

Prolonged grief disorder: Nature, risk-factors, assessment, and cognitive-behavioural treatment

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Most people who are confronted with the death of a loved adjust without needing professional help. A significant minority of people confronted with loss develops symptoms of prolonged grief disorder (PGD), sometimes accompanied by bereavement-related post-traumatic stress disorder (PTSD) and depression. PGD is newly included in the psychiatric classification systems of the ICD-11 and DSM-5-TR. In Ukraine, many people are currently facing losses, in circumstances that may render them vulnerable to develop PGD and associated symptoms. In this article, we address “healthy” grief and discuss the nature, assessment, risk factors, and treatment of “unhealthy” grief, now referred to PGD. We also introduce a cognitive behavioural theory that helps to understand problematic psychological processes involved in the persistence and maintenance of PGD and that offers a clear framework for the application of all kinds of cognitive behavioural interventions and other treatment interventions that can be used to alleviate the pain of people with PGD. Examples of these interventions are described. Attention is paid to how the situation of war affects the development and treatment of PGD.

1. Introduction

Most people who are confronted with the death of a loved one do not develop serious and long-term mental problems (Galatzer-Levy, Huang, & Bonanno, 2018). Most people adjust well to loss, especially if there are sufficient mental, social, and other resources to incorporate the loss into one’s inner and outer living world. In some cases, however, deaths lead to serious mental health problems. This is more likely if people suffer sudden losses, in unstable contexts, where many stressors have to be dealt with, and natural resources are less available. Many people in Ukraine are currently in situations where they face multiple losses in extremely difficult circumstances. In this article, we address healthy grief and more extensively discuss the nature, assessment, risk factors, and treatment of unhealthy or problematic grief, that is currently referred to as prolonged grief disorder (PGD). We also introduce a cognitive behavioural theory that helps us to understand problematic psychological processes involved in PGD and that offers clear targets for treatment interventions that can be used to alleviate the pain of people with PGD.

2. What is grief?

Grief is sometimes defined as encompassing all emotional, cognitive, and behavioural responses that may follow the death of a loved one. This is broadly true. But although grief may include many different feelings and responses, separation distress is at the heart of grief. Separation distress is a state of acute emotional distress arising when a loved one dies; a state characterized by yearning,

despair, and preoccupation with the deceased and the circumstances of the loss. A state in which, at some moments, the reality of loss intrudes into awareness causing intense pangs of pain and, at other moments, is hidden behind disbelief. Separation distress gradually decreases when bereaved people can reconcile with the irreversibility of the separation and can gradually focus on thoughts, memories, and activities unrelated with the lost person (Boelen, 2016; Shear & Shair, 2005).

The process of adjustment to loss has often been described as a process of stages. For instance, drawing from Kübler-Ross (Kübler-Ross & Kessler, 2005), it has been proposed that bereaved people go through a sequential process of denial, anger, bargaining, depression, and, finally, acceptance. This, however, suggests that there is a standard for how healthy grieving should go and that deviations from this standard point at an abnormal grieving process. That is not true: there is not a single way to grief, nor a single order of prescribed responses (Stroebe, Schut, & Boerner, 2017). It makes more sense to say that processing loss involved accomplishing several tasks or challenges (Worden, 2009). A first task is to face the reality of the loss (and not doing as if the loss did not happen or can be made undone). A second task is allowing and working through the emotions that one experiences (and not suppressing these feelings, because of fear or shame). A third task is to continue usual social, occupational, educational, and relaxing activities that enhance a sense of meaning and continuity in life (**Box 1**).

Box 1. Stages or tasks Grief is not about stages. It is about working through tasks. Coming to terms with loss means that a person has to face the reality of the loss, allow the emotions to be felt, and continue to engage in meaningful activities as best as possible.

3. Unhealthy grief and prolonged grief disorder (PGD)

Separation distress is a normal reactions to loss. It has emotional, cognitive, and behavioural elements. Emotional elements of separation distress are yearning for the lost person, missing him/her, and feeling somewhat lost in the world without a clear anchor or beacon. Sometimes bereaved people experience panic and despair because they feel a deep sense of emptiness and do not know how to escape from that. Cognitive elements of separation distress include a sense of confusion about the reality of the loss. People may feel as if the person is just temporary gone and will return soon. This is sometimes accompanied by a sense that one hears or sees the deceased person. The confusion can also relate to one's own roles and identity. A mother may experience confusion about her role in life after losing her only child. Cognitive elements also include being preoccupied by thoughts about the loss and having frequent vivid images of moments surrounding the death. Behavioural elements of separation distress include proximity seeking behaviours such as going to places where the deceased person used to come, setting up the environment at home as if he/she might return at any moment, and “searching” for him or her (while realising that this is futile).

