For the Practitioner / Für die Praxis

Verhaltenstherapie
Praxis | Forschung | Perspektiven

(English Version of) Verhaltenstherapie
DOI: 10.1159/000489509

Published online: ■■■

Integrative Cognitive-Behavioral Therapy for Prolonged Grief Disorder: Introduction of a Treatment Manual

Rita Rosner[a] Gabriele Pfoh[b] Michaela Kotoučova[b] Hannah Comtesse[a]

[a]Katholische Universität Eichstätt-Ingolstadt, Eichstätt, Germany; [b]Private Practice, Munich, Germany

Keywords
Prolonged grief disorder · Treatment manual · Cognitive-behavioral therapy

Summary
This paper introduces the integrative cognitive-behavioral treatment manual for prolonged grief disorder. This outpatient treatment manual is suited for persons who suffer from severe, disabling, and persistent grief reactions for more than 6 months after the loss of a loved person. The treatment aims at resolving grief complications and adjusting to life without the deceased. Cognitive-behavioral treatment strategies are combined with systemic and gestalt therapy techniques. 20 weekly sessions are divided into 3 phases. The first phase concentrates on stabilizing and motivating. The second phase allows for different foci: feelings of guilt, adjustment to new living conditions, attachment to the deceased, or avoidance. Employed techniques are prolonged exposure, cognitive restructuring, and empty-chair work. In vivo exposition is applied if necessary. The third phase focuses on future prospects while maintaining a healthy bond to the deceased, and relapse prevention. Up to 5 optional sessions directed toward special or critical situations (e.g., anniversaries) can be added. Altogether, the manual facilitates a feasible and effective treatment of prolonged grief disorder.

Schlüsselwörter
Anhaltende Trauerstörung · Behandlungsmanual · Kognitive Verhaltenstherapie

Zusammenfassung
Integrative kognitive Verhaltenstherapie für die anhaltende Trauerstörung: Vorstellung eines Behandlungsmanuals
Das Manual der integrativen kognitiven Verhaltenstherapie zur Behandlung der anhaltenden Trauerstörung bei ambulanten Patienten wird in Kurzform vorgestellt. Das Behandlungsmanual wurde für Personen entwickelt, die mehr als 6 Monate nach dem Verlust einer Bezugsperson unter anhaltenden und schwerwiegenden Trauersymptomen leiden. Therapieziele sind ein veränderter emotionaler Umgang mit der Trauer sowie eine funktionale Anpassung an die neue Lebenssituation ohne die verstorbene Person. Dazu werden kognitiv-verhaltenstherapeutische Methoden mit systemischen und gestalttherapeutischen Interventionen kombiniert. Die 20 wöchentlichen Therapiesitzungen sind in 3 Phasen unterteilt. In der ersten Phase stehen Beziehungsgestaltung, Informationsvermittlung und Veränderungsmotivation im Vordergrund. Die zweite Phase erlaubt unterschiedliche Schwerpunkte: Bearbeitung von Schuldgefühlen, Anpassung an veränderte Lebensbedingungen, Trauer als Mittel zur Aufrechterhaltung der Bindung an die verstorbene Person oder Bearbeitung der Vermeidungssymptomatik. Dabei kommen Exposition in sensu, kognitive Umstrukturierung und gestalttherapeutische Stuhlarbeit zum Einsatz. Exposition in vivo kann bei Bedarf angewendet werden. In der dritten Phase geht es um die veränderte Beziehung zur verstorbenen Person, die Entwicklung neuer Lebensziele und um Rückfallprophylaxe. Weiterhin können optionale Sitzungen, die sich mit besonderen Gelegenheiten wie Jahrestagen befassen, in den Therapieverlauf integriert werden. Insgesamt ermöglicht das vorgestellte Manual eine flexible und effektive Behandlung der anhaltenden Trauerstörung.

KARGER

E-Mail karger@karger.com
www.karger.com/ver

Prof. Dr. Rita Rosner
Clinical and Biological Psychology
Katholische Universität Eichstätt-Ingolstadt
Ostenstraße 25, 85071 Eichstätt, Germany
rita.rosner@ku.de

Background on Prolonged Grief Disorder

Grief is a universal response to the loss of a loved one, which paves the way for adjustment to a new situation in life. The acute phase of bereavement is characterized by intense yearning for the deceased and symptoms that differ from person to person (e.g., rage, guilt, or sleep disturbances) and may be associated with functional impairments (such as increased morbidity [Stroebe et al., 2007]). Yet, most people overcome this painful phase; the intensity and frequency of grief decline steadily, and it becomes possible to continue life under the changed circumstances. For some bereaved people, however, the intensity of mourning does not ease. They continue to suffer from strong yearning and various complaints on the emotional, cognitive, and behavioral levels, associated with psychosocial impairments. This pathological grief reaction is termed prolonged grief disorder (PGD); alternative terms used to describe this phenomenon were 'complex grief' or 'traumatic grief'. The disorder is not rare, as a representative survey found a point prevalence of 3.7% in the German general population [Kersting et al., 2011]. International estimates are significantly higher [Lundorff et al., 2017], which is consistent with the large variation in the measures used and the risk populations studied (e.g., often 'bereaved parents').

