When grief gets complicated

by Dr. Susan Delaney

Abstract

Much has been written, argued and debated about whether complicated grief exists and whether we are merely pathologising a natural event when we attach a diagnosis to it. This article provides an overview on current thinking about the role of attachment in how we grieve, it introduces an evidence-based protocol which has been shown to provide better treatment results and considers how the research in therapy efficacy relates to working with clients presenting with complicated grief.

Introduction

Popular notions about how we grieve, including the idea of fixed stages of grief and the importance of closure have, for the most part, now been discarded as research evidence has failed to support their validity. Neuro- imaging findings have reawakened an interest in human attachment and researchers, such as Mikulincer, have refined the early work undertaken by John Bowlby to explain the central role of attachment in our lives and in our losses. As human beings we are hard-wired to attach to others throughout our life span. We thrive emotionally and socially when we have attachment figures in our lives who provide a safe haven for us. These attachment relationships help to regulate important aspects of our functioning- from sleeping and eating to feelings of self-esteem and self-confidence. Well-functioning adults will typically have about five significant figures in their lives at any one time. We seek out these people when we need comfort and feel confident in exploring the world knowing they "have our backs". We develop a mental representation ("working model") of these figures which are updated as changes occur in the relationship.

Grief is a natural consequence of forming these emotional bonds to others; we grieve when we lose someone (or something) that is important to us. When we experience the loss of an important person in our lives, our physical and emotional well-being is disrupted; we resist accepting the finality of the loss and struggle to make sense of what has happened and how to live without that person.

If our attachment figures are so central to our functioning, then how do we ever learn to manage without them? Is grief so destabilising that we can never recover from it?

Bowlby recognised that a successful period of mourning consisted of acknowledging the finality of the loss and its consequences, revising the internal representation of the person who died and redefining life goals. This is echoed in William Worden's more contemporary work on grief tasks. Research by George Bonanno highlighted the role of resilience and added significantly to our understanding of grief trajectories by evidencing the fact that failure to integrate grief was the exception rather than the rule. We now know that in parallel to our physical immune system, we also have a psychological immune system which facilitates emotional healing. So although grieving can be a very difficult experience, most people find their way through their grief journey with the support of family and friends. As we process the loss, our acute grief gradually becomes integrated and no longer dominates our emotional landscape, but is incorporated into our understanding of ourselves and our world view. The working model is

updated to reflect the loss and we find new ways to remain connected to the person who has died, recognising that death ends a life not a relationship.

Complicated grief

However, for a small number of bereaved individuals this adjustment does not occur. Instead of the grief integrating, the process is derailed, sending it into a repetitive loop with intense yearning, avoidance and preoccupation with the death predominating the emotional and cognitive landscape. The bereaved person has little enthusiasm for life and cannot imagine a time that they will ever feel joy or passion in their life again. This is what is known as complicated grief (CG). The analogy of a train can be a useful way to explain complicated grief; if grief is imagined as a train journey, then each bereaved person finds their own route, stopping at different stations for different lengths of time and arriving at their own destination. When someone has CG it is as though obstacles have caused the train to derail and no progress can be made until the debris is removed from the track. To work effectively with CG practitioners must recognise and attend to the debris so that the train can get back on track and the grief journey can continue. The incidence of CG is low; estimates range from 2% to 20% and most cases are still unrecognised and untreated.

DSM-5 has included CG as a recognised disorder under the title Persistent Complex Bereavement Disorder. Lack of an agreed set of criteria resulted in the disorder being placed as a condition for further study, however must researchers agree that key features include a bereavement reaction out of proportion or inconsistent with cultural/religious or age-appropriate norms and a level of disturbance that causes clinically significant distress of impairment of functioning in social or occupational settings. It is expected that the disorder will also appear in the new edition of the ICD due to be published in 2015.

