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Understanding and Treating Complicated Grief: What Can We Learn from Posttraumatic Stress Disorder?

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Abstract

The paper outlines possible parallels between the phenomenology and treatment of complicated grief and PTSD. In particular, it explores how treatment procedures used in *Cognitive Therapy for PTSD* (Ehlers & Clark, 2000) may be adapted for the treatment of complicated grief. *Stimulus Discrimination* may be helpful in breaking the link between everyday triggers and “felt presence” memories of the deceased. *Memory Updating* procedures may help the patient accept that the deceased is no longer alive and no longer suffering. *Reclaiming your Life* procedures may help the patient access autobiographical memories that are not linked to the deceased and counteract beliefs about the value of life without the deceased. The paper further addresses the necessity of specifying the idiosyncratic beliefs that prevent coming to terms with the death, of understanding the relationship between beliefs and coping strategies, and of distinguishing memories from rumination.

Boelen, van den Hout, and van den Bout (this volume) present a thoughtful and intriguing conceptualization of complicated grief (CG) that will certainly stimulate research and treatment developments in the years to come. The field will eagerly await outcome data on their promising treatment approach. Boelen et al.'s conceptual framework bears some similarities with Ehlers and Clark's (2000) cognitive model of posttraumatic stress disorder (PTSD). In this commentary, I will therefore address the question of whether and in what way the lessons our group learnt in developing and evaluating this theoretical model and the corresponding treatment program (Ehlers, Clark, Hackmann, McManus, Fennell, Herbert & Mayou, 2003; Ehlers, Clark, Hackmann, McManus & Fennell, 2005) may be useful in understanding and treating CG.

Understanding the phenomenology of memories and their triggers

A central feature in CG are recurrent impressions that the dead person is present. These experiences resemble involuntary memories of the trauma in PTSD. A lack of autonoetic awareness (i.e., awareness of the self in the past) seems to be at the core of such involuntary memories (Ehlers & Clark, 2000; Ehlers, Hackmann & Michael, 2004; Michael, Ehlers, Halligan & Clark, 2005), and may include “affect without recollection” (Ehlers & Clark, 2000), i.e., reexperiencing of affect without a conscious recollection of the trauma. In CG, the “felt presence” can similarly be understood as a memory of the presence of the deceased in the absence of the awareness of remembering.

A systematic analysis of the triggers helps in understanding intrusive reexperiencing in PTSD. Ehlers and Clark (2000) observed that the triggers are often cues that bear a *sensory* resemblance to stimuli encountered at the time of the trauma, even if there is no link in *meaning*. We concluded that the easy triggering of involuntary memories by matching

sensory cues in PTSD is due to strong perceptual priming and strong associative learning at the time of the traumatic event. Furthermore, as autobiographical memory is normally organized in a way that makes such cue-driven retrieval unlikely (Conway & Pleydell-Pearce, 2000), we concluded that in PTSD there is poor inhibition of cue-driven retrieval due to an inadequate integration of the trauma memory with other autobiographical information. In our view (Ehlers & Clark, 2000), poor integration in itself is not a sufficient condition for intrusive memories, as cue-driven retrieval of such memories requires that the corresponding associations of the cue with the intruding experience have been formed.

It would be interesting to systematically observe what cues trigger the impression that the dead person is present in CG. In contrast to PTSD, which is based on learning in exceptional circumstances, however, such “felt presence” memories are based on prior learning on numerous occasions. In CG, many objects, daily routines and situations in the patient’s everyday life are likely to be strongly associated with the deceased, so that they represent possible triggers of such involuntary memories. As in PTSD, it will thus be an important step in treatment to break the link between these triggers and the automatic retrieval of the “felt presence” of the deceased, so that remembrance can become a controlled voluntary rather than a cue-driven involuntary experience.

Implications for treatment

Building on the observation that intrusive memories in PTSD are often triggered by sensory cues although they appear to come “out of the blue”, *Stimulus Discrimination* became an important element of *Cognitive Therapy for PTSD* (Ehlers et al., 2003, 2005; Ehlers, Hackmann & Michael, 2004). In short, patients first need to learn to identify the sensory triggers of their reexperiencing symptoms. They then learn to discriminate the current triggers and their (benign) context from those that they encountered during the traumatic event. This involves the realization that they are responding to a memory rather than current reality, disengagement from the memory and attention to current context. Adaptations of the procedure may be a promising tool in breaking the link between everyday triggers and “felt presence” memories of the deceased. It will be important to be respectful of the fact that the deceased has an important place in the patient’s life, even beyond their death. It will thus be important to simultaneously work on dedicating specific situations and times for intentional remembrance (preferably outside the patient’s home, e.g., visiting the grave at specified times, dedicating a remembrance spot on a favorite walk to the memory of the deceased). With repeated *Stimulus Discrimination* and intentional remembrance in dedicated locations, memories of the deceased will become more strongly associated with the “remembering place” rather than with cues that are part of the patient’s everyday routine.