PG is included as a distinct diagnostic category in the 11th edition of the International Statistical Classification of Diseases and Related Health Problems (ICD-11) [WHO, 2018]. The death must have occurred at least 6 months previously, with the duration of mourning exceeding cultural norms. At least 1 major symptom must have been present most of the time, such as intense yearning or prolonged preoccupation with the deceased, accompanied by strong emotional pain from grief, guilt, anger, inability to accept the death, avoidance of things that remind one of the deceased, or emotional numbness. There must also be psychosocial functional impairment. In the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), the diagnosis is called 'persistent complex bereavement disorder' and considered as a condition for further study [APA, 2013]. Most of the main and secondary symptoms are similar to those in the ICD-11, although the time criterion, unlike in the ICD-11, is 12 months.

Psychotherapeutic interventions for PGD should be distinguished from prevention programs for normal grief. Meta-analyses showed that preventive interventions for bereaved persons failing to screen for abnormal grief can achieve at most small effects or even negative effects on the normal grief process [Currier et al., 2008; Wittouck et al., 2011]. Thus, a psychotherapeutic intervention is indicated only if PGD actually exists. The meta-analyses showed moderate effect sizes after the end of treatment, which were also maintained over the long term, and the more severe the patients' distress, the larger were the effect sizes [Currier et al., 2008; Wittouck et al., 2011]. In the meta-analysis by Wittouck et al. [2011], 4 out of the 5 treatment studies achieved a significant reduction in grief symptoms, with all 4 studies being based on a cognitive-behavioral approach. The treatment approach of Shear et al. [2005] is commonly used in English-speaking countries, combining cognitive-behavioral methods with individual elements of interpersonal therapy and aiming for acceptance of the loss, reorganization of the attachment to the deceased, and development of new life goals. Overall, the efficacy of the approach has been well studied, and in a direct comparison it was superior to both interpersonal therapy [e.g., Shear et al., 2005, 2014] and pharmacological treatments [Shear et al., 2016]. Treatment success seems to be mediated primarily by the reduction of loss- and grief-related avoidance [Glickman et al., 2017]. Integrative cognitive-behavioral therapy was developed for PGD (PG-CBT) [Pfoh et al., 2005] on the basis of our own review article [Rosner and Hagl, 2007] and the meta-analyses published up to 2005. It has already been evaluated [Rosner et al., 2011, 2014, 2015]. PG-CBT uses classical cognitive-behavioral methods adapted for grief and supplemented by elements of other therapeutic approaches (solution-oriented therapy, systemic therapy, psychodrama, hypnotherapy, and relaxation techniques).

Efficacy of PG-CBT

The efficacy of PG-CBT was supported for both outpatient [Rosner et al., 2014, 2015] and inpatient settings [Rosner et al., 2011]. In the inpatient setting, PG-CBT was compared with treatment as usual (TAU) [Rosner et al., 2011]. TAU corresponded to the intensive program of a psychosomatic hospital. 50 people were non-randomly assigned to PG-CBT + TAU and 22 people to TAU. In the controlled comparison, PG-CBT + TAU achieved a moderate effect (d = 0.72). In the outpatient setting, the efficacy of PG-CBT was tested on 51 people with PGD who were randomized to the PG-CBT or a wait list condition [Rosner et al., 2014, 2015]. PGD symptoms as the primary outcome variable were assessed at the beginning and end of the therapy/waiting period. To assess long-term effectiveness, the prolonged grief symptoms were measured again about 1.5 years after the end of treatment. At the end of therapy, the PG-CBT group showed greater improvement in PGD severity than the wait list group (d = 1.32). This improvement was also stable 1.5 years after the conclusion of treatment (d = 1.24 comparing pre to follow-up). In addition, comorbid depression symptoms were significantly reduced compared to the wait list

group (d = 0.73). At the end of the therapy/waiting period, 42% of the patients from the PG-CBT group no longer met the criteria for PGD, whereas that was true for only 4% of the wait list group. After 1.5 years, 49% of the patients treated with PG-CBT no longer met the PGD criteria. The 21% dropout rate for PG-CBT corresponds to that in other randomized controlled trials [e.g., 20–30% in Boelen et al., 2007; approximately 23% in Byrant et al., 2014].

Format, Indication, and Goals of PG-CBT

PG-CBT was developed for use in individual outpatient settings. It includes 20 therapy sessions and lasts about 4–6 months. It can also cover up to 5 optional sessions dealing with special occasions (e.g., anniversaries, holidays, or court appearances) or including significant others (e.g., family conflicts due to different ways of coping with bereavement). These sessions are integrated into the course of therapy as needed. Therapy sessions take place weekly and last 50 min, with 2 double sessions. PG-CBT can also generally be used in group settings. There is an inpatient manual for this, which divides the treatment into 9 double sessions and integrates additional elements of art therapy [Rojas et al., 2015].

