APPLICATION OF THE CASE CONCEPTUALIZATION MODEL TO PATIENTS EXPERIENCING PROLONG AND COMPLICATED GRIEF REACTIONS

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BACKGROUND INFORMATION

1. In the aftermath of the death of a loved one or due to some other forms of losses most individuals are able to negotiate the grieving process in a culturally acceptable manner and NOT develop any specific adjustment disorders.

2. Approximately some 15 % will experience prolong and complicated grief reactions. A CCM will be a useful tool to identify what distinguishes these two groups and develop an individualized treatment program;

3. Assessing the circumstances of the loss with the patient and his/her coping strategies informs treatment planning.

LEARNING OBJECIVES

1. To be able to use a CLCOK metaphor with the patient in order to explore both the external and internal triggers (12 O'clock), accompanying feelings (3 O'clock), Cognitive (6 O'clock) and behavioral (9 O 'clock) features of his/her grief reactions.

2. To be able to use the Patient Coping with Grief Checklist in order to assess the patient's coping strategies

3. To be able to implement the Core tasks of psychotherapy.

THE NATURE OF PROLONGED COMPLICATED GRIEF REACTIONS

Complicated Grief Reactions consist of a variety of components including how survivors perceive and appraise interpersonal, intrapersonal (reminders), situational triggers and the emotions they elicit, as well as the accompanying automatic thoughts, images, beliefs, schemas which contribute to how survivors behave (what they do and do not do) and how others react. This interconnective chain can occur in a variety of ways and can lead to a downward "loss spiral", or can lead to a "recovery process". The following CLOCK metaphor can be used to summarize and educate clients about the mourning process.

Use of a CLOCK Metaphor to Summarize Complicated Grief Reactions

12 o'clock - External and Internal Triggers

3 o'clock - Primary and Secondary Emotions

6 o'clock - Automatic thoughts and images, Thinking Processes, Schemas and Beliefs

9 o'clock - Behavior and Resultant Consequences

12 o'clock - External Triggers
- Circumstances of the death
- Reminders of death, losses
- Other people's losses act as triggers
- Memorial events, routines

Internal Triggers
- Reminders such as an anniversary and situational reminders (holidays, special times and events)
- "Echoes of other losses".

3 o'clock – Primary and Secondary Emotions and The Survivor's Attitude About Emotional Expression

Initially, stunned, shocked, disbelief, confused, emotionally numb, angry, enraged, sad, anxious, bitter, psychologically hyperaroused, devastated, sense of unreality about the loss, dissociated, disgusted, guilty, shamed, humiliated.

This may be followed by feelings of longing, yearning, emptiness, loneliness, fear that something else bad is going to happen, powerlessness, helplessness and hopelessness, separation distress and depression, "emotional anesthesia" and feelings of unreality.

6 o'clock – Automatic thoughts and images, thinking processes, schemas and beliefs

Initially, a sense of disbelief depending on the circumstances of the death, rumination on circumstances of the death, difficulty accepting the loss, disbelief, denial of the death.

Subsequently, sense of purposelessness, ongoing rumination and increased vulnerability to intrusive ideation, hallucinatory experiences, sense of losing control, "going crazy", overgeneralized memories that contribute to not envisioning a future and that undermines problem-solving, mistrust of others, and identity confusion, enduring search for meaning, engage in contra-factual thinking (Ask "Why Questions" for which there are no satisfactory answers), engage in "Only if" type thinking. Continually replay circumstances of the death, self-blame and critical negative thinking, hold onto unachievable goals. (See Janoff-Bulman, 1989, 1992; Nolen-Hoeksma, 2001; Stroebe & Stroebe, 1999, 2006).

The following are examples of the LOSS MINDSET and the accompanying METAPHORICAL NARRATIVES that characterize individuals who experience PCG. Such thinking processes and the accompanying emotional reactions contribute to the perpetration of complicated grief. The thinking processes include:

1. Inconsolable emotional pain.

2. A lack of a future outlook.

3. Guilt-engendering thoughts, self-blame, "hindsight bias" (judging something in the past on the basis of knowledge that one has now, but did not have then; "Monday Quarterbacking").

4. Ongoing search for meaning.

5. Ruminations and self-doubt.

6. Contra-factual "If only" and "If then" thinking processes.

7. Thoughts that undermine help-seeking.

8. Low self-efficacy statements

Examples of the Narrative of Individuals with PCG

1. Inconsolable Emotional Pain

- *"I am (lost, adrift, bereft, a cry baby, entangled in a cascade of grief, a loop of unresolved grief)."*
- *"I am experiencing a (fog of grief, bereavement overload, waves of grief)."*
- *"I feel (alone in my suffering, stuck in the past, frozen in Time, an emptiness with a hole in my heart that cannot be filled)."*
- *"I don't know who I am any more. The light in my life is no longer living."*

2. A Lack of Future Outlook

- *"There is no future. My life is over."*

- *"I will never get better."*
- *"I am stuck in this forever."*
- *"This will never end."*
- *"There is no way to be happy again."*
- *"I don't deserve to be happy, laugh, love again."*
- *"His pain ended, but mine will be forever."*
- *"Time has stopped for me."*
- *"It feels like it just happened."*
- *"I don't have confidence in the future."*
- *"There are more yesterdays than tomorrows. I have nothing to look forward to."*
- *"I feel an impending doom."*
- *"I am waiting for the other shoe to drop."*