Separation distress is normal in all the forms it may have. However, separation distress can turn into a grieving disorder if it persists for a long period of time and if it dominates a person's psychological functioning many months or years after the loss. In the most recent editions of the International Classification of Diseases (the ICD-11; WHO , 2019) and the Diagnostic and Statistical Manual of mental disorders (the DSM-5-TR; APA, 2022), a new diagnostic category is included by which we can designate unhealthy, persistent grief. This disorder is called prolonged grief disorder (PGD). PGD is defined as the presence of symptoms of separation distress (yearning, preoccupation) and accompanying symptoms (identity disruption, avoidance, anger) causing intense, persistent psychological suffering and significant impairments in functioning (**Box 2**). The criteria for PGD in ICD-11 and DSM-5-TR are similar in many respects, but the timing criterion differs: PGD in DSM-5-TR can be diagnosed beyond 12 months after the loss and PGD in ICD-11 beyond 6 months (Prigerson, Kakarala, Gang, & Maciejewski, 2021).

Box 2. Prolonged Grief Disorder criteria (summarized)DSM-5-TR: The person has experienced the death of a loved one, ≥ 12 months ago. He/she experiences yearning/longing and/or preoccupation, and at least three of the following symptoms: identity disruption, disbelief, avoidance, intense emotional pain, difficulties moving on with life, emotional numbness, a sense of meaninglessness, and loneliness. ICD-11: The person has experienced the death of a loved one, ≥ 6 months ago. He/she experiences yearning/longing or persistent preoccupation accompanied by intense emotional pain (e.g. sadness, guilt, anger, denial, blame, difficulties accepting the death, feeling that a part of self is lost, an inability to experience positive mood, numbness, difficulties engaging in social or other activities). Both DSM-5-TR and ICD-11: The reactions exceed social, cultural, and religious norms and cause significant distress and disfunction.

There are similarities between symptoms of PGD and symptoms of posttraumatic-stress disorder (PTSD) and depression that may also occur following loss. All three disorder include difficulties to downregulate negative emotions and to upregulate positive emotions. All three disorders are characterized by negative beliefs about oneself, the future, or the world. There are, however, also important differences. In terms of emotions, yearning, longing, and separation distress are central to PGD, anxiety is central to PTSD, and low mood and reduced positive affect are central to depression. In terms of memory phenomena, PGD is characterized by memories of the deceased and circumstances causing the death, whereas PTSD is characterized by flashbacks and unbidden thoughts connected with specific events that were threatening to self or others. Considering behaviours, PGD is associated with proximity seeking behaviour, aimed at feeling close to the deceased person. PTSD is characterized by avoidance of cues that remind of the threatening event and cues announcing that the threat may return. Depression is characterized by inactivity and withdrawal. PGD can be considered as a chronic activation of the attachment system (driving a continues search for the lost person); PTSD involves a chronic activation of the fear network (driving a pervasive sense of current threat, hypervigilance, and avoidance); depression is a chronic disturbance in mood and approach motivation (maintaining negative self-focus and withdrawal).

The distinction between PGD, PTSD, and depression has been confirmed in research. E.g., network, factor analytic, and latent class analysis have shown that symptoms of PGD, PTSD, and depression represent distinct phenomena (Djelantik et al., 2020; Lenferink et al., 2021). Prospective studies have shown that elevated PGD symptoms predict impairments in health later in time (Boelen & Lenferink, 2022). Treatment studies have shown that PGD symptoms do not respond sufficiently to therapies focused on PTSD and depression and that PGD, therefore, should be treated with specific grief-focused interventions (Reynolds et al., 1999).

4. Assessing PGD

For caregivers, it is important to be able to assess whether someone is experiencing healthy grief or unhealthy, disturbed grief (what we now call PGD). Healthy grief requires a different kind of help than PGD. Psychological help for healthy grief should mainly consist of providing support, a space to share the story of the loss and reinforcing helpful ways of coping. Psychological help for PGD should be focused on removing barriers that block the grief from taking a healthy course. In the assessment of grief and PGD, it is important that caregivers consider four factors (i) the time since the loss, (ii) the pervasiveness of grief reactions, (iii) the emotional distress connected with the grief, and (iv) the extent to which the grief interferes with everyday functioning. If we think of grief as a continuum, running from healthy grief to severe PGD, then we can say that the likelihood of someone meeting criteria for PGD is higher (i) if more time has passed since the loss (someone is never diagnosed with PGD in the first 6 months following loss or 12 months when using DSM-5-TR criteria), (ii) if, over time, the person's grief reactions become more and not less intense, (iii) if, over time, someone experiences more distress and emotional pain associated with the loss, and (iv) if someone is more hindered by the grief in social, occupational, or other areas of functioning.