What does “poor integration” into the autobiographical memory base mean?

Boelen et al. suggest that poor integration of the loss into the autobiographical memory base is one of the core processes in the development and maintenance of CG, as it thought to lead to easy triggering of thoughts, feelings and recollections linked to the loss. This suggestion parallels Ehlers and Clark’s (2000) suggestion that the poor integration of the trauma with other autobiographical information leads to poor inhibition of cue-driven retrieval of trauma memories. When exploring the concept of poor integration in greater detail, Ehlers et al. (2004) concluded that the *disjointedness* in memory between the most distressing moments of the trauma and other information that is available to the patient and updates the meanings of these “hot spots” is central. For example, the moment when the patient thought they were going to die and would never see their children again remains disconnected from the fact that they are still alive and living with their children; or the moment that the patient thought

they were responsible for the event is not linked with information that showed that it was not their fault.

Consequences for treatment

The disjointedness of trauma memories has the consequence that new information obtained in therapy is not easily incorporated into the memory. Important insights may remain at an intellectual level, without affecting patients' feelings or reexperiencing symptoms. Ehlers and Clark (2000) therefore concluded that active efforts are necessary to help the patient *link* the worst moments of the trauma in memory with information that updated predictions made during the trauma or corrects impressions at the time of the trauma that did not turn out to be true. This led us to develop a set of treatment procedures called *Updating the Trauma Memory* (Ehlers et al., 2003, 2004, 2005). In short, the patient goes through a "hot spot" (either in imagination or with the help of a narrative), and then, while holding the "hot spot" in their mind, brings into their awareness the updating information verbally (e.g., "I *now* know that the gun was a toy gun"), by actions (e.g., moving about when visualizing the hot spot "I am paralyzed"), by sensory cues (e.g., looking at pictures of themselves with their children after the trauma) or with imagery (e.g., visualizing how one's scars have healed after an accident). In our experience, the *Updating the Trauma Memory* procedures significantly reduce the number of imaginal exposures necessary to achieve therapeutic change (on average, patients in our trials only received 90 to 100 min of imaginal reliving of the trauma during the whole course of treatment, Ehlers et al., 2003, 2005; compared to the usual 1 hour per treatment session in exposure programs).

It would be of interest to explore how these procedures could be adapted for CG. Boelen et al. suggest repeated imaginal exposures to the patient's experiences at the time of the death and discussions of the implications of the loss. This is thought to promote the integration of the loss into the autobiographical knowledge base. I would expect that for particularly distressing moments, especially if the death was caused by a traumatic event or a sudden or very painful illness, the *Updating the Trauma Memory* procedures would be useful, and may reduce the number of exposures necessary. This raises the question of what the *updating* information would consist of in CG. If the "hot spot" concerns the circumstances of the death (e.g., the dying person's suffering; patients blaming themselves for things they have done), the PTSD procedures can be adapted straightforwardly. If however, the "hot spot" is mainly about the loss itself, the updating needs further thought. Boelen et al. emphasize that the patient needs to understand that the death is irreversible. This is an idea that is difficult to grasp for most people, who will find it difficult to comprehend that a person can be alive one moment and then cease to exist the next moment. Without an idea of where the deceased "went to" it will thus be difficult to update the memory. This suggests that it is useful to explore the patient's ideas about what happens to people after death. Most religions provide elaborate ideas about this question, and even non-religious people usually believe in a peaceful state after death that is free of pain and negative emotion. The goal of the discussion is to identify a plausible idea and, if possible, an image of a peaceful state that the deceased has now achieved, which is consistent with the patient's general beliefs. This idea/image is then used for updating the memory (i.e., the moment of death in memory is linked with images of the dead person going to a peaceful state/place). The idea/image of the peaceful state is also useful for *Stimulus Discrimination*, i.e., when "felt presence" memories are triggered by cues in the patient's environment, patients remind themselves that what they are experiencing is a memory and that the deceased is now at the peaceful state/place. The image of the peaceful state/place should be better tolerated than just reminding oneself that the deceased is no longer there.