3. Guilt-engendering thoughts: Influence of Hindsight Bias

- *"I killed him/her. His/her death was my fault."*
- *"I was too busy and too self-absorbed that I overlooked (denied) the warning signs."*
- *"I didn't do anything right when he/she was alive."*
- *"I am a bad person for letting this happen."*
- *"I must suffer like he suffered. It is not right to enjoy myself."*
- *"This is God's punishment."*

- *"I feel guilty about all of the unfinished business between us. I never got a chance to say 'I was sorry'."*
- *"I never got a chance to say a proper goodbye."*
- *"I was not there to comfort him when he died. He died alone."*

4. Ongoing Search for Meaning

- *"I haven't been able to put the pieces of my life together since this event."*
- *"I have trouble making sense of her death."*
- *"How unfair that he/she died. It makes no sense?"*
- *"His/her death was useless. What did he/she sacrifice his/her life for?"*
- *"I am devastated. Since his/her death, life has no meaning. It is purposeless."*
- *"I feel cheated."*
- *"I asked God to protect her, and He did not."*
- *"I was betrayed."*
- *"His/her death has robbed my life of meaning."*
- *"Since _____ died, I feel worthless, directionless."*
- *"Life has nothing to offer me."*
- *"I am trapped. I am up against a wall."*
- *"I keep asking why questions, but there are no satisfactory answers."*

5. Rumination – "Not Let It Go"- "Re-enactment Story; Desire for Retribution

- *"I keep thinking about how he/she died."*
- *"I replay it over and over."*
- *"I repeatedly think about how things could have been different."*
- *"It is too painful. I do not want to think about it, but I can't stop thinking about his/her death."*
- *"I keep asking, 'Why me?'; 'Why my child?'"*
- *"I continually dream about revenge."*
- *"I am suffocated by my anger."*
- *"I can never feel completely safe again."*

6. Contra-factual Thinking Processes: "If only" and "If then…" Thinking

- *"If only X (I had, or I had not), I could have prevented his/her death."*
- *"Only if I had X, he/she would be alive today."*
- *"If I did X before and things turned out badly, how can I ever trust myself to make good decisions?"*
- *"If only he/she were here now."*
- *"If I get better, then his/her death has no meaning."*
- *"If I don't continue mourning, there is no one to hold onto his memory."*
- *"My grieving keeps his/her memory in the public "eye."*

7. Thoughts That Undermine Using Social Supports and Accessing Help

- *"No one knows how bad I feel."*
- *"No one can help me."*
- *"This is too painful to bear and share."*
- *"This is the worst thing that could happen. If I talk about his/her death, I will go crazy."*
- *"I cannot confront the reality of his/her death."*
- *"Nothing and no one can ease my pain."*
- *"No one will want to be around me when I am so miserable."*
- *"I am not whole. I have lost an important piece of me and it is not reparable."*
- *"I can't trust anyone."*
- *"I feel shut out, a stigma over my head, like I had the plague."*
- *"I avoid and limit contact with others."*

8. Lacking Ability to Cope: Low Self-efficacy

- *"I can't cope."*
- *"I am emotionally worn out."*
- *"I can't cope with anything that reminds me of him/her."*
- *"I can't make myself better. I am trapped."*

- *"I will never have someone this close again, this important."*
- *"I don't want to have someone this close to me again, and have them die on me."*
- *"Others will die and I won't be able to bear it."*
- *"I was so dependent on _____. I cannot function without him/her."*
- *"Here I go again. The same vicious cycle that I cannot stop."*
- *"I don't mourn the way I should."*
- *"I feel as if part of me has died."*
- *"I can't trust my own judgment any longer."*
- *"Drained my vitality. My life has no purpose and meaning."*
- *"My life is now filled with never agains."*

9 o'clock – Behavior and Resultant Consequences

Uncontrollable crying spells, sighing, fatigue, decreased appetite, difficulty sleeping, nightmares, neglect of self-care, increased use of substances, increased tobacco use. Difficulty concentrating, irritability, restlessness and difficulty reinvesting in life.

Proximity seeking behaviors- - wear deceased cloths, sleep in his/her bed, lie near the grave, hallucinatory experiences, hard to part with loved one's possessions.

Avoidance of emotions and reminders, withdrawal, disengaged from usual activities that give pleasure, engage in mindless self-distraction activities, keeping busy, lack of acceptance of death, denial. Attempts to control rumination by suppressing thoughts and engaging in avoidance behaviors.

Difficulty "moving on" with life, failure to engage in memorial, commemorative ceremonies, avoid seeking social support and help/treatment.

Social withdrawal can contribute to feelings of isolation, estrangement, loneliness. Self-isolation is an important factor associated with health problems, PTSD and complicated grief. Not participating in leisure activities that one enjoyed with the deceased because they trigger bittersweet memories; not participating in religious-based activities because disillusioned with one's faith, engaging in overprotective behaviors with surviving loved ones can each contribute to PCG. Such reactions by survivors can be exacerbated by the social ineptitude of others who minimize the loss, or who offer "moving on" statements, or who avoid contact or fail to offer comforting supportive emotional and tangible assistance. (Dyregov, 2003-2004; Wolfert, 2006).