If caregivers suspect that someone is suffering from PGD, the Traumatic Grief Inventory Self Report Plus (TGI-SR+) can be administered. This is a 22-item questionnaire. The items represent all criteria for PGD as included in DSM-5-TR and ICD-11. Bereaved people can easily complete the TGI-

SR+ themselves. Caretakers can look at the item scores to see what grief reactions the person is particularly plagued by. The item scores can also be summed to obtain a total score (**Box 3**). A total score of 71 or higher is indicative of possible PGD (Lenferink et al., 2022).

Box 3. Traumatic Grief Inventory Self Report Plus (TGI-SR+)The TGI-SR+ is a 22-item measure of PGD. It is available in Ukrainian and other languages via <https://osf.io/rqn5k/>. Individual item scores give an indication of the most severe PGD symptoms. Item scores can be summed to obtain a total score. That can range from 22 (all items are scored 1) to 110 (when all items are scored 5). If someone scores 71 or higher, there is a considerable chance that he/she meets the criteria of PGD. At that score, psychological help is indicated. The TGI-SR can also be completed in Ukrainian, via www.вимірюваннягоря.com. On that website it is called the Griefmonitor («Вимірювання горя»).

When a bereaved person seeks help, caregiver should consider the diagnosis PGD, but should also consider other diagnoses. Many people experiencing PGD, also suffer from symptoms of PTSD and depression (Komischke-Konnerup et al. 2021). It is important to consider whether a person's problems are best classified as PGD, PTSD, or depression. Important also is that, although separation distress, anxiety, and dysphoria are key emotions among people who get stuck in their grief, losses can also yield other responses. For instance, when a person feels responsible for not having prevented the death, feelings of guilt may be present. When a loss is the consequence of someone else's deliberate actions or negligence (which is often the case with deaths caused by war violence), intense anger and revenge thoughts and feelings may be present. When a loss leads to negative, stigmatizing responses from the social environment, this may cause shame.

Notable too is that the death of a loved one may precipitate episodes of other disorders, except PGD, PTSD, and depression. In a large epidemiological study, Keyes et al. (2014) found that a sudden loss often coincided with the onset of substantial psychological problems. For example, compared to peers who had not experienced a sudden loss, people between 60 and 65 years of age who suffered a sudden loss had seven times as much chance of a first depression, eight times as much chance of a first episode of alcohol addiction, and 37 times as much chance of developing PTSD. Similar results emerged in other age groups.

5. Risk factors

The nature and intensity of emotional responses to loss are determined by different interacting factors. *Characteristics of the relationship with the lost person* have an impact: losing a partner or child gives a higher risk of emotional problems compared to losing more distant family or relatives. This is because partners and children are often very important attachment figures. Partner are sources of safety and security. Children are people's main targets of caring and nurturing. The *circumstances of the loss* have an impact: deaths that are sudden and caused by deliberate violence are generally more difficult to process than anticipated deaths caused by illness. The degree of suffering of the deceased relative, known or imagined, also influences the emotional consequences; knowing that a loved one suffered before he or she died can cause intense pain and helplessness. Sudden, violent deaths are more likely to shatter a person's sense of safety, control, and trust in other people.

Events happening after the death have an impact. In times of war, various circumstances can hinder saying goodbye to the dead. There may be no intact body, making the loss more difficult to believe and to accept. There may be a lack of resources to organize a dignified funeral and it may be impossible to carry out valuable religious and non-religious customs. Family and friends who one usually relied on for support may not be present. In times of war, there are likely many ongoing stressors after the loss that interfere with a healthy process of grieving. Ongoing threats of danger, serious damage to one's community, the confrontation with overwhelming tangible and intangible losses, and ongoing uncertainty about the future; all these factors place additional pressure on recovery after the death of a loved one (Shalev, 2022).

Apart from these factors, other factors influence responses to loss. For instance, the risk of emotional problems is associated with sociodemographic variables as being female, having lower educational level, unemployment, and limited availability of social support. In addition, if a person had mental or physical health problems before, processing the current loss is likely to be more difficult. Furthermore, elevated emotional distress following loss has been associated with personality related variables such as neuroticism and attachment anxiety (see, e.g., Dyregrov, Nordanger, & Dyregrov, 2003; Heeke, Kampisiou, Niemeyer, & Knaevelsrud, 2017; Lobb et al., 2010).