The treatment was designed for bereaved persons suffering from PGD. PG-CBT should start no sooner than 6 months after the loss of a loved one. Treatment with PG-CBT is only recommended if PGD is primary disorder. A large proportion of patients with PGD suffer from comorbid disorders [Simon et al., 2007]. For example, in a German outpatient sample comorbidity rates of 62% for depression, 22% for post-traumatic stress disorder, 24% for panic disorder, and 54% for somatization disorder were reported [Rosner et al., 2014]. PGD is always the focus of treatment, although comorbidities associated with that disorder should be considered. If there is a comorbid post-traumatic stress disorder, the intrusions should be explored in more detail, especially since an unnatural death, such as suicide or an accident, can also lead to a primary post-traumatic stress disorder. If there are intrusions associated with yearning for the deceased and characterized by both negative and positive feelings, PGD symptoms should be treated first. On the other hand, if there are intrusive symptoms concerning the traumatic event (e.g., the situation in which death occurred, notification of the death) that are accompanied by fear, shame, or disgust, post-traumatic stress disorder treatment might be indicated. A thorough evaluation of suicidality is also imperative. Patients with PGD often express the desire to meet the deceased person in the afterlife, but the death wish often simply expresses yearning for the deceased and not the intention to commit suicide.

PG-CBT deals both with loss-oriented tasks, which require emotional coping with the loss (such as reducing the avoidance of loss-related feelings and thoughts), and restorative tasks, which foster adjustment to the new circumstances (e.g., assuming new roles; cf. the dual process model of Stroebe and Schut [1999]). Furthermore, the aim of the treatment is not dissolution of bonds, but a changed relationship to the deceased from the perspective of 'continuing bonds' [e.g., Mikulincer and Shaver, 2008].

Cross-Session Topics of PG-CBT

Several aspects must particularly be considered in treatment of patients with PGD. The patients' motivation to change is often fluctuating and ambivalent. For example, patients may fear that therapy will loosen or even devalue their attachment to the deceased or that the importance of the deceased person will diminish, or they may expect that therapy will make the pain of loss even stronger. The patients suffer greatly from PGD symptoms and want to ease their negative feelings, but at the same time their yearning and grief give them a feeling of closeness to the deceased (e.g., a positive sense of closeness can be caused by rumination). This ambivalence is acknowledged and treated early in PG-CBT by motivational interviewing methods. In addition to a session focusing on motivation (table 1), motivational techniques are also employed later in the therapy. To ease the patient's fear of diminishing the significance of the loss, sufficient time must be devoted at the beginning of the therapy to introduce and appreciate the deceased and the very specific relationship the mourner shared with the deceased (Session 5; table 1). The way of speaking about the loss during therapy should reflect the current situation (for example, using past tense when speaking about the deceased). Patients with PGD have often lost a major source of positive reinforcement, which is also addressed at various points in the manual (for example, the assumption and delegation of tasks that the deceased used to perform; table 1). But contact with the therapist can also become reinforcing. For example, some patients may try to offset their loss by long-term attachment to a new attachment figure such as the therapist. Therefore, PG-CBT emphasizes from the beginning that the treatment is of limited duration and is intended to help the patient establish or regain independence in various areas of life. It is also stressed out that change is possible. At the beginning of each session, following the principle of solution-focused therapy, the patient is asked what has changed since the last treatment session.

Table 1. Overview of session content

Session	Topics	Homework
1	therapeutic alliance, administrative tasks, psychoeducation – normal versus prolonged grief, dealing with crises, and the toolbox	lifeline
2	dealing with the high and low points in life, identification of grief reactions, forms of grief and family mourning traditions	
3 and 4	psychoeducation about prolonged grief disorder, individual disorder model, identification of avoidance behavior and dysfunctional thoughts, dealing with grief triggers	introducing the deceased
5	introducing the deceased, identification of tasks that the deceased performed, secondary losses	tasks of the deceased / secondary losses
6 and 7	summary, treatment goals, motivation for therapy	
8	progressive muscle relaxation, guided imagination	relaxation exercises
9	psychoeducation – cognitive model, dysfunctional thinking process, dealing with dysfunctional thinking processes	self-observation and recording of rumination
10	identification of the content of grieving thoughts, questioning and examining dysfunctional grieving thoughts	practicing strategies for dealing with dysfunctional thoughts
11	recognizing and noticing emotions, preparation for exposure	Emotion Circle
12/13	exposure in 4 passes	
14	debriefing after the exposure, correction of dysfunctional thoughts	
15/16	exercise: 'Walk to the Grave'	
17	legacy: what does the patient want to preserve from the deceased? Continuing bonds: how should the deceased be remembered?	writing down the content discussed
18	remembrance: dedication to the deceased; future: where do patients see themselves in 3, 6, and 12 months?	writing down future plans
19	identification of roles and desires in the 'new' life	writing down plans and role expectations
20	parting	