The grieving process can also be impacted by the legal system and media coverage in the aftermath of traumatic violent death of the deceased and by the need for victim impact statements.

Challenges of fulfilling new social roles and responsibilities (financial, parenting, role models). Loss of self-identity (e.g. being a "military spouse") can contribute to Prolonged and Complicated Grief.

STRATEGIES FOR COPING WITH GRIEF CHECKLIST

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The process of grieving is like going on a "journey." There are multiple routes and people progress at different rates. There is no right way to grieve, no one path to take, no best coping approach. These grief coping strategies list some of the pathways that others have taken in their journey of grieving. It is *not* meant to be a measure of how well you have coped or how you should cope, since there is no one way to manage the pain following the aftermath of the loss of a loved one, no matter what the cause of his or her death. Rather, the strategies listed are suggestions of things you might consider doing to help you on your journey.

We suggest that you look through this list and put a mark by the coping strategies that you've tried. Hopefully, these strategies have helped you. But if you feel that you could use a little extra help, we suggest that you look through the list and then choose some new items that you would like to try. You may find them helpful, and you can add them to the strategies that you've already tried. This list is intended to help you discover new ways that you can move forward on your journey through the process of grief. If there are things you have done that you have found helpful that are not on this list of coping strategies, please add them at the end so we can share these with others.

Sought comfort and help from others

1.	●	I examined the thoughts that kept me from seeking help from others, such as the beliefs that "I am a burden to others," "No one can help me, no one understands," "I have to do this on my own," "I should be stronger," "Listening to the grieving stories of others will make me feel worse," or "People are tired of hearing about my loss."
2.	●	I reached out to family, friends, elders, or colleagues for comfort and companionship, but gave myself permission to back-off when I needed time alone.
3.	●	I took the initiative to reach-out to folks from whom I might not normally seek help. I looked for new friends in church groups, social groups, work, school, or I went on the internet to find others who experienced a similar loss. I made a list of these supports to turn to when I was struggling or experiencing pain.
4.	●	I forced myself to be with people and to do things, even when I didn't feel like it. I put something on my calendar almost every day, with back-up plans.
5.	●	I allowed myself to tell people how much I loved, admired, and cared for them.

6.	●	I hugged and held others, but felt free to tell people when I did not want to be touched.
7.	●	I learned to grieve and mourn in public.
8.	●	I shared my story with others who I thought would appreciate and benefit from it. I told anyone who would listen to the story of the deceased, even if they had nothing to say back.
9.	●	I gave and received random acts of kindness.
10.	●	I connected with animals and nature, for example, the deceased's pet, a beautiful sunset, hike, or garden.
11.	●	I cared for or nurtured others. For example, I spent time caring for my loved ones or children.
12.	●	I found my faith or religion comforting. I participated in religious, cultural, or ethnic mourning practices, such as attending church services, sitting Shiva, participating in a Wake, celebrating the Day of the Dead, visiting a memorial shrine, etc.
13.	●	I sought help from organized *supportive* bereavement groups, hospices, religious groups, grief retreats, talking circles, or groups specific to the way the deceased died, such as cancer support groups or survivors of violent loss groups, such as suicide or homicide.
14.	●	I sought help from mental health professionals. For instance, attended counselling sessions or took medications as advised by my providers.
15.	●	I read books written by others who have coped with the loss of a loved one. I read about the grieving process, loss, and advice books about other issues that arose.
16.	●	I made a list of all the professional resources that I could use in a crisis, such as suicide hotlines, mental health crisis lines, mentors, clergy or imam, or mental health providers.
17.	●	I decided not to walk through the grieving process alone, so I visited websites that focus on the grieving process (*Refer to the list of websites at the end of this list.)*

Took care of myself physically and emotionally

18	●	I examined the thoughts and feelings that kept me from taking care of myself physically and emotionally, such as guilt, shame, sense of lost self, and loss of the will to live
19.	●	I established routines of daily living. Although things were different, I made new routines and did not berate myself when I was not "perfect." I maintained personal hygiene, medical care, healthy nutrition, and regular sleep.
20.	●	I reconnected with my body through exercise, yoga, Tai Chi, or expressive arts, allowing myself time to get stronger.
21.	●	I recognized that my brain needed time to heal and for things to improve, so I forgave myself when I made mistakes, became distracted, couldn't remember or understand.
22.	●	I avoided the excessive use of alcohol, tobacco, recreational drugs, and caffeine as a coping mechanism.
23.	●	I relinquished avoidance and learned to face my fears by engaging in life. I participated in activities that had meaning and kept me occupied, such as work, hobbies, crafts, singing or dancing.
24.	●	I allowed myself to pursue and feel positive emotions, such as compassion toward myself and others, expressions of gratitude, and emotions of love, joy, awe, and hopefulness.
25.	●	I recognized and labeled my feelings, viewing them as a "message" rather than something to avoid. I accepted and dealt with these emotions, understanding that the less I fought them, the more I was able to handle them.
26.	●	I regulated my strong negative emotions using slow smooth breathing, coping self-statements, prayer, or other mood-regulating techniques.
27.	●	I allowed myself time to cry at times and gave words to my emotional pain. I distinguished feelings of grief from other feelings such as fear, uncertainty, guilt, shame, and anger.
28.	●	I expressed difficult feelings through writing and talking to supportive others. I used journaling, reflective writing, letter or poetry writing, or other expressive arts of scrapbooking, dance or music.
29.	●	I engaged in gratitude activities, such as telling others how much I appreciate their love and support, reminding myself of the things that I am thankful for, and being grateful that I knew the deceased.