Box 4. Risk factors for PGD and other emotional problems following loss. The closeness and quality of the relationship with the lost person, specific traumatizing features of the circumstances of the loss, and distressing events and experiences after the loss all interact in contributing to symptoms of PGD, PTSD, depression and other emotional responses. On top of these factors, sociodemographic variables, vulnerabilities in personality and health, and social reactions affect these responses.

6. A cognitive behavioural approach to prolonged grief disorder

Many, if not all, of the aforementioned risk factors affecting responses to loss cannot be changed with psychological interventions. Obviously, psychological interventions to mitigate such responses should focus on processes and mechanisms that are amenable to change. We developed a cognitive behavioural conceptualization that tries to explain which problematic psychological processes are responsible for the persistence of PGD and associated symptoms, and that offers clear targets for psychological interventions to treat PGD (Boelen et al., 2006). The model draws from cognitive models of psychopathology, specifically PTSD (e.g., Dalgleish & Power, 2004; Ehlers & Clark, 2000). The starting point of the model is that symptoms of PGD are not qualitatively different from normal grief. Instead, PGD symptoms can be seen as reactions of acute grief that persist and deteriorate. The model proposes that three interrelated processes are critical to acute grief becoming chronic: (i) Lack of integration of the loss within existing knowledge, (ii) maladaptive cognitions, and (iii) anxious avoidance and depressive avoidance.

Lack of integration of the loss within existing knowledge

In healthy grief, the fact that the separation is final slowly but surely becomes integrated with the view the person has of his/her own identity and roles, assumptions about life and future, and the “working-model” of the relationship with the lost person. In PGD, this occurs insufficiently; although the person knows that the lost person will not return, this knowledge remains disconnected from information about self-identity and is not well integrated in views of life, the future, and the relationship with the lost person, that are all part of the bereaved person’s autobiographical memory base. This leads to a recurring sense of shock (even after months, the loss may be experienced as something that happened very recently), a sense of confusion about self (with the person struggling to define who he/she is and what he/she stands for), and a sense of “unrealness” about the loss (a feeling that the lost person will return one day).

Maladaptive cognitions

After a loss, people may have negative cognitions about themselves, their life and future, and about their own reactions to the loss. Generally, such cognitions gradually become more adaptive and positive, as time goes by and people experience things that positively influence their views on themselves, their lives, and futures. People with PGD continue to believe that the self is unworthy, life meaningless, and the future bleak, now that their loved one is dead. Such cognitions directly fuel dysphoria and keep people focused on what is lost. When people hold themselves responsible for the death, cognitions about self-blame may be present, causing guilt. When other people are held accountable for having caused or not having prevented the loss, cognitions about other-blame may cause anger and retaliatory tendencies. Maladaptive cognitions may also come in the form of

catastrophic misinterpretations of grief reactions (“My pain is abnormal”; “If I allow my feelings, I’d go crazy”). In fact, research has shown that such misinterpretations are strong predictors of persistent grief (Boelen, Van den Bout, & Van den Hout, 2010).

Anxious avoidance and depressive avoidance

Anxious avoidance, also termed loss-reality avoidance (Eisma et al., 2013), refers to the avoidance of internal cues (thoughts, images, memories) and external cues (situations, people, places) that remind the person of the reality of the loss. Anxious avoidance is often driven by catastrophic misinterpretations of grief reactions. For instance, people may avoid looking at pictures of the deceased person, because they think that doing so would be too painful and cause them to “go mad”. Depressive avoidance refers to the discontinuation of usual social, leisure, and occupational activities that were fulfilling and meaningful before the loss. It may be driven by at least three mechanisms. First, it may be driven by cognitions that, without the loved relative, engaging in these activities is meaningless or impossible (e.g. “Going to work won’t make me feel better”, “Seeking social contacts is impossible without ...”). Second, a sense that it is unfair towards the deceased to continue with normal activities may drive inactivity (“It is unfair toward ... if I continue my life”). Third, depressive avoidance may be connected with people having a very limited repertoire of activities and actions, because their whole identity was intertwined with the deceased person.

Box 5. Theories that help to understanding PGD From the perspective of the *cognitive behavioural conceptualization of PGD* (Boelen et al., 2006) acute grief becomes chronic under the influence of implicit memory processes (i.e. disconnection between knowledge that the separation is irreversible and other autobiographical knowledge), explicit and “editable” negative cognitions (about the self, life, the future, and one’s grief reactions), and maladaptive coping behaviours (phobic-like anxious avoidance and depressive withdrawal). These assumptions parallel elements of other theories. In terms of the *dual process model of grief* (Stroebe & Schut, 1999) anxious avoidance can be considered a lack of healthy loss-orientated and depressive avoidance a lack of restoration-oriented coping. The notion that insufficient integration of the loss is important resembles an assumption from Shear and Shair’s (2005) *biobehavioural model of bereavement* that disordered grief is associated with a failure to revise the internalized representation of the deceased in line with the new reality of his/her death. That negative views of self and depressive avoidance are crucial, mirrors element of the *cognitive attachment model* from Maccallum and Bryant (2013) that proposes that PGD is maintained by a merged self-identity, resulting from insufficient changes in a person’s identity to incorporate the reality of the loss.