PG-CBT Structure and Procedure

Structure and Core Elements

The prerequisite for PG-CBT is always a detailed diagnostic assessment to confirm the existence of PGD. Previous meta-analyses have suggested that psychotherapy is not helpful for sub-clinical grief [Currier et al., 2008; Wittouck et al., 2011]. In the initial clinical interview, loss-related data are compiled (e.g., reasons for and circumstances of death, relationship of the patient to the deceased, perceived social support), along with the impairment caused by the grief symptoms and comorbid disorders. The treatment can begin immediately after the intitial clinical interview. The 20 sessions can be divided into 3 treatment phases: (1) stabilization, exploration, motivation, and goal setting; (2) reinterpretation and exposure; (3) integration, transformation, and completion. The second phase forms the core of PG-CBT and allows different focal points, depending on which aspects contribute most to maintenance of PGD symptoms and which treatment goals were agreed upon in Phase 1. There are 4 possible focal points: (1) dealing with feelings of guilt, (2) adjustment to changed life conditions, (3) the function of grief as a medium of maintaining attachment to the deceased, and (4) explaining and dealing with avoidance symptoms. With exposure in sensu, patients are exposed step-by-step to the worst reminders or images of their loss [Foa and Rothbaum, 2001]. At the end of the exposure, the story of loss can be changed in imagination, replacing painful memories with comforting ones. Furhtermore, dysfunctional thoughts can be corrected and alternative viewpoints developed. Further cognitive restructuring is based on known methods [Beck, 1979]. Exposure in vivo can be used as needed (i.e., in relation to external grief triggers associated with the deceased, the reality of the death, or the circumstances of death). It should be noted that PGD is not so much an anxiety disorder as an attachment disorder [Boelen and van den Bout, 2005; Shear et al., 2007]. This means that coping with anxiety and reducing avoidance are less central and also often not as difficult as for anxiety patients. In fact, exposure also serves to identify aspects of avoidance that had not previously been addressed. With empty-chair work (as employed in Gestalt therapy or Psychodrama), a conversation can be conducted with the deceased person, achieving acceptance of the loss and an opening to the patient's future life without the deceased. Building on this, the third phase of treatment discusses how the deceased can continue to have a place in the patient's life (e.g., through rituals or objects). Throughout the entire treatment, patients are continuously motivated to practice and implement the learned strategies for coping with grief in their daily life. All exercises are designed so that they can be practiced at any time and any place (e.g., relaxation exercises are performed in a sitting position rather than lying down). The procedure for each session is described in detail below (table 1).

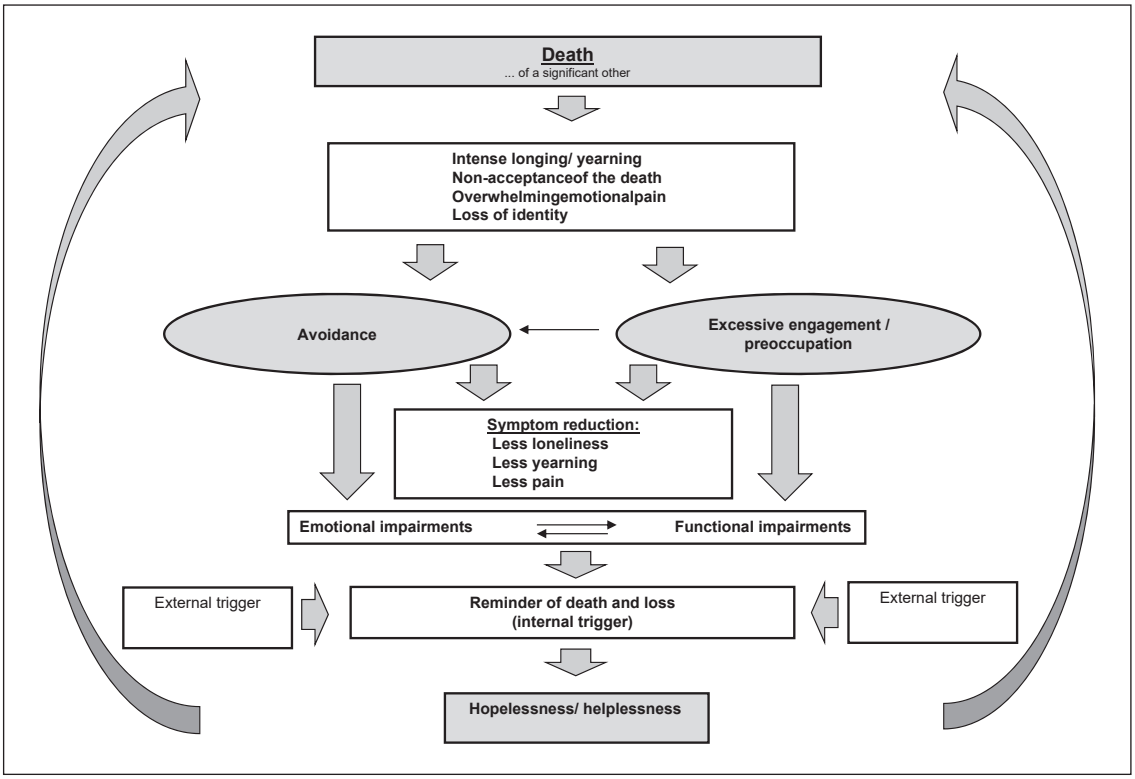

Fig. 1. Model of prolonged grief (from Pfoh et al. [2015]; ©2015 Hogrefe, Göttingen).