30.	●	I established a safe and comforting space for myself, either physically or through imagery.

Stayed connected to the deceased and created a new relationship, while recognizing the reality of the loss.

31	●	I examined the feelings and thoughts that kept me from forming an enduring connection with the deceased, such as the fear of what others would think of me, guilt, shame, humiliation, disgust, or thoughts of anger, revenge or being preoccupied with my grief.
32.	●	I participated in practices, such as visiting the grave or memorial site, celebrating special occasions, prayer and candlelight vigils, public memorials, or commemorative services.
33.	●	I commemorated the deceased's life with words, pictures, things, or created a small place of honor for the deceased, which I could visit any time I chose.
34.	●	I thought about what I received from the deceased and the legacy and mission to be fulfilled. I became involved in a cause or social action that was important to the deceased or myself.
35.	●	I created a legacy such as planted a tree, started a scholarship or charity in the deceased's name, started an internet blog, or launched new family or community practices.
36.	●	I allowed myself to talk to the deceased and allowed myself to listen. I wrote a letter to my loved one and asked for advice.
37.	●	I asked for forgiveness, shared joys and sorrows, and constructed a farewell message.
38.	●	I accepted that sadness was normal and learned how to be with my grief. I learned how to contain my grief to a time and place of my choosing. However, I understood that intense upsurges of grief may arise unexpectedly and without warning, and I developed coping strategies to handle such events.
39.	●	I used imagery techniques, shared stories and photos of my loved one, or purposefully used reminders such as music or special routines to recall positive memories. I cherished and hung onto specific, meaningful possessions (objects, pets, etc.). I actively reminisced, holding onto our relationship in my heart and mind

40.	●	I reached out to help and support others who are grieving for their loved ones. Helping others is a way to reengage in life and combat loneliness and tendencies to withdraw and avoid social contacts.

Created safety and fostered self-empowerment

41	●	I examined the thoughts that fuel my fears, avoidance, and the belief that I cannot or should not feel happy and that things would never get better.
42.	●	I took a breather and gave myself permission to rest knowing that grieving takes time and patience, with no quick fixes.
43.	●	I identified memories that trigger or overwhelm me and disengaged and/or established boundaries by limiting people, places, or things that cause me stress or overwhelm me so that I could address them one by one, in my own time. I learned to say "no" to unreasonable requests.
44.	●	I identified important activities, places, or things that I was avoiding due to fear of my grief reactions. I slowly reintroduced them or allowed myself to choose those I never wanted to encounter again.
45.	●	I began to think of myself as a "survivor,", if not a "thriver" of my own story, rather than as a "victim." I reminded myself of my strengths and of all the hard times that I have gotten through in the past.
46.	●	I wrote out reminders of how to cope and put them on my fridge, cell phone, or computer. I looked at them when I was struggling and reminded myself of ways to be resilient.
47.	●	I created a plan about how to cope with difficult times. I learned to anticipate and recognize potential "hot spots" of when things are most difficult. I rated each day on a 1 to 10 point scale on how well I was doing. I asked myself what I can do to make things better and increase my rating. I worked on increasing the number of good days compared to the number of bad days.
48.	●	I avoided thinking "This is just how it is," realizing that I have choices no matter how hard life is. I came to recognize that emotional pain can be a way to stay connected with my loved one.

49.	●	When I was overwhelmed by negative memories of the past, I avoided "time-sliding" into the past. a) I "grounded" myself to the present by refocusing my attention on the environment around me, b) I changed my self-talk by telling myself "I am safe and that this will pass," c) I controlled my bodily reactions by slowing down my breathing, and d) I oriented to people's faces, voices or touch or called for help from a friend.

Moved toward a future outlook and a stronger sense of self

50	●	I examined the thoughts and feelings that kept me from moving forward, such as "I am dishonoring the deceased by getting better," or "I am leaving him/her behind," or "Feeling happier means that he/she is no longer important to me," or that "My love for him/her is fading."
51.	●	I regained my sense of hope for the future. I worked to reestablish a sense of purpose, with meaningful short-, mid-, and long-term goals. I am creating a life worth living, taking control of my future.
52.	●	I worked on regaining my sense of self-identity, knowing that my life had changed, but that I am still *me*. I focus on what is most important. I developed new goals and action plans, consistent with what I value.
53.	●	I created purpose by keeping the memory of the deceased alive in others. I kept others aware of the circumstances of the death, so that some good could come from the loss. I transformed my grief and emotional pain into meaning-making activities that created something "good and helpful," for example Mothers Against Drunk Driving and the Melissa Institute for Violence Prevention.
54.	●	I use my faith-based and religious and spiritual beliefs to comfort me and move on. People hold different beliefs, such as "My loved one can continue to influence the lives of others in the world," or "My loved one is no longer suffering and is in a safe place," or "We will be reunited in the future."
55.	●	I examined the reasons why some of the activities that have been helpful to others in the grief process were not helpful for me, and what I can do to help myself further in the journey through grief.