7. Cognitive behavioural interventions to alleviate prolonged grief disorder

Based on the cognitive behavioural model explained above, interventions to reduce PGD and associated symptoms should be focused on the following four targets:

- [1] Integrating knowledge about the reality of the loss with the person’s views of self, life, and the working model of the relationship;
- [2] Identifying and changing maladaptive cognitions;
- [3] Reducing anxious avoidance;
- [4] Reducing depressive avoidance.

Cognitive behavioural therapy (CBT) interventions to target these processes include exposure, cognitive restructuring, and behavioural activation. But other interventions may be used also. Below, we describe the steps of a prototypical CBT-treatment, including these interventions. Not every component is equally relevant in every therapy, but we describe a complete process of a therapy as it might proceed. For clarity, we refer to *patients* when talking about people with PGD

undergoing CBT.

Step 1: Setting the stage

In the starting phase of treatment, agreements are made about confidentiality, the duration of sessions, and the timeframe of treatment. In addition, obstacles to therapy are discussed (e.g., such as resource constraints) and what patients should do in the time of crises (e.g., consult a friend or the family doctor). The therapist identifies key complaints, sets a descriptive diagnosis, and (if needed) a formal DSM-5-TR or ICD-11 classification. Earlier, we considered that many factors may affect responses to loss (see **Box 4**). In the early stage of treatment, it is useful to map out precisely which factors and circumstances are complicating the individual patient's grieving process. This can provide some counterbalance to the confusion and multitude of feelings that so often characterizes grief. In this stage, the therapist starts formulating hypotheses about cognitions and behaviours blocking adjustment. In addition, the rationale for treatment is explained. The aim of CBT is to change the stagnated unhealthy grief into a healthy grieving process. This encompasses working on the achievement of three tasks: (1) Facing the loss and the pain that goes with it; (2) Regaining and maintaining confidence in oneself, other people, life, and the future; (3) Engaging in helpful activities that promote adjustment to the new situation. Additional personal goals are set as well. For instance, reducing reexperiencing symptoms can be a goal when PTSD symptoms connected with traumatic circumstances of the loss are present, strengthening confidence in self and others when insecure attachment colours the picture, and reducing retaliatory tendencies when someone is preoccupied by anger and blame toward others held accountable for the loss.

Step 2: Involving a supporting family member or friend

The second step is to encourage involvement of a supporting family member or friend. This person's role is to act as sounding board, advisor, and companion while the patient goes through the treatment and does his/her assignments. CBT is an active approach. Between the sessions with the therapist, patients are encouraged to actively do particular assignments such as completing cognitive diaries (to identify and alter unhelpful cognitions), confronting situations he/she would rather avoid, and gradually giving form to life without the lost person. Involvement of a supporting friend or family member can be of great value in this process.

Step 3: Exposure

Exposure encompasses the gradual confrontation with internal and external cues associated with the loss. The aim of this is to reduce maladaptive anxious avoidance behaviours and to actively encourage the elaboration of the implications of the loss and to integrate these implications with the patient's view of self, life, and the relationship with the lost person. As such, exposure is all about working on the first task: Facing the loss and pain that goes with it. One key intervention is *working through the story of the loss*. The patient is encouraged to give a detailed narrative of what happened, starting with the moment he/she first was aware of the sudden or impending death, through the moments of farewell, to after the first weeks of mourning when most people in the patient's social environment had returned to their normal routines. While doing so, the therapist encourages the patient to focus on moments that are most meaningful and painful. Another key intervention is *confronting the irreversibility of the loss*. This is done by reviewing the relationship with the deceased, zooming in on what is missed most, now that he/she is gone, and articulating all consequences of the loss for one's own identity, life, and future. The person is stimulated to look at photos, visit places, talk to people, and engage in other activities reminding him/her of the loss. This is a difficult part of therapy because it touches on the heart of the pain, connected with the realisation that the separation is permanent.