Phase 1 – Stabilizing, Exploring, Motivating, and Goal Setting

Session 1: Introduction, Organization, Psychoeducation, Coping with Crises

At the beginning of the first session, the patient is provided with a worksheet with information about the differences between normal and prolonged grief with regard to duration, symptoms, and consequences [cf. Znoj, 2004]. Then, the formal parameters and treatment procedure are explained. The patient's concerns and the possibility of ambivalent change motivation are addressed. At the end of the session, an emergency plan is worked out for dealing with crises (e.g., intensified grief when attending a funeral), as well as an imaginary toolbox, which is a collection of helpful strategies. As therapy proceeds, the toolbox is filled with additional techniques (e.g., relaxation exercises), from which the patient always selects the tools. As homework, the patient is asked to record a 'lifeline', or personal narrative.

Session 2: Coping with Momentous Life Events and Information about the Family

Patients first introduce their lifeline in this session, reporting, in the past tense, the prior trajectory of their grief. Next, the grief story is told from the perspective of the deceased, during which habituation can be introduced. The patient and therapist together construct a genogram [see McGoldrick and Gerson, 1985] to reflect on family mourning traditions.

Session 3 and 4: Psychoeducation about Prolonged Grief Disorder and Identification of Dysfunctional Cognitions and Behavior Patterns, As Well As Individual Grief Triggers

Sessions 3 and 4 are closely interrelated, which is why they are discussed together here. The control loop model of PGD is explained at the beginning (fig. 1). The model describes how initial grief symptoms can be amplified by the way we cope with them: on the one hand avoidance, on the other prolonged preoccupation with the deceased, which is ultimately a means to avoid dealing with the absence of the loved one. In the short term, both coping strategies lead to a decline in yearning and loneliness. Over the long term, however, this leads to emotional and functional impairment and thus to more yearning. It is impossible to completely block out the loss, because external triggers (such as the empty home) or internal ones (such as reminders of the circumstances of death) trigger feelings of hopelessness and helplessness, which eventually lead to a more intense experience of grief symptoms. Using this model, an individual vicious circle of grief is then developed. Situations from the patient's everyday life are also analyzed in detail, as the patient is trained to

Table 2. Examples of common dysfunctional thoughts and strategies for prolonged grief disorder

Topics	Examples
Questions about why and how (rumination)	'How much did she/he have to suffer?'
	'Would she/he have expected something more from me?'
	'Was it an accident or not?'
Consequences of the loss	'My life is meaningless since she/he died'
	'I can no longer trust other people'
Grief reaction	'I can't bear the pain'
	'If I let my feelings surface, I'll go crazy'
Future	'I will never have a relationship like that again'
	'I can never be happy again'
Feelings of guilt	'If I had done ..., it would not have happened'
	'It's all my fault'
Anger	'Why did she/he do this to me?'
	'It's so unfair that this had to happen to him/her'

recognize individual avoidance or preoccupation behaviors, dysfunctional grieving thoughts, as well as grief triggers. The difference among triggers of trauma, grief, and change is explained. As homework for the next session, the patient is asked to prepare an introduction of the deceased.

Session 5: Introducing and Learning About the Deceased, and Secondary Losses

At the beginning of the session, the patient introduces the deceased, using any method desired (e.g., a collage, music, or an oral presentation). This intervention helps the patient to perceive the loss in its full personal significance and to see the deceased not only as an idealization. The patient next identifies tasks that the deceased had performed and that now remain undone (such as providing emotional support, managing the family finances). The patient writes down how these tasks can be done now or how the needs can be met. The identification of tasks is continued as homework until the next session.

Sessions 6 and 7: Summary, Working Out Goals, and Motivation

Sessions 6 and 7 are also closely linked thematically. First, the therapist and patient together summarize the previous topics, helpful strategies for dealing with grief (the toolbox), and the patient's core problems. Treatment goals are worked out from there. The fact that it is impossible to resume one's former life is a particular focus, and that the new stage of life has to be planned in detail. Treatment motivation is encouraged by means of a 4-field grid. The advantages and disadvantages of the current state as well as a change in the patient's behavior are worked out. For example, the current state may have the advantage that the deceased remains present in the patient's life and so feelings of loneliness are reduced. Among the disadvantages could be 'few real friends' and 'no new relationships'. Among the advantages and disadvantages of a change could be 'a new perspective on the future' and 'dealing with the pain'. Possible ambivalences about particular goals are identified (e.g., 'If I enjoy myself with friends now, I am betraying the deceased'), but do not need to be resolved in this stage of treatment. Finally, the treatment goals are agreed upon.

