



Complicated Grief Treatment

*Instruction Manual Used in
NIMH Grants^{1,2}*

M. Katherine Shear, M.D.

Copyright ©2015, Columbia Center for Complicated Grief, The Trustees of Columbia University in the City of New York. All rights reserved.

¹ This manual was used in the following NIMH-funded R01 studies: MH60783, MH70741, MH085297, MH085308 and MH085288

² This version is lightly edited for use by practicing clinicians. The editing includes a preface with useful information for users.

Not to be cited or used without the written permission of the authors

“By following the instructions in this manual and using other training supports as needed, you can learn to administer a simple, highly effective treatment that can change the lives of people caught in a seemingly endless cycle of grief.”

- M. Katherine Shear, M.D.

CONNECT WITH US:

<http://complicatedgrief.columbia.edu>

@CompGrief



DISCLAIMER

The information provided in this Manual is for educational and informational purposes only. The Manual is intended for use by experienced mental health professionals, and in conjunction with training and supervision by experts. Columbia University and the Columbia University School of Social Work make no warranties, express or implied, as to the value, usefulness or completeness of any information that is made available in this Manual.

CONNECT WITH US:

<http://complicatedgrief.columbia.edu>

@CompGrief



Table of Contents

Preface

- [Using this Manual](#)
- [Summary of Efficacy Study Results](#)
- [Identifying People With CG](#)
- [Co-Occurring Conditions and Suicidality](#)
- [Measurement-Based Care](#)
- [Common Challenges in Learning CGT](#)
- [Overview of the Thinking Behind the Treatment](#)
- [Some selected references](#)

Phase I: Getting Started

(Sessions 1-3)

Overview, Phase I Tools and Their Use,
Session Instructions

- [Session 1: History Taking](#)
- [Session 2: Information about CG and CGT](#)
- [Session 3: Including a Close Friend or Family Member](#)

Phase II: Core Revisiting Sequence

(Sessions 4-9)

Overview, Phase II Tools and Their Use,

Session Instructions

- [Session 4: First Imaginal Revisiting](#)
- [Session 5: Adding Situational Revisiting](#)
- [Session 6: Adding Memories Forms](#)
- [Session 7: Full core revisiting \(1\)](#)
- [Session 8: Full core revisiting \(2\)](#)
- [Session 9: Full core revisiting \(3\)](#)

Phase III Midcourse Review

(Sessions 10)

- [Topics for Consideration during midcourse review](#)
- [Session 10 instructions](#)

Phase IV Closing Sequence

(Sessions 11-16)

Overview, Session Instructions

- [Sessions 11 – 15: Closing Sequence Personalized Sessions](#)
- [Session 16: Ending CGT](#)
- [References](#)
- [Appendix](#)



Preface

Pages 5-15

Preface

Using this Manual

This manual provides instructions for a 16-session intervention for complicated grief (CG). CG is a painful and impairing condition that affects tens of millions of people worldwide. People with CG have lost someone close and are caught up in relentless pain that dominates their lives and holds hostage their future. Complicated Grief Treatment (CGT) is a well-specified evidence-based approach that can help these people. This treatment has been evaluated in 3 separate clinical trials with a total of 641 participants. These studies, funded by the National Institute of Mental Health, were uniformly positive with an average response rate of 70%. CGT is the best documented treatment for CG in the world. By following the instructions in this manual and using other training supports as needed, you can learn to administer a simple, highly effective treatment that can change the lives of people caught in a seemingly endless cycle of grief.

Working with bereaved people can seem sad and hopeless so clinicians sometimes shy away from it and fear burnout. It may seem paradoxical, but therapists have often told us that learning CGT has been the most rewarding experience of their career. Knowing how to administer a short-term treatment that has a 70% response rate is very gratifying and a powerful antidote to burnout. A component of learning CGT entails being mindful of your own reactions to death and loss and developing ways to use your responses most effectively. Most therapists find this one of the rewarding aspects of working with bereaved people.

People sometimes imagine bereavement as the beginning of a journey but grief is not a voyage from which people return. We do not experience a period of grief, come back, and return to life as usual. Instead, grief is a new homeland. It is a permanent place in which bereaved people must reside and redefine their lives. Life is permanently changed by an important loss. Still, it is possible to restore the sense that life can be rich and satisfying even though grief is not over. To restore enthusiasm for life is a natural goal of bereaved people. Yet the ways we transform our lives after death of a loved one are as individual and personal as the love that was lost. Bereaved

Preface

people differ in the kinds of problems they face, and in the adjustments they must make after a loss. People also differ in the availability of supportive companionship and the effectiveness of personal coping mechanisms. People with CG have usually exhausted their supply of both and feel they have nowhere to turn. As a result their grief does not mature and it remains intense and disruptive. Grief complications prevent people with CG from finding a place of integration where loss and renewal coexist. A CGT therapist can help. This treatment guides people through a process by which they can restore their capacity for joy and satisfaction in life while accepting the finality and consequences of their loss and maintaining a sense of connection to the person who died.