CG- as it continues to be called by clinicians- can be diagnosed using standardised inventories coupled with a thorough grief history and assessment. DSM-5 sets 12 months post bereavement as the minimum time frame for diagnosis; however Holly Prigerson's work indicates that it may be diagnosed as early as six months post bereavement. The inclusion of the disorder has been criticised by some as an attempt to pathologise grief- in this author's opinion, it merely confirms what most practitioners have long been aware of; the failure of a small number of clients to progress in therapy despite everyone's best efforts. Wherever we position ourselves on the debated-diagnostic categories ultimately serve only one purpose and that is to reduce the suffering, incapacity and misery of clients who seek our help.

Treating complicated grief

The acceptance of CG as a disorder has led to the development of innovative treatment protocols, most notably that developed by Shear (2006) known as CGT, which has been shown to reduce symptoms of grief and improve level of functioning when compared to more traditional talk therapy. CGT is based on attachment theory and integrates strategies drawn from Interpersonal Psychotherapy, Cognitive-Behavioural Therapy and Motivational Interviewing. It is a 16 week, strengths-based model which mirrors the Dual Process Model (DPM) described by Stroebe and Schut. DPM recognises the importance of oscillating between focusing on the grief and defensive exclusion to allow for restoration work. People with CG frequently struggle to dose their grief; they have likely developed strategies to avoid their grief, because they feel overwhelmed when they do attend to it. CGT models this oscillation in the therapy work and allows clients to develop the capacity to move towards their grief and away from their grief.

The CGT protocol uses strategies and techniques which facilitate the three main processes of grief resolution; acknowledging the death and its consequences, revising the mental representation of the person who has died and redefining life goals in light of the life changing events. Sessions are structured and follow a similar format, beginning with a review, moving on to particular exercises focusing on the death and consequences, then shifting to activities of restoration and ending with plans for the following week. Clients are active collaborators in the process and are asked to engage in daily activities of grief monitoring, goals work and self-compassion. Both imaginal and situational activities are utilised as well as structured memory work, photographs and an imaginal conversation with the deceased. Progress is monitored regularly and feedback is used to structure the protocol to the client's needs and to refine the understanding of why the grief process became stuck. As the instinctual healing process is activated, the working model updates and the grief begins to integrate.

Of course protocols and techniques alone don't heal people, and effective treatment will always be predicated on the ability to form a strong therapeutic alliance and

tailor treatment interventions to fit with the client's experience and interpretation of the problem. Duncan Hubble and his colleagues provide an excellent overview of what makes for effective therapy in their book; The heart and soul of change. They break down the effectiveness variance into; 40% -client factors, 30% - therapeutic relationship, 15% accounted for by the instillation of hope and expectation and 15% accounted for by the techniques utilised. One of the best predictors of negative outcome in therapy is a lack of focus and structure, when working with CG it becomes even more important to have a clear hypothesis rooted in bereavement theory and a therapeutic approach with an evidence base. To ensure that bereavement therapy is both effective and self-sustaining David Morawetz recommends that therapists focus on using the relationship to empower the client both in and outside of session, generate realistic hope without minimising the difficulties and utilise relevant and proven techniques to ensure that the therapy is effective and self-sustaining.

CS Lewis reminds us in A grief observed; *"Bereavement is a universal part of the experience of love… it is not the interruption of the dance, but the next figure of the dance"*. People with CG erroneously believe that they need to hold tightly to their grief as a way of staying connected to their loved one, they fear forgetting and can become locked in a vicious cycle of either feeling bad or feeling bad if they start feeling better. The truth is that we are forever connected in a deep way to those we love, but it is possible to remember them with love rather than with pain and it is possible to reconnect with life and find meaning and joy after bereavement. Again CS Lewis in observing his own grief noted; *"I have learned that passionate grief does NOT link us with the dead, but cuts us off from them….. It is just at those moments when I feel least sorrow that H rushes upon my mind in her full reality"*.

With the establishment of the Complicated Grief Programme at the Irish Hospice Foundation, Ireland has taken a lead in providing evidence-based treatment for people presenting with complicated grief and is one of only two sites in Europe providing treatment and training in CGT. With growing awareness and better understanding of the principles of effective intervention there is now hope for this debilitating condition.

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