Other coping activities or strategies I have used to cope with my loss

_____

_____

_____

_____

Helpful websites:

www.griefnet.org
www.compassionatefriends.org
www.dougy.org
www.taps.org
www.missfoundation.org
www.afsp.org/coping-with-suicide
www.opentohope.com

EXAMPLES OF THE CORE TASKS OF PSYCHOTHERAPY

1. Establishing, Maintaining and Monitoring the Psychotherapeutic Alliance

   The psychotherapist should act as a non-judgmental, "compassionate guide" who uses empathetic attunement, encouragement, supportive collaboration, understanding and respect for the client's symptoms and struggles. For instance, validate the client's feelings so the client feels heard and understood.

   > *"I am so sorry this happened to your loved one."*
   > *"I think you are brave for seeking help in the midst of your grief."*
   > *"You seem connected to your experience and can still be able to talk about it."*
   > *"I wonder if you have allowed yourself to express and share the full (fear, anger, guilt) you experience?"*
   > *"What do you fear will happen if you allow yourself to feel (your emotions, grief, anger, fears)?"*
   > *"I can see that you are learning to express your feelings without trying to escape from them."*
   > *"There may be obstacles along your path, but we can address them in a way that frees you up."*

   The therapist can also employ the language of possibilities, change and becoming. For example, bathe the social discourse with such evocative verbs as "notice, catch, handle, tolerate, confront, take control, choose" and a variety of "*RE*" verbs - - "regain, reclaim, redefine, reaffirm, reauthor, restore, reconcile, reengage, remind, reconnect." See Meichenbaum's Roadmap to resilience book (pp. 127-128 and 136-137 for a discussion of how psychotherapists can ask clients for examples for each "RE" activity, and moreover, what does this mean for the client's journey? In this way, the psychotherapist can use a Constructive Narrative strength-based approach to help client's develop a "coherent healing story."

   As Perlman (2016) highlights, the therapist needs to explore collaboratively with the client, empathize, educate and encourage.

2. Conducting Psychoeducation

   Psychoeducation may take various forms that include the art of questioning; client feedback on assessment; descriptive sharing of information about specific topics such as the nature and rationale of treatment; the role of avoidance, specific bereavement issues; "myths" about the mourning process; self-monitoring procedures, coping skills and self-attributional training and relapse prevention procedures.

   Psychoeducation is not a didactic process, but a highly collaborative, discovery-oriented Socratic questioning approach. Psychoeducation is ongoing and occurs throughout the course of treatment. It is not as if one does psychoeducation and then one does treatment. The two processes are highly interweaved, as in the case of the Coping with Grief Checklist.

Examples of Psychoeducation

1. Provide a description of what therapy entails and the rationale for each aspect of treatment. Check for the client's understanding throughout.

2. Discuss the nature of grief and the mourning process. Highlight the following:

    a) Grief is often accompanied with sadness, anxiety and uncertainty about the future, and feelings of yearning and longing;

    b) There is no one right way to cope with the death of loved ones. There is no timetable. The grief process unfolds naturally over time.

    c) There are no specific stages that individuals go through in the mourning process.

    d) Most individuals are impacted by the death of loved ones, but they go onto evidence resilience or the ability to "bounce back". Some individuals need the assistance (help) of others. Joy and sorrow can co-exist.

    e) Individuals can learn to contain their grief, like putting it in a "grief drawer" (see Harris, 2016). They can choose when and to whom to share their grief. They can put their emotional pain into words, or into some other forms of expression (painting, dance), and they can embed their loss into a life-time autobiographical history. Some individuals go back and look at photographs and cherish their memories and their legacy. They learn to support themselves in ways that no other person can. They come to live life fully, even in the wake of their losses.

    f) Highlight that relationships are not really lost when a loved one dies, and who is not physically present, but the relationship is "changed."

    g) Ask if the client can learn to leave a space in his or her life for their loved one's presence?"

3. Discuss the nature of avoidance and its impact. For instance:

    "It is human nature for individuals to desire to avoid painful events, disturbing thoughts and distressing feelings about the loss and avoid any reminders that may trigger such emotional pain. But such avoidance actually prolongs the pain in the long run. Unfortunately, such avoidance usually does not work, and pain finds its way into our lives, one way or another" (with the therapist's assistance, have the client give examples).

Convey how treatment can help individuals, in a safe and supportive environment, develop the courage to express and share their emotional pain, without becoming overwhelmed, and even learn to view such "emotional pain" as a form of connection with the deceased

(reframe the pain). Address the client's attitude toward expressing feelings and discuss and train emotion-regulation skills on how to tolerate and manage negative emotions and "broaden and build" positive emotions (See Meichenbaum, 2013).