Summary of Efficacy Study Results

CGT has been tested in three NIMH-funded randomized controlled trials entailing six separate grants. The first was a randomized controlled trial conducted at the University of Pittsburgh comparing CGT to interpersonal psychotherapy (IPT), a well-tested and very effective treatment for depression. Results published in 2005 showed CGT was significantly better at alleviating CG symptoms and reducing their impact. The second study also compared CGT to IPT, this time in older adults. This study was conducted at Columbia University in New York City. Results published in 2014 mirrored those in our 2005 study with a lower drop out rate and a higher response rate to CGT but not IPT. The third study was a four-site trial conducted in Boston, New York, Pittsburgh, and San Diego. We compared antidepressant medication to a pill placebo. All patients received either citalopram or placebo. Half of the participants were also randomly assigned to receive CGT. Results again strongly supported the efficacy of CGT. The paper reporting these results has been submitted for publication.

Study therapists were experienced mental health clinicians, including psychiatrists, psychologists, social workers, marriage and family counselors or grief counselors. They were trained to deliver CGT using the instructions provided in this manual along with ongoing supervision. Therapists

Preface

attended a didactic workshop and then treated at least two training cases. Often a third case was required to reach competence. Each session was audiotaped reviewed separately by the therapist and supervisor and then discussed. Weekly group supervision meetings were held to review cases throughout the study and treatment sessions were audiotaped for adherence assessments.

CGT is not difficult to learn. The treatment is simple and well-specified. However, many therapists have questions when they are learning a new approach and it is often useful to have an opportunity to discuss difficult cases. We offer a range of different ways to supplement the information in this manual. If you want consultation or supervision or if you have any questions you can contact us at the Center for Complicated Grief www.complicatedgrief.columbia.edu.

Identifying People With CG

Identification of CG is not difficult or complicated. However, the lack of official consensus criteria can be confusing. We provide a simple way to screen and diagnose CG that is very similar to the one we used in our treatment studies. You can also contact the staff at the Center for Complicated Grief if you have questions about assessment of CG. The way we identified people with Complicated Grief in our studies was as follows:

1. A score of 30 or greater on the 19-item Inventory of Complicated Grief (ICG Prigerson et al 1995)
2. A clinical interview in which there was evidence for:
 - a) Clinically significant symptoms of prolonged acute grief and impairment in daily functioning. Typical symptoms include frequent yearning, longing and sorrow, frequent insistent preoccupying thoughts of the deceased, difficulty acknowledging the painful reality of the loss such as a sense of disbelief, difficulty accepting the loss, persistent intense emotional or physiological activation when confronted with reminders of the loss.

Preface

b) Grief complications e.g. maladaptive rumination about troubling aspects of the circumstances or consequences of the death—frequently counterfactual in nature — excessive avoidance of reminders of the loss, inability to regulate emotions or severe social or environmental problems.

c) A determination that grief was the person's most important problem.

1) Screening for the possibility of CG

The first step in screening is to determine that a person has lost someone close. Then you should evaluate grief symptoms, including the frequency and intensity of yearning, sorrow, preoccupying thoughts of the person who died, feelings of estrangement from other people and from activities that are usually meaningful, and frequency of behaviors that foster escape from the painful reality or avoidance of reminders of the loss. You can use the Brief Grief Questionnaire, available through the Center for Complicated Grief as a screening tool if you wish.

You also want to consider the time since the loss. There is as yet no set time after which grief is considered complicated. We know that normative time to restore a sense of vitality varies depending upon the circumstances of the loss. For example, normative time to regain a footing in life is generally longer after loss of a child or young adult or when a death occurs violently, by suicide, homicide or accident. At present the question of time rests on clinical judgment that is based upon the severity of current symptoms and impairment, the trajectory of adaptation to the loss, and by the attitude of the bereaved person as well as their friends and family. As a rule of thumb, we do CGT only after at least six months have passed since the death. We also consider whether the bereaved person seems to be on a course that is progressing or not. Sometimes people are confused by the intensity and duration of their grief and when they are reminded that suffering after

Preface

an important loss is universal and permanent, they stop questioning themselves and no further treatment is needed. More commonly, a person who is still grieving intensely after many months or even years have passed has gotten caught up in grief complications and needs some help to move forward.

