
What activities can foster adjustment and recovery?
What are valued social, work/education, recreational activities?

Step 3: Set goals and make (step-by-step) plans

Step 4: Address negative (sabotaging) cognitions

"If I go out with friends again, that will not give me pleasure"
"I am not able yet, to go back to work"
"If I reengage in social activities, I would be betraying the deceased"

Step 5: What new skills are needed to achieve goals?

# Writing assignments

[1] Ongoing farewell letter to the deceased

*To finish unfinished business; say goodbye.*

[2] Three Letters Task including angry (negative) letter, loving (positive) letter, and balanced (integrated) letter

*To articulate, accept, and integrate ambivalent thoughts and feelings*

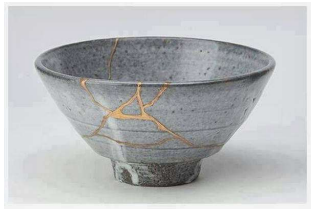
[3] Letter to an imaginal friend who is going through the same process

*Helping someone else to help oneself.*

[4] Angry letter to person responsible for death

*To channel and verbalize the anger (and work toward acceptance or action)*

# (Farewell) rituals



A symbolic way to say goodbye to deceased, to express thoughts/feelings, and to mark transition to new phase/role

Patient designs and plans the ritual (with friend or relative)

Plan is discussed in treatment; therapist is not present when the ritual is performed

Examples:

- *Visit a special place*
- *Create a symbol of remembrance*
- *Perform a culturally appropriate ritual*
- *Renounce things related to the circumstances of the death*
- *Write and burn the angry letter*

**Toward Cultural Assessment of Grief and Grief-Related Psychopathology**

Geert E. Smid, M.D., Ph.D., Simon Groen, M.A., Simone M. de la Rie, Ph.D., Sandra Kooper, M.D., Paul A. Boelen, Ph.D.

*Psychiatric Services 2018; 69:1050–1052; doi: 10.1176/appi.ps.201700422*

Utrecht University

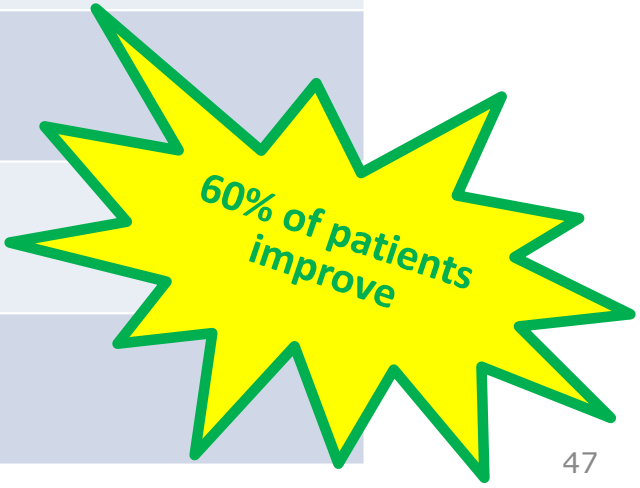
15-7-2020

# *Studies on psychotherapy for disturbed grief*

# Research findings

*Effect Sizes d, 'completers', all 'large effects' (ds >. 8)*

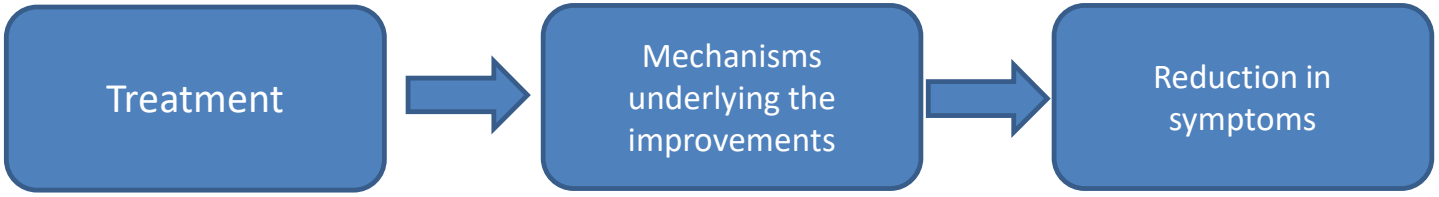
| Research | Treatment | Pre-post treatment *d* |
|---|---|---|
| Boelen et al. | 12 sessions CBT live | 1.80 |
| Wagner et al. | 10 x 45 minutes writing | 1.25-1.52 (PTSD) |
| Shear et al. | 16 sessions Complicated Grief Treatment | 1.64 |
| Papa et al. | 12–16 sessions Behavioural Activation | 1.74 |
| Bryant et al. | 10 x 90 group CT plus 5 x exposure | 1.77 |