Step 4: Cognitive restructuring

This part is focused on the second task: Regaining and maintaining confidence in oneself, other people, life, and the future. Cognitive restructuring is not about changing all negative cognitions that a person may have. Instead, it is focused on changing cognitions that are central to the patient's problems: cognitions that inflate emotional pain, block constructive coping, and reinforce a continued focus on the past. Typically, people have one or two dominant types of cognitions, which can be derived from their dominant emotions. In the more depressed patients, there may be negative cognitions about the self ("I cannot mean anything now that my husband is dead") or the future ("I will never be happy again"). In the more anxious patients, there may be negative beliefs about safety ("I am not safe anywhere") and control ("I have no control over things happening"). When there is a lot of anger, the patient probably has the conviction that others have wilfully done something wrong and should be punished for it ("That perpetrator is responsible. I won't rest until he gets his punishment"). When guilt dominates, someone usually thinks that he/she has made a huge mistake with terrible consequences and that one has to do something to make up for that ("I did not prevent the death. I am therefore partly to blame and do not deserve to just go on living").

When key cognitions are identified, the therapist uses various means to raise doubt about the credibility and usefulness of these cognitions. This can be done by using Socratic questioning and behavioural experiments. With Socratic questioning, the therapist asks questions to help the patient to gather evidence supporting or refuting his/her cognitions and to explore the consequences of holding onto particular cognitions. In an Socratic dialogue, the therapist should search for cognitions that can be falsified; cognitions that are absolute and clearly contain a line of reasoning that can be challenged. A cognition like "I should have prevented his or her death" is hardly refutable. The therapist can look for a possible cognition behind it that can be refuted, such as: "That I did not prevent his death, means that I am a bad person and do not deserve to be happy". Behavioural experiments can be used to test the validity of negative predictions by engaging in specific activities. A mother who lost her son in a violent encounter with an enemy may be encouraged to talk to witnesses of his death to test the prediction "If I would hear about the details of his death, I will be overwhelmed by pain and lose control" and the alternative prediction "If I would hear these details, that would give clarity about what happened and, ultimately, bring some relief". A spousally bereaved woman, depressively avoiding activities that used to be fulfilling, may initiate a relaxing activity with a friend to test out which of two alternative predictions is more valid, the negative one, "If I contact this friend, she will respond negatively" or the alternative, more positive predicting "If I contact this friend, she will respond enthusiastically".

Step 5: Behavioural activation

Behavioural activation aims to break through patterns of inactivity and withdrawal. This is done by helping people to (re)engage in activities that are rewarding and help in becoming more independent from the deceased. Behavioural activation is specifically focused on the third task: Engaging in helpful activities that promote adjustment to the new situation. However, it is also useful for the other tasks, as it helps to face the consequences of the loss (Task 1) and strengthens confidence in oneself and other people (Task 2). Before encouraging patients to start doing more, it is useful to address the mechanisms underlying passivity and withdrawal. This may mean that sabotaging cognitions about the usefulness of doing things without the deceased need to be identified and altered. When the patient thinks that engaging in potentially enjoyable activities means that he/she is "betraying" the lost person, the therapist discusses whether or not the deceased would really blame the person for continuing his or her life. If depressive avoidance is maintained by a limited repertoire of activities, a first step is to raise awareness about all the things that one might do (e.g., by completing lists of activities one might do).

After the necessary preparations, the therapist focuses on truly making the client more active. That involves several steps. First, the patient is helped to become more aware of valued goals: social contacts and community activities that are important to him/her, ambitions regarding personal growth, work, and education, and valuable activities that help to relax and counterbalance the stresses of everyday life. Then, a number of goals are selected and small, concrete steps towards

achieving them are formulated. In addition, consideration is given to skills that need to be acquired to enable the achievement of goals. Next, the therapist and patient carefully monitor whether goals are being achieved and reformulate goals and steps, if so needed.

Box 6: CBT for PGD The CBT perspective on PGD proposes that three interrelated problematic psychological processes are responsible for acute grief becoming chronic: (i) a lack of integration of the loss within existing knowledge stored in one's autobiographical database, (ii) maladaptive cognitions, and (iii) anxious and depressive avoidance strategies. Accordingly, CBT interventions are focused on [1] integrating the fact that the separation is permanent into the person's views of self, life, and the working model of the relationship; [2] identifying and changing maladaptive cognitions; [3] decreasing anxious avoidance; and [4] decreasing depressive avoidance. This encompasses working on the achievement of three tasks: (1) Facing the loss and the pain that goes with it; (2) Regaining and maintaining confidence in oneself, other people, life, and the future; (3) Engaging in helpful activities that promote adjustment to the new situation. Exposure, cognitive restructuring, and behavioural activation are the most important interventions to achieve these tasks. Exposure is focused on confronting and not avoiding the reality of the loss, cognitive restructuring on replacing unhelpful cognitions by helpful cognitions, and behavioural activation on breaking the cycle of sadness and passivity patients with PGD may be caught in.