2) Using a structured clinical interview to identify people with CG

We developed a structured clinical interview for CG that can also be used as a self-report questionnaire. The interview consists of 12 questions and takes about 10 minutes to administer. You can obtain this instrument from the Center for Complicated Grief at www.complicatedgrief.columbia.edu.

Co-Occurring Conditions and Suicidality

Patients suffering from CG often have co-occurring mental and physical disorders. As always, it is important to complete a full assessment of anyone you are planning to treat. You should be aware of the likelihood of suicidal thinking and behavior associated with CG and you should monitor suicidal thinking throughout the treatment. As with anyone, any suicidality is of concern and active plans or actions require intervention. When CG occurs in a setting of long-standing problems or comorbid chronic disorders, you need to decide what to address first. Rather than interweaving CGT into treatment for depression, anxiety or other disorders, it is generally better to focus on one at a time. If you decide that another problem is more pressing, treat that problem first. If a new problem emerges during the treatment, stop doing CGT while you deal with that problem. For people with multiple problems, CGT is intended to be one component of a sequenced model whereby at the end of the sixteen-session model you re-evaluate the patient to decide if you need to address a different problem. Of course a life crisis or emergency psychiatric problem must be addressed immediately. Sometimes such events can be managed in a short period of time and you can return to the work with CG. Sometimes you need to shift to work on the new problem and postpone further work with CGT.

Preface

Measurement-Based Care

“Measurement-based care” is a term coined by depression researchers (Trevedi et al 2006) to describe an intervention approach that includes regular structured assessment with simple validated instruments. Using this approach for bereaved people enables you to systematize the selection of individuals, who are similar to those who participated in the research studies that validated the treatment. Validated questionnaires can help benchmark your progress with a patient, compare this progress to others you work with and to patients treated by others who use the same scales. Questionnaires provide a common language you can use to describe symptoms. The questionnaires we developed are available from the Center for Complicated Grief. This manual includes information about how we used this approach in our research studies.

Common Challenges in Learning CGT

Our experience in training hundreds of people in this model is that once you master it, the approach is simple and one of the more effective brief therapies available for mental health problems. We alert you to four common issues that may arise as you are learning the treatment: 1. Activation of personal feelings about loss and/or death; 2. Unfamiliarity with using principles and procedures from positive psychology; 3. Discomfort with the structure of the treatment, or 4. Discomfort with one or more of the core procedures. If you find yourself confronting one or more of these issues, it can be helpful to know that this is common and that these issues can be resolved and should not stand in your way.

3) Activation of personal feelings about loss and/or death

Almost everyone reacts emotionally to thoughts of loss and death. We know that death is inevitable and unknowable and it is natural to feel anxiety when contemplating our own death or that of people we love. Most therapists I have worked with have been surprised and somewhat unsettled by their reactions to hearing the stories of people with CG. Not infrequently, new CGT therapists find themselves wanting to tell their loved ones how

Preface

much they care about them. When learning CGT you may have intrusive thoughts or dreams about death, dying, or loss. If you have experienced a difficult loss yourself, you may find your thoughts and feelings about that loss are activated. This kind of response to thoughts of death or loss and it is natural and not a problem for the therapy unless you are uncomfortable. Most CGT therapists find it is important to think through their own feelings about losing a loved one and about dying themselves. You can do this in a variety of ways such as turning to your own religion, journaling, meditating, talking with a close friend or a therapist, reading stories or philosophical texts, using artistic expression, etc. However you chose to do it, the important thing is to focus on self-awareness, monitor your own thoughts and feelings and find ways to manage your reaction so that it can be useful in the treatment.