4. Use a CLOCK metaphor to help clients better appreciate the interconnections, and links between how they appraise events, experience primary and secondary emotions, have automatic thoughts and beliefs, and behave and the consequent reactions from others.

5. Psychoeducation can also be used to have the client reexamine "realistically", the nature of his/her relationship with the deceased (both positive and any negative/disappointing aspects) of their relationships. The therapist can ask:

   "What are some things you <u>most appreciated</u> in your relationship with your loved one (spouse, parent, friend, coworker)? What do you miss the most?"

   "Permit me to ask, what do you wish could have been different in your relationship with X? Is there anything you did <u>not</u> appreciate or wish was different in your relationship with X?"

Such questioning reduces the likelihood of the survivor idealizing the past relationship and may help the client be open to developing new relationships. Also, conduct goal-setting that nurtures hopefulness and the language of becoming.

"What would you like to be doing if you were no longer grieving?" (See the Section on Questioning)

6. Psychoeducation should include a discussion of <u>possible</u> <u>barriers/obstacles</u> that may undermine the client's personal journey of mourning. Reinforce the client's development of a "New Identity", a "New Me." The therapist can convey:

   "Each person is unique. Each person's situation is different. Each person negotiates the mourning process at his/her own pace and manner. What, if anything, might get in the way of your personal journey? How can you learn to anticipate these potential barriers and address them ahead of time?"

   "How can you learn to reengage the most painful aspects of your account of loss (narrative), while also learning how to contain the emotional pain and come to terms with it?"

   "Is there any way you can mobilize social supports?"

   "Healing, in the case of grief, involves hearing. Is there someone in your life you can count on, or with whom you can share your story?"

3. Restorative Retelling Procedures

Restorative re-telling procedures may take many different forms (Neimeyer, 2002, 2012). Each of these procedures are designed to help the survivor to process grief and establish a new relationship with the deceased, but maintain the deceased person's presence in the life of the survivor. One prominent procedure is to use the Gestalt empty-chair technique ("chair work" Paivio & Greenberg, 1995). In Litz et al.'s (2016) Adaptive Disclosure therapeutic approach, they use the "empty chair" procedure as a vehicle to generate a conversation with the deceased person. It facilitates corrective information, especially when loss and guilt are entangled. They divide the imaginal dialogue into three sequential steps:

1. Preparing the client for the processing of the loss;

2. Engaging in this breakout procedure of loss in which the client has a conversation with the deceased person, in real time (right now);

3. Post breakout component discussion about the meaning and implications of the loss and the client's experience of talking to his or her lost person.

As described by Litz et al. (2016, pp. 107-117), the following clinical guidelines should be followed. (A similar approach has been used with clients who have experienced "moral injuries" (See Litz et al., 2016 pp. 117-139). When clients experience moral injuries, the empty chair procedure may employ a "moral mentor", rather than a deceased person (Litz, 2004).

I. Preparing the client for the Breakout Imaginal Dialogue Procedure

The therapist should describe the "empty chair" procedure and address the client's questions, concerns and possible sources of resistance. The therapist should offer a rationale for the need to emotionally process the nature of the loss. Discuss the impact of avoidance behaviors. The therapist can ask the client:

> *"By focusing on the impact of the death of X, you will have an opportunity to understand and begin to recover and heal and master your grief. This can create a positive ripple effect in your life. Does this make sense? Do you have any questions?"*

> *"What do you imagine may be any concerns you may have in engaging in this empty-chair activity? Can we discuss these?"*

II. Imaginal Dialogue with the Deceased

1. The client is asked to have a conversation with the deceased person, in real time right now, as if the deceased person was sitting in the empty chair.

2. The conversation with the deceased uses the first person present tense and the client is encouraged to tell the deceased anything he/she wants, highlighting how the loss is affecting him or her. The client should be encouraged to provide a real emotional confession of how the client feels (haunted, guilty, unhappy). The client may wish to close his/her eyes when conducting the empty chair activity. The therapist may use prompts, as suggested by Litz et al. 2016, p. 108).

   "Now I want you to go back to the image of [person who died]. This time, I want you to have an actual conversation with X. What would you like to tell him/her, here, now?"

   "I know he/she is gone, but take this chance to talk to him/her and make it real."

   If the client gets stuck, the therapist should guide him/her by suggesting:

   "Why don't you start with what you remember from when he or she was alive? Why don't you talk a bit about how much you miss him/her; how sorry you are and why?

   After a period of time, the therapist can ask the client to tell the deceased person what has changed behaviorally in him/her since the loss. As suggested by Litz et al. (2016, p.108).

   "Tell him/her what changed for you after his/her death, and tell him/her how his/her death has affected you. Tell him/her how his/her death has changed your views of yourself, others, and the world."

   "Tell him/her how stuck you are, and be sure to describe any struggles you are now having."

   To this imaginal dialogue, the client can be encouraged to share what efforts he/she has taken to honor the memory of the deceased and what coping activities he/she has taken. To facilitate level of resilience, Litz et al. (2016) propose that the therapist ask the client to share what the dead person would say to him/her right now, after hearing all of this.

   "What is she/he telling you now, after hearing all you have said?"

   "What advice would he/she have for you?"

