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Complicated Grief Treatment for older adults: The critical role of a supportive person

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ABSTRACT

In the wake of the increased interest in treatment for complicated grief (CG) symptoms, research has reported the promising effect of CG treatment (CGT) on CG symptoms. This study compared CGT with supportive counseling (SC) in terms of improvement in CG symptoms. A randomized trial design was used to compare the effectiveness of CGT with that of SC in treating CG symptoms, depressive symptoms, and social impairments. The primary outcome was the Inventory of Complicated Grief. Relative to SC, CGT resulted in improved CG symptoms and depressive symptoms. Among those receiving CGT, participants with a supportive person in their sessions showed more beneficial results in CG and depressive symptoms than those without a supportive person did. This suggests that CGT is superior to SC in reducing CG symptoms and depressive symptoms, and in improving work and social functions during bereavement. Moreover, having a supportive person plays a critical role in the effectiveness of CGT sessions.

1. Introduction

Complicated grief (CG) is a persistent and intense type of grief accompanied by complicating thoughts, behaviors, and dysfunctional emotional regulation, such as persistent feelings of shock, disbelief about death, troubling ruminations about the consequences of death, feelings of estrangement from other people, and excessive avoidance of or adhesion to reminders of loss (Shear et al., 2011). By using varied scales and sampling methods, the prevalence of CG has been found to be approximately 6–25% in bereaved individuals and 10–25% in older adults (Fujisawa et al., 2010; Kersting et al., 2011; Newson et al., 2011). The Inventory of Complicated Grief (ICG; Prigerson et al., 1995a) has been broadly used to diagnose CG based on a total score of >25.[1]

CG can lead to adverse health outcomes including sleep disturbances, high blood pressure, and suicidal ideation (Germain et al., 2005; Prigerson et al., 1997). Debilitatingimpairment in daily life, such as social and occupational functions, makes CG a particularly

difficult problem (Prigerson et al., 2009). Among older adults, CG is negatively associated with mental health and physical functioning (Boelen and Bout, 2005; Ott et al., 2007).

Promising clinical trials and growing research evidence support the effectiveness of *Complicated Grief Treatment* (CGT) for CG (Shear et al., 2001, 2005). Moreover, a recent trial of older adults with CG compared the effectiveness of CGT in reducing CG symptoms with that of Interpersonal Psychotherapy (IPT) and demonstrated a greater reduction in CG symptoms in the CGT group than in the IPT group (Shear et al., 2014). Another recent trial of CGT demonstrated the superiority of CGT in reducing CG symptoms over standard treatments, including psychoeducation on grief and conversations regarding stress reduction (Supiano and Luptak, 2013).

CGT is a psychotherapeutic treatment approach based on attachment theory and the dual-process model (Bowlby, 1980; Shear and Shair, 2005; Stroebe and Schut, 1999). From an attachment theory perspective, when an individual goes through acute grief after the loss of a close person (i.e., attachment figure), the attachment system is disrupted, leading to intrusive thoughts of the deceased person, a sense of disbelief of the loss, and adjustment inhibition towards one's new life without the deceased person (Shear and Shair, 2005). With successful grieving, the bereaved individual can encompass the death of the attachment figure and move from a state of acute grief to integrated grief where emotions become more positive, the death is acknowledged, and new life goals are integrated the consequences of the death. The successful grieving process occurs through a dual-process model (described below in more details). In contrast, bereaved

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[1] CG, included in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013), is referred to as a Persistent Complex Bereavement Disorder including emotional and cognitive symptoms related to the loss of a close person, reactive distress to the death; and social/identity disruption, although some have questioned these criteria (Boelen and Prigerson, 2012; Cozza et al., 2016).

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individuals with CG are derailed from the transition process from acute grief to integrated grief, such that the loss of attachment figure is not acknowledged in his/her implicit memory, leading to an absence of acceptance of the loss, and distancing from others and one's new life without the deceased person (Shear and Shair, 2005).

The dual-process model postulates that an individual who has lost a loved one recovers from an acute grief state by alternating between repeatedly confronting and avoiding loss-oriented stress, such as that caused by intrusion of grief, grief work, breaking bonds with the deceased person, and restoration-oriented stress such as that caused by attending to life changes and doing new thing without the deceased person. For example, the bereaved person tends to experience strong and painful emotions, particularly early on in bereavement. However, when the bereaved person needs relief from the painful emotional work, they tend to avoid memories of the loss by concentrating on their new life without the deceased person, until they go through emotional suffering for the loss. This repeated-alternation process (called oscillation) is postulated to be the fundamental component for healthy grieving (Stroebe and Schut, 1999). According to this theoretical framework, extreme rumination or extreme avoidance of grief cues can be interpreted as a lack of oscillation. An individual who fails to complete oscillation is vulnerable to a pathologic form of grief, such as CG.