The discussion may also reveal that the patient believes that the deceased is unable to find such peace, a belief which is often confirmed by involuntary memories of the dying person.

Additional imagery work may be necessary before the patient can believe that the dead person is in a peaceful place and state. For example, if the deceased suffered a violent death that involved severe damage to the body, it may be necessary for the patient to visualize the body being restored before the deceased can move on to the peaceful state.

A second treatment onwards, patients are encouraged to resume activities that they have given up since the trauma (e.g., exercise, meeting friends). We think that, besides creating hope and serving as behavioral activation, this treatment component helps patients with retrieving memories of themselves *before* the trauma. Such memory retrieval is impaired in PTSD (e.g., McNally, Lasko, Macklin & Pitman, 1995), which contributes to the patient's belief that they have changed permanently for the worse or are no longer the same person (e.g., Ehlers, Maercker & Boos, 2000). Accessing pre-trauma autobiographical memories thus helps putting the trauma and the patient's appraisals in perspective, and also helps with accessing the patient's pre-trauma problem solving resources.

In CG, the problem is somewhat different as the deceased was a significant part of the patient's life for a protracted period of time, so that the patient's everyday life and routines are intertwined with the presence and now absence of the deceased. In parallel to the problems in accessing memories from before the trauma in PTSD, there will be a problem in accessing memories of one's life *without* the deceased in CG. This will feed into appraisals such as "I cannot live without my loved one" or "My life is now meaningless". Parallel to *Reclaiming your Life* in the treatment of PTSD, it should therefore be beneficial to encourage the patient to engage in activities that are *not* associated with the deceased. For example, if the patient used to enjoy certain leisure activities that the deceased did not share, it may be helpful for the patient to re-engage in these activities.

Specifying beliefs that prevent coming to terms with the death of significant others

Boelen et al. suggest that negative global beliefs and misinterpretations of grief reactions are crucial in the development and maintenance of CG. The authors focus on global beliefs about the future, the meaning of life, or negative views of the self. It will be interesting to explore further what kinds of beliefs are especially important in CG. It is likely that separation distress and traumatic distress are linked to different groups of beliefs. Our experience would suggest that in traumatic grief it is important to understand the patient's appraisals of the particularly distressing circumstances of the death and of their intrusive memories of the deceased. The latter are important sources of beliefs that the deceased is not really dead, still suffering or unable to find peace. For example, intrusive memories of the dying person's facial expressions are important subjective "evidence" for appraisal about the ongoing suffering of the person. Such memories can also be so dominant that they prevent the patient from having positive memories of the deceased.

Typical examples of problematic appraisals in traumatic grief are:

- Appraisals about the dead person's suffering, e.g., belief that the suffering was unbearable, that the dead person is still suffering or that the person is still in the process of dying.
- Appraisals about troubling aspects of deceased's afterlife, e.g., that they are stuck in an unpleasant limbo state between life and heaven.
- Self-blame for the circumstances that led to the death or for failure to prevent the death.

- Preoccupations with the unfairness of the death, especially if the deceased was young.
- Belief that patient was the one who deserved to die.
- Appraisals of the patient's last interactions with the deceased, e.g., things that the patient said, or did not say to them (which now appear unforgivable).

For separation distress, the following appraisals appear relevant:

- Beliefs that prevent "letting go", e.g., beliefs that the patient would let down/dishonor/offend the memory of the deceased if they moved on with their lives.
- Beliefs about the value of the patient's life without the deceased, e.g., without the deceased, life is not worth living, or they will never be able to feel happy again.

Implications for treatment

Many of the problematic beliefs outlined above are difficult to address by verbal restructuring alone. One problem with addressing the beliefs about the deceased is that no direct evidence for disconfirmation can be obtained. Imagery techniques are a very useful tool in making changed meanings "stick", e.g., that the dead person has forgiven the patient for things said/not said, or that the dead person approves of the patient moving on with their life. *Updating the Trauma Memory* procedures will be helpful for beliefs about the circumstances of the death, especially in dealing with interpretations of involuntary memories of the deceased.

For the beliefs related to traumatic distress, it will be helpful explicitly discuss the beliefs about what happens after death, in what form/way the deceased may still exist, and what the deceased would wish for the patient. When dealing with beliefs about the patient's life without the deceased, it will be preferable to formulate them as *conditional beliefs*, i.e., "If I cannot be with X, my life is meaningless" rather than "My life is meaningless." A review of the relationship with its good and less good sides will be helpful. The adaptation of the *Reclaiming your Life* assignments described above will also be useful in providing evidence against appraisals that life is not worthwhile without the deceased.