Phase 2 – Reinterpretation and Exposure

Session 8: Relaxation Techniques

The patient can be taught the short version of progressive muscle relaxation according to Öst [1987] as a strategy for coping with acute stress. If the patient has experience with other relaxation techniques, these can be used. The strategies are practiced after a training session. The patient is asked to practice every day until the next session.

Session 9: Coping with Dysfunctional Cognitions (Dysfunctional Thought Processes)

The cognitive model according to Beck [1979] is taught to introduce the cognitive elements of treatment. The role of automatic grieving thoughts and rumination in triggering and maintaining grief symptoms is then explained to the patient. Grieving thoughts often have the character of rumination, whereby the perpetuating thoughts mostly pertain to the past. Circular ruminations revolve around the theme of death, the deceased, and the circumstances of death. Chains of ruminations refer to negative thoughts about the future, such as how life could continue without the deceased. This is intended to help the patient learn to identify symptom-triggering thoughts. Later in the session, strategies are practiced by which to recognize and control or break off dysfunctional thought processes: thought-substitution and here-and-now techniques. Patients are asked to record their grieving thoughts

on a daily basis between sessions and to apply the learned strategies, noting which was most helpful.

Session 10: Coping with Dysfunctional Cognitions (Content of Dysfunctional Thoughts)

Individual dysfunctional grieving thoughts are identified first. Dysfunctional beliefs in patients with PGD are related to known error categories (such as catastrophizing, counterfactual thinking), but are characterized by grief-specific content (table 2). Then, the consequences that can result from typical dysfunctional thoughts in different situations are illustrated with an example. The individual dysfunctional thoughts are examined for their usefulness and reality content, and functional thoughts are developed. If the patient feels guilty about the death of the loved one, the pie chart technique concerning guilt is helpful for restructuring [see Ehlers, 1999]. To consolidate their progress, patients are asked to practice the learned strategies independently between sessions.

Session 11: Dealing with Emotions and Perceptions

Many patients use avoidance of grief feelings and thoughts as a coping strategy, so this session teaches them to recognize and influence their emotions. Two exercises are used for this purpose (Computer Scan [based on Kabat-Zinn and Kesper-Grossmann, 2004] and a 12-field Emotion Circle [modified according to Abram and Hirzel, 2007]). The patient is instructed to go through the Emotion Circle again before the next session, to augment the listed emotions with reminders of experiences with the deceased. Exposure is discussed later in the session.

Session 12/13: Exposure

This is a double session, as it deals with highly emotional topics. The goals of the session are to become accustomed to feelings related to the worst images or reminders of the loss, as well as to identify other dysfunctional thoughts. Elaboration of trauma memory is a subordinate goal, because this is especially relevant for non-natural deaths. Exposure occurs in 4 passes, with the therapist writing down the narrative. First, the patient depicts the history of the loss on a factual basis, without offering their own interpretations. In the second pass, the facts are extended to include the patient's thoughts. In the third step, the patient adds emotions and sensory perceptions. In the last pass, the patient's narrative is repeated in a relaxed state, with the eyes closed or focused on a single point. The therapist then reads the entire story aloud and asks the patient to finish or change it. By repeatedly reading aloud and adding to the story, the patient can slowly get accustomed to stressful feelings and thoughts [cf. Foa and Rothbaum, 2001]. Changing the story itself involves a re-evaluation. At the end of the session, the patient's stability is checked.

Session 14: Summary of the Exposure

The session begins with a discussion of thoughts that surfaced during the most difficult point of the exposure or after the session. These dysfunctional thoughts are then scrutinized. The individual thoughts are checked for their reality content and usefulness (see Session 10), and thoughts are examined which involve decisions that brought the patient's norms into conflict (e.g., 'Did I have the right to end my daughter's life-support measures?') [cf. Stavemann, 2007]. By ending or changing the story (Session 12/13), the patient is able to revise certain thoughts and replace them with comforting memories. Finally, the next session is discussed.

Session 15/16: Acceptance

The purpose of this session, using Gestalt therapy techniques, is to achieve cognitive restructuring, acceptance of loss, to bid farewell to the deceased, as well as to open oneself up to a new life. The 'Walk to the Grave' exercise is used for this purpose. The grave is understood here symbolically and can be replaced by other places or things (for example, a lake or an urn). First, the patient describes the grave and lays out its actual dimensions on the floor. Then, the patient describes the grave as seen from objects such as a candle. The patient then speaks to the deceased. Things that had been left unsaid or requests that were never made can be formulated here for the last time (e.g., 'What I always wanted to tell you ...'). Finally, the patient changes roles and speaks from the standpoint of the deceased. This allows patients to receive answers or the permission to continue with their lives (e.g., 'For the rest of your life, I wish you ...'). Although the exercise is initially difficult for many patients, it is a turning point in therapy for most.