   If the client has difficulty coming up with positive forgiveness-type statements, the therapist can offer suggestions:
   Does he/she want:

   "You to carry on?"
   "What is best for you?"
   "You to live the fullest life possible?"

"You to claim your life and live it fully for <u>both</u> of you?"

The imaginal dialogue may be repeated during multiple sessions in order to help the client shift his/her perspective and contribute to benefit-finding, meaning-making narratives that nurture healing. This form of restorative retelling can contribute to the reconstructing, rather than to severing one's relationship with the deceased.

III. Post-breakout Component

The therapist starts this phase by asking the client to open his eyes and return to the here and now and then to discuss his/her experience of what just happened.

"What was that like for you?"

"What are you going to take from this session to think about throughout this week?"

"What really stood out for you?"

The therapist can also provide normalizing and reassuring comments, and encourage the use of coping behaviors should the client become emotionally upset. Litz et al. (2016, p.117) offer the following examples of possible therapist's comments:

"I know this was difficult, and more than likely you will continue to think about it from time to time throughout this week. This is normal."

"I often find that as clients start to look at difficult experiences, they sometimes have more unwanted thoughts about the experience. This usually goes away with time."

See work by Pearlman, Rando, Shear for additional examples of ways to conduct Restorative Retelling Procedures.

Restorative retelling and empty-chair interventions provide individuals with opportunities to reconstruct and reframe the "stories" they tell themselves and others. Making meaning through the construction of stories and the use of metaphorical language contributes to the healing process (Meichenbaum, 2013; Neimeyer et al., 2010).

4. **<u>Exposure-based and Supplemental Interventions</u>**

In order to address the lingering impact of trauma and to confront avoidance behaviors that undermine recovery, various forms of imaginal and in vivo exposure-based interventions have been developed. Foa et al., (2007), Pearlman et al. (2014), and Steenkamp et al., (2011) provide specific treatment guidelines on how to conduct such exposure-based interventions so clients learn to purposefully tolerate and manage their fears and overcome any avoidant

activities. In the case of imaginal exposure, clients are asked to tell and retell their "story" in the first person using the present tense and to listen to the tape recordings of these sessions as "homework". The in vivo exposure activities are arranged along a gradual hierarchy of increasing demanding challenges. Such exposure exercises should be conducted for at least 45 minutes, three times a week to the point where the client can learn to tolerate his/her fears. The exposure activities may be learning to use coping skills such as breathing retraining and cognitive restructuring.

Jordan and Litz (2014) raise questions about the use of imaginal exposure therapies of having clients repeatedly retell (relive) memories of the moment of death, or related scenes. Such exposure-based interventions follow from trauma-focused treatment approaches that embrace a conditioning model that targets fear-based memories. They note that PCG is not characterized by such fearful memories and

> *"therapeutic rationale for repeated and sustained reliving of the traumatic moment is unclear. Moreover, there is no evidence that 'working through' a loss by sustained focus on it is necessary for healing for all individuals" (Jordan & Litz, 2014, p. 186).*

Restorative retelling and exposure-based interventions may be supplemented by cognitive restructuring procedures that address the client's Automatic Thoughts and beliefs (shattered "Assumptive World"). Another procedure is the use of Activity Scheduling that provides a means to address the client's depression, inactivity and withdrawal by means of physical exercise and related engaging social activities (exercise with others).

The therapist should encourage the client to reengage in pleasurable activities, reattach with others, and pursue various wellness activities. As suggested by Litz et al. (2016, p.114), the therapist can ask:

> *"What type of pleasurable or healthy activities are you keeping yourself from doing since the death/loss of X?"*
>
> *"Of those who care about you in your life, who are you not spending quality time with?"*
>
> *"Are there new challenges you might attempt or activities you might devote specifically to the memory of X? Are there life experiences that you might plan to honor X?"*
> *"Are there ways to memorialize (remember and honor) X?"*

The therapist can use the Coping with Grief Checklist (see pages 21 to 25) as a way to review possible coping activities. In a collaborative manner, the therapist should elicit specific client commitments and discuss possible barriers that may interfere with the client implementing specific "homework" activities between sessions.

> *"What do you think would be useful for you to do before our next session?"*

"What would you be willing to try to work on for next week?"

"What kind of practice assignment seems doable in the next week?"

Neimeyer (2012) has proposed another cognitive restructuring activity that asks clients to share "stories" of their relationships with the deceased as a way to reaffirm and reorganize their attachment with their loved one. He proposes the use of the following set of questions as a way to initiate such accounts:

Could you introduce me to _____ ?
What did knowing _____ mean to you?
Are there particular times, places, or ways in which you recall _____ importance to you?
What kind of things did _____ teach you about life, and about how you could manage the challenges you now face?
What might _____ say he/she appreciated most about you?
What strengths did _____ see in you?
In what ways might you strive to grow closer to _____ across time, rather than more distant?
What difference might it make to keep _____ stories and memories alive?
What has _____ given you that has had enduring value?
What do you want _____ to know about you and your relationship?
Can you describe the lasting impact, of _____ on your life?