Relationship between beliefs and coping strategies

The third factor contributing to the development and maintenance of CG in the Boelen et al. model is depressive and anxious avoidance. Both are thought to prevent acceptance of the reality of the loss. The avoidance is thought to interact with the patient's problematic memory and beliefs. The Ehlers and Clark (2000) model of PTSD similarly states that patients engage in a range of dysfunctional behaviors and cognitive strategies that are meant to control the perceived current threat brought about by problematic appraisals and reexperiencing symptoms. These are thought to maintain the disorder by preventing a change in the trauma memory (e.g., cognitive avoidance) and/or appraisals (e.g., safety behaviors), or by increasing symptoms (e.g., thought suppression). The Ehlers and Clark (2000) model makes an additional assumption, which we have found very useful in treatment, namely that the behaviors/cognitive strategies are *motivated* by the problematic appraisals. In short, patients' behavioral and cognitive attempts to control the perceived threat make sense if we understand how they interpret the trauma and its consequences.

Implications for treatment

The assumption that the patient's behavioral and cognitive strategies are motivated by corresponding appraisals in a meaningful way helps with focusing treatment. First, the behavioral and cognitive strategies are useful tools in accessing relevant appraisals (e.g.,

“What do you think would happen if you did not do X?”). Second, the manipulation of the behavioral and cognitive strategies is a useful *Behavioral Experiment* to test the appraisals. For example, patients who believe that they will go crazy if they do not control their memories may be asked to experiment with alternating between suppressing and not suppressing their memories of the trauma to test their belief. In the treatment of anxiety disorders, including PTSD, such *Behavioral Experiments* are essential tools in restructuring beliefs, as they provide convincing evidence that the belief does not match reality well. I expect that *Behavioral Experiments* will also be very useful in the treatment of CG. For example, patients who believe that they can never feel good again without their loved one and consequently spend a lot of time reminiscing about the deceased and seeking out reminders, can be encouraged to test their belief by spending one day as usual reminiscing and another day engaging in another activity (e.g., taking the grandchildren to the zoo). Obtaining mood ratings for each day will then provide a test of the belief.

Distinguishing memories from rumination

The Ehlers and Clark (2000) model distinguishes two types of intrusive cognitions in PTSD, intrusive memories of the trauma and rumination about the trauma. These are thought to be phenomenologically and functionally distinct. There is preliminary evidence for this distinction (e.g., Evans, Ehlers, Mezey & Clark, in press). Whereas intrusive memories appear to reflect the unintentional retrieval of parts of the traumatic experience and are predominantly sensory experiences, rumination is thought to be predominantly a verbal process that represents a dysfunctional coping response, which is motivated by appraisals of the trauma. For example, patients may be preoccupied with the appraisal “What happened to me is unfair” and ruminate about how they can take revenge. Others may believe that the trauma was their fault and ruminate about how they could have prevented the event from happening. In CG, it would be useful to make a clearer distinction between unintentional memories triggered by cues in the patient’s everyday life and the preoccupation with the deceased and active seeking of reminders, which in my view parallels rumination in PTSD.

Implications for treatment

The *Stimulus Discrimination* and the *Updating the Trauma Memory* procedures outlined above target involuntary triggering of involuntary memories, but are unlikely to be sufficient in treating the preoccupation with the deceased and the active seeking of reminders in CG. Useful procedures are a *Cost-benefit Analysis* and adaptations of Borkovec, Wilkinson, Folsensbee & Lerman’s (1983) *Worry Chair* technique (i.e., reducing the remembrance to a defined time and space). Often, however, a functional analysis of what beliefs drive the preoccupation will be necessary and the beliefs will need to be addressed directly in treatment. Examples may include beliefs that giving up the preoccupation/searching would betray the memory of the deceased or that life without the deceased is worthless.

One central cognitive theme for complicated grief?

Is there one central cognitive theme that characterizes CG? In PTSD, both the problematic nature of the trauma memory and the excessively negative appraisals contribute to a sense of serious current threat (Ehlers & Clark, 2000). It remains to be determined whether there is a similar overarching theme in CG (e.g., “X is not gone yet”), or whether there are separate themes for separation distress and traumatic distress.

Implications for treatment

Patients often present with a wide range of “irrational” beliefs, and it can be difficult to decide on which ones to focus in treatment. To guide treatment decisions in PTSD supervision, we have found it very useful to come back to the question “Which particular

beliefs contribute to the sense of current threat?”. A better understanding of the common theme or themes in CG is likely to be similarly helpful.

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