# Improving treatments?

Learn more about "mechanisms of change" in treatment

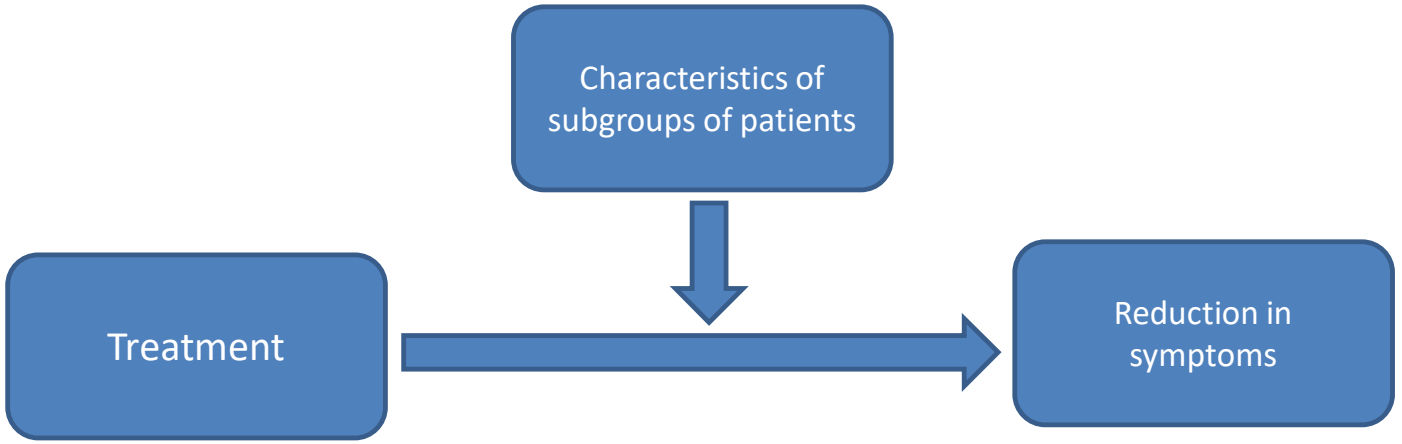
- Our own study on CBT? Strong relationship between decrease in PGD and decrease in 'catastrophic misinterpretations' and rumination.
  - Implication? More focus on rumination + catastrophic misinterpretations
- Study from Bryant et al.? Individual exposure was very important addition to group cognitive therapy.
  - Implication? More attention for exposure!



# Improving treatments?

Learn more about "moderators of change" in treatment

- Treatments are less successful for vulnerable groups, low SES, low education, traumatic loss
  - Implication: combine PGD + PTSD treatment



# Improving treatments?

Intensive daycare treatment

- Individual therapy focused on processing traumatic loss;
- Involving the family system in treatment.
- Group therapy focused on sharing experiences, sharing experiences, working toward future.

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CLINICAL PRACTICE ARTICLE

**Brief Eclectic Psychotherapy for Traumatic Grief (BEP-TG): toward integrated treatment of symptoms related to traumatic loss**

Geert E. Smid[1]*, Rolf J. Kleber[2,3], Simone M. de la Rie[1], Jannetta B. A. Bos[1], Berthold P. R. Gersons[3,4] and Paul A. Boelen[2]

# To conclude …

- Many people are resilient in the face of traumatic loss.
- Traumatic loss can lead to severe emotional distress or “traumatic grief” (PGD + PTSD + depression)
- A complex interplay of variables inflates the risk of emotional distress.
- CBT perspective helps to understand persistence of emotional distress
- CBT interventions are very promissing
  - Exposure to the reality of the loss is critical ingredient
- Future research questions:
  - How does CBT work (via which processes)?
  - What works best for whom?
  - How best to treat severe, chronic PGD and PTSD following multiple loss?

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