Litz et al. (2016, pp.115-116) have offered the following exercises as a way to help clients express their grief and develop possible coping strategies. They ask the client to:

"Think or write about the following:

- *How has losing _____ affected me?*
- *How would ____ say I impacted him her?*
- *How did ____ impact me? How have I grown as a person because of ____?*
- *How can I honor _____now and move forward in my life?*
- *What are some of the positive memories I have of ____?*

The therapist may ask the client to "write a goodbye letter to ____. Include how the loss has changed you; what you will miss most about the person lost; how do you want to remember him/her; and how will you continue to honor him/her?"

The average length of this comprehensive treatment program for clients with Complicated Grief and Traumatic Bereavement is 19 sessions, as described by Pearlman et al., (2014) (See *www.guilford.com/pearlman-materials* for a collection of client worksheets). Also see Harris (2011) and Jeffreys (2011) for examples of additional supportive activities.

5. **Addressing Bereavement Specific Issues**

Bereavement-specific issues focus on reawakened intense waves of grief when one least expects it. Rando (1993) have termed these acute grief responses to varied triggers that underscore the absence of the deceased, as Subsequent Temporary Upsurge of Grief (STUG) reactions. These triggers, may occur in social settings, at cyclical times like anniversaries, holidays or in response to particular occasions such as weddings, graduations. The STUG reactions, or powerful unexpected waves of grief that trigger a crisis of memory and undermine adaptive functioning, can lead to feelings of losing control, embarrassment, and result in withdrawal and avoidance that reinforces a loss grief cycle.

Psychotherapists need to "validate and normalize" such STUG reactions as part of the mourning process. Such emotional pain can be viewed as one way of staying connected to the deceased. In a collaborative fashion, the therapist should help clients anticipate and prepare (have coping strategies in place) in order to handle such episodes or "rough patches". Role plays and exposure activities can be employed to address STUG reactions. There is also a therapeutic need to address any accompanying self-critical automatic thoughts. The therapist can use the CLOCK analysis to help clients cope with STUG reactions, as well as conduct relapse prevention stress inoculation interventions (Meichenbaum, 2013).

6. Self–attribution training or helping clients "take credit" for changes

A key aspect of relapse prevention interventions is to help clients develop coping skills for bereavement-specific upsurges ("rough patches") and to ensure that clients monitor their progress and attribute any positive changes to their own personal coping efforts. Psychotherapists can facilitate this process by using Client Checklists, engage in discussions of how clients have handled tough situations, and ways they can anticipate and address future potential challenges (anniversary dates, reminders, and the like). The therapist can "go public with the data" of reported or observed changes.
For instance, *"It sounds like you have learned to:*

"Draw upon your resources."
"Identify warning signs."
"Tolerate strong feelings."
"Move back and forth (oscillate) between your loved one and beginning your life again"
"Reach out for help."
"Do so many of the things your spouse used to do."
"Trust your judgment."
"Express difficult feelings."
"Catch and challenge your negative automatic thoughts."
"View your emotional pain as a way of remaining in touch with your loved one."
"That in spite of your fears, you were able to be courageous and not withdraw."

The therapist should provide specific examples and have the client offer specific examples of each of these changes. This should be followed up with queries of "How" the client was able to accomplish each activity?

There is also value in discussing what the client has gotten out of treatment and what, if any, "unfinished business", and issues remain to be addressed. Discuss the possibility of seeking future help if the need arises. *"What was the client like when he/she entered treatment and what has changed?" "How has the client's 'story' changed and the accompanying new skills and new identity developed?"*

Two additional ways to bolster the client's level of self-efficacy and resilience is for the therapist to:

1) share examples of coping observations that other clients have offered;

2) ask the client for examples of "RE" based activities that he/she may have engaged in.

I. The therapist can say to the client:

> *"We have asked other clients, like yourself, to share with us some of the things they have learned over the course of treatment. With their permission, they have offered the following examples and given permission to share them with other clients, like yourself:*

LIST OF COPING OBSERVATIONS OFFERED BY INDIVIDUALS WHO HAVE LOST LOVED ONES

- *"I now recognize that pain is inevitable, but suffering is optional."*
- *"I unburdened myself by disclosing/sharing my loss with people I can trust and respect."*
- *"I benefitted from the feedback and advice I received."*
- *"I reached a turning point, when I began to let go of some of my grief."*
- *"I am having more good days than bad days."*
- *"I am in a better place now."*
- *"I found a new normal, a footing in the world."*
- *"I have become more buoyant in dealing with the waves of grief."*
- *"I have learned to compromise with life."*
- *"I can engage in heart-mending activities."*
- *"I have been able to transform my pain into compassion for myself and for others."*
- *"I have learned to invite my emotional pain to tea."*
- *"I have hope for the future."*
- *"I cherish life more now. I don't take life for granted."*
- *"I now value more of what I have, like my remaining children."*
- *"I give myself permission to close the lid on my loss and grief in order to turn my energy elsewhere, as needed."*
- *"I can use my spirituality. I have found God again."*
- *"I believe they are watching over me."*
- *"They are in a better place."*
- *"I can create a space for my loved one to fill in the future."*
- *"I have chosen <u>not</u> to wrench out of my life, my _____ (loved one), but instead to include him/her to be with me and continue to share my challenges, alongside me."*

- *“I have a sense of peace.”*
- *“I mastered my grief.”*