Additional interventions

During CBT for PGD, several additional interventions can be used to encourage integration of the loss and change maladaptive cognitions and avoidance. These include writing assignments, imaginary conversations, and therapeutic rituals. *Writing assignments* can be applied in different forms. Instructing people to write about the circumstances of the loss, in a step by step manner, and including increasingly detailed accounts of the most painful moments, can help people to confront and process the story of the loss, at a pace that is suitable to them. Writing a farewell letter to the deceased, in which the patient articulates what he/she misses most now that the loved one is dead is a powerful tool to gradually confront the reality of the loss and the associated pain. Writing specific advices to a hypothetical friend, who is struggling with similar thoughts and feelings after a similar loss, may help to get a different perspective on negative beliefs (for instance, having the patient write an encouraging, optimistic letter to a hypothetical friend when he/she has a pessimistic view of the future). Last, writing what one has done in CBT treatment and the effects thereof is useful to consolidate the things that one has learned during treatment (see also Cummings, Hayes, Saint, & Park, 2014; Wagner, Knaevelsrud, & Maercker, 2006).

Conducting an *imaginary conversation with the deceased* is useful when patients suffer from certain feelings towards the deceased that are unspoken. In this intervention, the patient imagines that the deceased loved one is present in the therapy room, seated in an empty chair. He/she then verbalizes what he/she wants to say to the deceased, after having prepared that with the therapist. Finally, the person is encouraged to imagine as vividly as possible how the deceased would react to the message. This intervention is useful when patients feel guilty about things they believe they have done wrong towards the deceased, when they have not been able to say enough goodbyes, when they are angry about something the deceased did, or when they want to ask for "permission" to resume certain activities in life that have been put on hold. Clinical experience suggests that patients can often relatively easily imagine a helping, reassuring "response" from the deceased. If the deceased's "reaction" is negative or upsetting, the therapist can help the patient to deal with it.

Therapeutic rituals are ordered sets of symbolic and formalised actions that enable individuals to express their feelings and thoughts about the loss, to say goodbye to the deceased loved one (when this was impossible earlier), and to enable them to mark a transition to a new phase in their lives, without the lost person. Examples include lighting a candle to symbolize a continuing connection with the deceased, organising a ceremony or meal with family to mark the farewell of the deceased and to celebrate his/her life, and creating an object of art symbolizing a transition to a new future without the lost person (Wojtkowiak, Lind, & Smid, 2021). From a CBT perspective, such rituals foster integration of the reality of the loss, mark changes in one's self-view and relationship with the deceased person, and counter avoidant coping.

8. Conclusions and final remarks

The CBT perspective on PGD draws from cognitive behavioural theories of depression, anxiety, and posttraumatic stress; it is embedded in a gradually growing evidence base supporting the role of memory, cognitive, and behavioural process in the maintenance of PGD (Boelen, 2016). CBT is a time-efficient treatment, typically delivered in a limited period of time. The interventions are easy to explain by practitioners and easy to understand by patients; this makes it a didactically strong approach in which patients learn skills that they can continue using after treatment. In this closing part, some final issues will be address including the effectiveness of CBT for PGD and adjusting the treatment to the patient's circumstances.

Effectiveness

CBT interventions have been found to effectively reduce PGD and associated complaints in adults (Doering & Eisma, 2016). Deaths of loved ones in times of war are often traumatic losses leading to combinations of the PGD and PTSD. There is evidence that CBT can be successfully applied in traumatically bereaved samples, including people bereaved by homicide (Van Denderen, De Keijser, Stewart, & Boelen, 2018), people confronted with the long-term disappearance of relatives (Lenferink, de Keijser, Wessel, & Boelen, 2019), and people who lost loved ones in the MH17 plane crash (Lenferink, de Keijser, Smid, & Boelen, 2020).

CBT for PGD has mostly been studied among adults. Spuij et al. (2013) adapted CBT for delivery to children and adolescents. In a recent study, we compared this CBT for children (called "CBT GriefHelp") with non-directive supportive counselling (Boelen, Lenferink, & Spuij, 2021). Although both treatments alleviated PGD and bereavement-related PTSD and depression, the immediate and long-term effects of CBT GriefHelp were much stronger.