Phase 3 – Integration, Transformation, Completion

Session 17: Legacy and Continuing Bonds

After Session 15/16 has achieved an opening to a new life after the loss, the subject now is the continuing but changed relationship with the deceased (continuing bonds). First, it is discussed which dimensions of the deceased's life should be continued. This could be values, habits, activities, as well as personal items that belonged to the deceased. Later in the session it is discussed how the deceased should be remembered. Rituals, symbols, or objects, such as lighting a candle at certain times or carrying a photo of the deceased, allocate a continuing place for the deceased. For homework, the patient is asked to summarize in writing the reflections and decisions emerging from this session.

Session 18: Remembrance and the Future

At the beginning of this session, the homework is discussed and a dedication is decided upon – an action or a location is designated to honor the deceased (such as a park bench). Then the patient's future plans are discussed. Finally, patients are asked to consider what they would tell a real or imaginary friend who has also lost a loved one, about their own grief (social sharing [cf. Wagner et al., 2006]). This can be in the form of a letter or empty-chair work. The purpose is to help the patient achieve distance from the event and regain control. As homework, the patient is asked to write about his plans for 3, 6, and 12 months in the future.

Session 19: New Life

The purpose of this session is to encourage the patient to start a new life, one not overshadowed by grief. The focus here is particularly on new roles that have become possible as a result of the loss (e.g., 'I am a widow now and can do things that I could not do before'). For the next session, patients are instructed to write down specifically how they would like to shape their new life. Writing down future plans is part of this, but now with a focus on new roles and related expectations. Later in the session, the patient's toolbox is reviewed. The likelihood of a relapse is addressed, normalized, and preventive plans are made.

Session 20: Parting

This last session is about parting from the therapist. The session should have the character of a celebration. Appreciation is expressed for the patient's perseverance and new skills, and the beginning of a new stage of life is positively emphasized.

Outlook

Good treatment efficacy for PG-CBT was previously demonstrated in a randomized controlled trial [Rosner et al., 2014, 2015]. The extent to which these promising results can be confirmed in direct comparison with another active therapeutic method is currently being tested in a large-scale clinical trial [Rosner et al., 2018]. In this multi-center study, about 200 people in 5 German cities are being treated for PGD with PG-CBT or a present-centered therapy.

So far, no worsening of symptoms has been found during PG-CBT treatment [Rosner et al., 2015]. After the end of treatment, PGD symptoms were either stable or improved over a period of 1.5 years [Rosner et al., 2015]. Also, in other randomized controlled trials on the efficacy of cognitive-behavioral interventions for PGD, no undesired or adverse effects have so far been reported [e.g., Boelen et al., 2007; Bryant et al., 2014; Shear et al., 2014]. Learning PG-CBT requires current or completed training in psychotherapy. Participation in a 2-day PG-CBT workshop as well as regular participation in manualized case consultations to ensure adherence and to clarify questions that arise during therapy have also proven beneficial. Taken as a whole, PG-CBT is a flexible and effective method for treating PGD.

Disclosure Statement

Rita Rosner, Gabriele Pfoh, and Michaela Kotoučova are co-authors of the Hogrefe manual 'Anhaltende Trauerstörung' (Prolonged Grief Disorder) [Pfoh et al., 2015]. R.R. and G.P. provide training and continuing education for treatment of PGD.

Translated by Susan Welsh
welsh_business@verizon.net

References

Abram A, Hirzel D: Fühlen erwünscht. Praxishandbuch für alle sozialen Berufe mit 88 kreativen Übungen für verschiedene Zielgruppen und Symptomatiken. Paderborn, Jungfermann, 2007.

APA (American Psychiatric Association): Diagnostic and Statistical Manual of Mental Disorders, ed 5. Arlington, American Psychiatric Publishing, 2013.

Beck AT: Cognitive Therapy of Depression. New York, Guilford, 1979.

Boelen PA, de Keijser J, van den Hout MA, van den Bout J: Treatment of complicated grief: a comparison between cognitive-behavioral therapy and supportive counseling. J Consult Clin Psychol 2007;75:277–284.

Boelen PA, van den Bout J: Complicated grief, depression, and anxiety as distinct postloss syndromes: a confirmatory factor analysis study. Am J Psychiatry 2005;162:2175–2177.

Bryant RA, Kenny L, Joscelyne A, et al: Treating prolonged grief disorder: a randomized clinical trial. JAMA Psychiatry 2014;71:1332–1339.

Currier JM, Neimeyer RA, Berman JS: The effectiveness of psychotherapeutic interventions for bereaved persons: a comprehensive quantitative review. Psychol Bull 2008;134:648–661.

Ehlers A: Posttraumatische Belastungsstörung. Göttingen, Hogrefe, 1999.

Foa EB, Rothbaum BO: Treating the Trauma of Rape: Cognitive-Behavioral Therapy for PTSD. New York, Guilford, 2001.

Glickman K, Shear MK, Wall MM: Mediators of outcome in complicated grief treatment. J Clin Psychol 2017;73:817–828.

Kabat-Zinn J, Kesper-Grossman U: Die heilende Kraft der Achtsamkeit. Freiamt, Arbor-Verlag, 2004.

Kersting A, Brähler E, Glaesmer H, Wagner B: Prevalence of complicated grief in a representative population-based sample. J Affect Disord 2011;131:339–343.