Based on this theoretical approach, CGT aims to remove the obstacles to a successful grieving process, consisting of several cognitive and behavioral techniques such as revisiting the loved one's loss, and re-envisioning one's own future life without the deceased person to help the bereaved client to oscillate between the two types of bereavement-related stresses (Shear et al., 2005).

Specifically, CGT consists of three main phases (Shear et al., 2005). The introductory phase includes the establishment of a therapeutic alliance, provision of psychoeducation about CG, and attending a session with one or more supporters. The intermediate sessions include an exercise to induce healthy grieving. The client is encouraged to deal with painful emotional work and daily-life difficulties. This includes imaginal revisiting, which helps the bereaved client to visualize and tell a story of the time the client was aware of the loss and then to debrief with the interventionist. The goal of this exercise is to help the bereaved client come to terms with the death by going through emotional processing and integrating the emotional processing with the rational knowledge about the death. It also includes situational revisiting, which helps the bereaved client identify and address situations that have been avoided because of the loss. The goals of this exercise are to reduce the intensity of grief-related emotions and decrease isolation. The final sessions contain a review of the treatment processes and termination of the treatment.

One of the crucial features of CGT is the active participation of a supportive person in the treatment sessions with the following aims: 1) helping the bereaved person regain a sense of connection that may have been lost after the death of a loved one, and 2) facilitating the treatment process, which the bereaved person usually tends to avoid because of the associated pain and difficulty. However, some older adults with CG may lack the support of others because of the absence of an available social network. Such cases include older adults who lost their only available supporter (e.g., spousal loss) or single-living older adults who lost their only available close network (e.g., a friend). Despite the need of support from others in CGT, some older adults cannot bring their supporters; therefore, they may receive an inadequate version of CGT. This raises the need for a modified version of CGT, such as additional facilitation by a therapist's phone call to substitute the supportive role of others. This modification may be frequently needed for persons receiving CGT, particularly for older adults who lost their closest social tie; however, it might affect the CGT's results.

This study compared the efficacy of CGT with that of supportive counseling (SC) in older adults with CG. This study also investigated whether the supportive involvement of others in CGT results in a more substantial reduction in CG.

2. Methods

2.1. Participants

Study participants were recruited from two community senior centers and one hospice service. According to the suggestions of previous studies that examined the time course of problematic grief reactions, the initial inclusion criterion was that the participant must have experienced a loss of a loved one six months earlier than the start of the study (Prigerson et al., 1995b, 1997, 2009). Dysfunctional grief symptoms lasting six-months post loss for individuals with symptoms are difficult; therefore, the assessment of CG should not be delayed for individuals suffering painful symptoms from the loss of a loved one (Boelen and Prigerson, 2012). Among participants, the time range for loss of a loved one was 412 days to 495 days. Another inclusion criterion was that the participant should not be using prescribed medication for mental health problems, such as major depression. After applying the criteria, three individuals were excluded from the study.

CG was screened by community workers at the centers using the Brief Dimensional CG Assessment (BDCG; Shear et al., 2006) since community workers did not have much.

time to screen CG because of their work schedules. Bereaved individuals with a total score.

higher than 5 in the screening were considered positive for CG and included in the list of eligible participants. Among the 141 individuals who were defined as eligible for the current study, 100 older adults presented a total score higher than 5 in the BDCG. Eighty-nine of these adults volunteered to participate in the study while 11 refused due to difficulty in their schedules or health issues. Nine of the 89 participants dropped out during the study. Five were from the CGT participants and four were from the SC participants, leaving 80 participants in the final analysis (Fig. 1). After the recruitment process, each participant was randomly allocated to either the CGT (45 participants) or SC (44 participants) using a computer program.

2.2. Intervention conditions

Intervention procedures were approved by the Hallym University Institutional Review Board. Both CGT and SC intervention conditions consisted of 8 weekly sessions that were each approximately 2 h in duration. Six master and doctoral level therapists were trained by the author on the CGT and SC protocols. Four therapists conducted CGT and two therapists conducted SC. They were supervised on the intervention protocols by the author throughout the intervention sessions.

The 45 individuals underwent CGT including the following treatment: (1) psychoeducation about CG, (2) emotional management, (3) revisiting the story of the death, (4) imaginal conversation with the deceased, (5) situation revisiting, and (6) self-care planning during bereavement. Grief-monitoring homework was assigned for each session with a grief-monitoring diary wherein participants recorded their most distressing moments daily. This diary enabled an examination of the patterns of distressing moments within an individual, and allowed for the review of such patterns during the intervention sessions. In the first