4) Unfamiliarity with principles and procedures from positive psychology

Most mental health professionals are taught to diagnose and treat psychological problems. Most consider it their mandate to understand and treat underlying vulnerabilities, correct maladaptive thinking and behavior and to relieve current emotional distress. They may not be in the habit of thinking of suffering as a common human experience. Additionally, when things are going well in a patient's life, many therapists are pleased but generally do not consider optimizing the positives to be as important to their work as minimizing the negatives. By contrast, positive psychology concerns itself with personal and community strengths that support the ability to thrive. The foundation for this approach is the idea that people are naturally oriented toward meaningful and fulfilling lives, that humans have a basic need to express themselves and to experience love, satisfying work, and enjoyable play. A corollary is that suffering also has its place in our lives. CGT makes these assumptions. The overarching model follows positive psychological thinking in that there is an assumption that suffering and adaptation to suffering is a natural experience and people will adapt to the most painful loss unless there is something blocking adaptation. CGT seeks to help people flourish and one of the core procedures is to facilitate

Preface

aspirational goals work. However, many therapists find it awkward or uncomfortable to focus on positive elements of a patient's life. To be effective, a CGT therapist needs to spend time helping patients capitalize on positives and conveying acceptance and comfort in confronting the painful reality. We do not seek to resolve grief or end the pain of loss but rather to ensure that people have the support and tools to find a pathway to restoration. If you are not in the habit of working in this way, you need to pay close attention to learning the aspirational goals component of the treatment and to checking your tendency to come up with solutions to pain.

5) Discomfort with the structure

CGT uses a structured approach to conceptualizing CG, assessing symptoms, and planning and implementing treatment. This does not mean that the treatment is implemented robotically. As always in psychotherapy, it is important to listen closely and tailor your work to each patient. To both implement structure and personalize the treatment may be difficult if you are not used to a structured treatment. It can feel uncomfortable to stop a patient and redirect them, especially if they are talking about emotionally meaningful material. CGT uses motivational interviewing skills that convey empathy and respect as well as guidance in redirecting the conversation. If you don't know motivational interviewing, there are many opportunities to learn this very useful and interesting approach.

6) Discomfort with one or more core procedure(s)

CGT includes 7 core procedures: 1. Psychoeducation about CG and CGT; 2. Self-assessment and self-regulation; 3. Aspirational goals work; 4. Rebuilding connections; 5. Revisiting the story of the death; 6. Revisiting the world changed by the loss; and 7. Memories and continuing bonds. Very often one or more of these procedures is difficult for the bereaved person. Sometimes therapists are uncomfortable encouraging someone to try

Preface

something difficult. It is important to remember that the choice is always the patient's but at the same time you need to feel comfortable and confident in recommending that she or he engage in the recommended activities. You need to convey a sense of safety in your presence and confidence in your skills so that your patient will feel comfortable taking some risks. The imaginal revisiting exercise is usually the most difficult for both patients and therapists because it can be intensely emotionally activating. Getting comfortable doing this procedure can take some time. You may want to seek consultation if you are uncertain about the wisdom of this component of the treatment. You need to be clear about how and why it is done. Although we have not specifically identified the mechanism of action of CGT, there are theoretical reasons why this is an especially important part of the treatment, and patients often tell us that it was doing this painful exercise that seems to have made the most difference for them.

Overview of the Thinking Behind the Treatment

This manual does not describe how CGT was developed and you do not need that information in order to do this treatment. However, you may be interested to know something about the logic and the empirical science behind the treatment. When asked to help identify an effective way to help people struggling with intense and persistent grief symptoms our team realized that in order to understand the experience of losing a loved one, we would need to understand what was lost. This led to an in-depth reading of theory and research related to close relationships.

There is an extensive body of knowledge pertaining to relationship science which we are not going to review here. However, it became increasingly clear that people we love become part of our lives in a myriad of ways, many of which you could list if you tried. In fact, our loved ones also impact our lives in many ways that are out of awareness. Knowing how pervasively they influence us helps explain why acute grief is such a surprisingly intense and lasting experience. But grief is not one thing. It's a small word for a big, complex, time-varying experience.

Grief is usually transformed from an acute dominant and disruptive form to a more subdued form

Preface

that provides the background for a “new normal” life moving forward. The transformation of grief occurs as we adapt to the large changes (both internal and external) that occur as a consequence of the loss, reconfigure our relationship to the deceased person, and redefine our own life goals and plans. Complicated Grief is the syndrome of persistent intense acute grief that occurs when adaptation is interrupted or stalled. The goals of CGT are to resolve complications and facilitate the natural adaptive process. To do so we draw upon self-compassion and self-determination theory as well as the science of learning and emotion regulation. You can learn more about the underpinnings of CGT by contacting the Center for Complicated Grief or visiting our website <http://complicatedgrief.columbia.edu>

Some selected references

Learning and using CGT is an ongoing process. You may want to do some reading to support this learning experience. You can find on our website a list of papers from our group and others that you might find helpful. Opportunities for learning collaboratives focused on studying the science of grief are available through the Center for Complicated Grief.