Lundorff M, Holmgren H, Zachariae R, Farver-Vestergaard I, O'Connor M: Prevalence of prolonged grief disorder in adult bereavement: a systematic review and meta-analysis. J Affect Disord 2017;212:138–149.

McGoldrick M, Gerson R: Genograms in Family Assessment. New York, Norton, 1985.

Mikulincer M, Shaver PR: An attachment perspective on bereavement; in Stroebe M, Hansson RO, Schut HAW, Stroebe W (eds): Handbook of Bereavement Research and Practice: 21st Century Perspectives. Washington, American Psychological Association, 2008, pp 87–110.

Öst LG: Applied relaxation: description of a coping technique and review of controlled studies. Behav Res Ther 1987;25:397–409.

Pfoh G, Kotoucová M, Rosner R: Integrative Kognitive Verhaltenstherapie: Eine ambulante Einzeltherapie für die anhaltende Trauerstörung bei Erwachsenen; in Rosner R, Pfoh G, Rojas R, Brandstätter M, Rossi R, Lumbeck G, Hagl M, Geissner E (eds): Anhaltende Trauerstörung: Manuale für die Einzel- und Gruppentherapie. Göttingen, Hogrefe, 2015, pp 32–90.

Rojas R, Rossi R, Brandstätter M, Rosner R, Geissner E: Gruppentherapie für die anhaltende Trauerstörung im stationären Setting; in Rosner R, Pfoh G, Rojas R, Brandstätter M, Rossi R, Lumbeck G, Hagl M, Geissner E (eds): Anhaltende Trauerstörung: Manuale für die Einzel- und Gruppentherapie. Göttingen, Hogrefe, 2015, pp 95–152.

Rosner R, Bartl H, Pfoh G, Kotoučová M, Hagl M: Efficacy of an integrative CBT for prolonged grief disorder: a long-term follow-up. J Affect Disord 2015;183:106–112.

Rosner R, Hagl M: Was hilft bei Trauer nach interpersonalen Verlusten? Eine Literaturübersicht zu Behandlungsstudien bei Erwachsenen. Psychodyn Psychother 2007;6:47–54.

Rosner R, Lumbeck G, Geissner E: Effectiveness of an inpatient group therapy for comorbid complicated grief disorder. Psychother Res 2011;21:210–218.

Rosner R, Pfoh G, Kotoučová M, Hagl M: Efficacy of an outpatient treatment for prolonged grief disorder: a randomized controlled clinical trial. J Affect Disord 2014;167:56–63.

Rosner R, Rimane E, Vogel A, Rau J, Hagl M: Treating prolonged grief disorder with prolonged grief-specific cognitive behavioral therapy: study protocol for a randomized controlled trial. Trials 2018;19:241.

Shear MK, Frank E, Houck PR, Reynolds CF: Treatment of complicated grief: a randomized controlled trial. JAMA 2005;293:2601–2608.

Shear MK, Monk T, Houck P, Melhem N, Frank E, Reynolds C, Sillowash R: An attachment-based model of complicated grief including the role of avoidance. Eur Arch Psychiatry Clin Neurosci 2007;257:453–461.

Shear MK, Reynolds CF, Simon NM, Zisook S, Wang Y, Mauro C, et al: Optimizing treatment of complicated grief: a randomized clinical trial. JAMA Psychiatry 2016;73:685–694.

Shear MK, Wang Y, Skritskaya N, Duan N, Mauro C, Ghesquiere A: Treatment of complicated grief in elderly persons: a randomized clinical trial. JAMA Psychiatry 2014;71:1287–1295.

Simon NM, Shear MK, Thompson EH, Zalta AK, Perlman C, Reynolds CF, et al: The prevalence and correlates of psychiatric comorbidity in individuals with complicated grief. Compr Psychiatry 2007;48:395–399.

Stavemann HH: Sokratische Gesprächsführung in Therapie und Beratung: Eine Anleitung für Psychotherapeuten, Berater und Seelsorger. Weinheim, Beltz, 2007.

Stroebe M, Schut H: The dual process model of coping with bereavement: rationale and description. Death Stud 1999;23:197–224.

Stroebe M, Schut H, Stroebe W: Health outcomes of bereavement. Lancet 2007;370:1960–1973.

Wagner B, Knaevelsrud C, Maercker A: Internet-based cognitive-behavioral therapy for complicated grief: a randomized controlled trial. Death Stud 2006;30:429–453.

WHO (World Health Organization): 6B42 Prolonged grief disorder. ICD-11 Beta Draft – Mortality and Morbidity Statistics. *https://icd.who.int/dev11/l-m/en#/http%3a%2f%2fid.who.int%2ficd%2fentity%2f1183832314*, 2018 (last accessed September 19, 2018).

Wittouck C, van Autreve S, de Jaegere E, Portzky G, van Heeringen K: The prevention and treatment of complicated grief: a meta-analysis. Clin Psychol Rev 2011;31:69–78.

Znoj HJ: Komplizierte Trauer. Göttingen, Hogrefe, 2004.