CBT for PGD via the internet

CBT for PGD can be effectively delivered online. Wagner et al. (2006) were among the first to do so. Their treatment modality encompassed ten specific writing assignments (guided by a therapist via email contact) focused on exposure to thoughts, memories, and images associated with the loss, changing unhelpful cognitions, and orientation toward the future; the treatment was found to effectively reduce symptoms of unhealthy grief. The same treatment, with slight adjustment for the target group, was also found to be effective for PGD in women suffering pregnancy loss (Kersting et al., 2011) and people bereaved by suicide (Trembl et al., 2021).

Adapting CBT for PGD

CBT for PGD is not a "one size fits all" approach; it is not meant to be applied as a recipe with fixed ingredients offered in a fixed order. This means that the three tasks (see **Box 6**) can be tackled in different orders. This also means that interventions are tailored to the patient's needs and possibilities. For example, different approaches can be used to help the patient face the reality of the loss. For one patient, a confrontational approach may be appropriate (reliving painful memories in the therapy room); for another patient, it is more appropriate to do exposure step by step (e.g., using writing assignments). And cognitive restructuring is not always focused on the same cognitions but, instead, on specific cognitions that are most undermining for a particular patient. Where possible, interventions should also be tailored to the patient's vulnerability factors that are known to inflate the grief. These factors include: losing a partner or child (which means that basic attachment needs may not be met), losing a loved one in violent circumstances (which means that attention must be paid to processing painful memories), a history of interpersonal difficulties and insecure attachment (which means that strengthening a positive view of self and other should be addressed), and a history or mental disorders (with means that attention should be paid to broader personality variables).

War time stressors

In times of war, people face many stressors, including losses and changes in many domains of life (e.g., loss of belongings, one's social network), uncertainties about short-term needs (security, food) as longer-term needs (home, work, financial security), and exposure to scenes of destructions both directly (in one's environment) and indirectly (via media) (Shalev, 2022). These stressors likely affect the circumstances and aftermath of the loss, as well as the psychological and social resources to come to terms with loss. As pointed out above, when a person seeks psychological help, it is helpful for the therapist to identify all factors that have amplified the distress of the individual, including such war stressors, and to help the person to handle these stressors as best as possible .

In the situation of war, the normal "dynamics" of grief are distorted, due to a loss of social resources (e.g., children, partners, colleagues that left the community) and shortage of material resources needed to perform everyday activities (shortage of electricity, heating, water and internet connection). Notably however, some people show a remarkably resilient response to losses in times of war. That may be fuelled by activation of survival instincts and increased connection with people from the community experiencing similar adversities (see also Mancini, 2019). But in general, especially for those who have lost children, the situation is difficult; for them, survival mode and ongoing exposure to daily media coverage of civilian casualties might prolong and exacerbate the grieving process.

When faced with loss in an acute crisis situation there is likely not much room for bereaved people to undergo CGT treatment. Acute stressors and stress can be so intense that the grief is pushed into the background and all help possible should primarily be focused on increasing safety, promoting calmness, and increasing self-efficacy, connectedness, and hope (Hobfoll et al., 2007). Moreover, therapists should be cautious in trying to change possible maladaptive thoughts and behaviours when the loss only happened very recently, because the natural grieving process of the person should be given room to take its natural course. At the same time, from the CBT perspective, it is always good to consider the following points when, as a psychologist or other counsellor, you offer help to people with grief:

- Acknowledge and accept all reactions the person has about the loss (all feelings are allowed, no feelings are abnormal); give the person space to verbalise and express these feelings.
- Help the person to gather or create one or more objects that represent the connection with the deceased (a photograph, a letter, an item of clothing, a small memorial).
- Help the person to articulate what kind of support he/she needs in coping with the loss and help him/her to mobilise sources of support.
- Help the person to protect himself/herself from disappointment about social reactions; if people give little support or recognition for the loss, do not assume that they do not care but assume they themselves are caught up in pain about their own losses or stressors.
- Encourage the person to continue normal routines as much as possible (eat well, sleep well, gather information, do things), while also saving time to mourn and to grieve.
- Encourage the person to face the reality of the loss and to slowly but surely consider the implications that the loss has for one's self, life, and future.
- Explain that it is normal that the death of a loved one can undermine different certainties, beliefs, expectations and goals; at the same time, encourage a person to also keep faith in himself, life, and the future.

Box 7. Website with information about grief and the TGI-SR+With Ukrainian colleagues, Lonneke Lenferink and Paul Boelen (living in the Netherlands) are developing a website with information on grief. This is meant for bereaved people and people providing help to them. On that website, people can complete the Griefmonitor («Вимірювання горя»). The result is then immediately presented with a brief advice. The address is www.Вимірюваннягоря.com. Questions and suggestions about the website are very welcome and can be sent to Paul Boelen, p.a.boelen@uu.nl.

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