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THEORETICAL REVIEW

Complicated grief therapy for clinicians: An evidence-based protocol for mental health practice

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Abstract

In the United States alone, about 10 million persons are newly bereaved each year. Most do not require professional intervention or treatment, but many can benefit from targeted support. However, a significant minority of bereaved persons experience intense, prolonged and disabling grief symptoms associated with considerable morbidity and mortality (aka, "Complicated Grief"). Individuals with Complicated Grief require more formal interventions. In this article, we describe a compassionate and evidence-based approach to bereavement-care that can be provided in varied mental health settings. For individuals struggling with acute grief, clinicians can help by providing recognition and acceptance of the grief, eliciting and compassionately listening to their narratives of their relationship with the deceased and the death, and regularly "checking in" regarding their grief experiences. For bereaved persons who are experiencing Complicated Grief, we recommend an evidence-based approach to bereavement-care, complicated grief therapy (CGT), that involves helping the individual accept and cope with the loss while simultaneously assisting them with adaptation to life without the deceased. We describe ways of implementing CGT's seven core themes: (1) understanding and accepting grief, (2) managing painful emotions, (3) planning for a meaningful future, (4) strengthening ongoing relationships, (5) telling the story of the death, (6) learning to live with reminders, and (7) establishing an enduring connection with memories of the person who died. This work can be done in a variety of settings, taking into consideration the needs of the patient, the limitations of the setting, and the skills and experiences of each clinician.

KEYWORDS

bereavement, complicated grief, grief, therapy, treatment

1 | INTRODUCTION

More than 2.7 million people died in the United States in 2016 (Murphy, Xu, Kochanek, & Arias, 2018), each leaving behind an estimated 1–5 close friends or relatives who are highly affected by the death. This means there are about 10 million newly bereaved persons each year. While the vast majority of these individuals adapt to their loss without needing professional help, a minority struggle with persistent, impairing grief, a condition we call complicated grief (CG). Various other terms have been used for this condition, including "persistent grief disorder," "prolonged grief disorder," "persistent complex bereavement disorder," "pathological grief," "traumatic grief," and "unresolved grief." Although differences exist in details of proposed criteria, all refer to a clinical condition of

intense, prolonged and impairing grief (Mauro et al., 2018). A higher percentage of those who have lost a child or have lost a loved one to suicide, accident or murder are at risk for CG (Middleton, Raphael, Burnett, & Martinek, 1998; Mitchell, Kim, Prigerson, & Mortimer, 2005; Tal Young et al., 2012).

Individuals with CG are susceptible to a host of negative health sequela and benefit from professional support (M. K. Shear, Muldberg, & Periyakoil, 2017; M. K. Shear, Muldberg, & Periyakoil, 2017; M. K. Shear et al., 2011). The authors of this paper developed and tested an evidence-based therapy for CG. Based on our extensive experience as both clinicians and clinical researchers, this article describes a compassionate and evidence-based approach to assessment and bereavement-care that can be provided in varied mental health settings, ranging from pharmacotherapy to psychotherapy practices.

2 | GRIEF AND ADAPTATION TO LOSS: ACUTE, INTEGRATED, AND COMPLICATED GRIEF

Grief is the natural response to loss of a loved one. When grief is acute there are intense emotions and preoccupation with thoughts and memories of the deceased person. While everyone grieves in their own way, bereaved individuals often feel a sense of disconnection from themselves, their past, present and future, and especially from the person who died. They may fear never again being able to feel happy or fulfilled. Yet, over time, most adapt to their loss by accepting its finality and consequences, evolving a changed but ongoing relationship with the person who has died, and re-envisioning a future with possibilities for happiness, joy, connection and meaning—albeit in a world without the deceased. This state is called integrated grief, as adapting to loss transforms and integrates grief. However, an estimated 7–10 percent of those bereaved of a spouse or other very close relationship do not adapt to the loss and instead develop CG (Kersting, Brahler, Glaesmer, & Wagner, 2011; Lundorff, Holmgren, Zachariae, Farver-Vestergaard, & O'Connor, 2017; Middleton, Raphael et al., 1998; Prigerson et al., 1997; Zisook, Iglewicz et al., 2014).

In CG, yearning for and preoccupation with the deceased remain intense and debilitating. CG is a unique and recognizable disorder that requires professional intervention (M. K. Shear et al., 2017; M. K. Shear et al., 2016). Without treatment, CG tends to be chronic (Zisook et al., 2014), associated with prolonged suffering and debility, as well as susceptibility to general medical deterioration (Prigerson et al., 1997), major depression (Monk, Houck, & Shear, 2006; Newson, Boelen, Hek, Hofman, & Tiemeier, 2011), substance use (Zisook, Shuchter, & Lyons, 1987) and suicidal thoughts and behaviors (Latham & Prigerson, 2004; Szanto, Shear et al., 2006).

3 | ASSESSMENT AND MANAGEMENT OF ACUTE GRIEF

Considering that all clinicians will work with grieving individuals, this section applies to all mental health professionals. Acute grief is an adaptive and universal response to loss and should not be pathologized. Neither should people requesting help be denied care. As outlined above, typical grief can be subcategorized into acute grief—the initial painful response—and integrated grief—the assuaged and enduring grief that remains after adaptation to the death of a loved one. Acute grief occurs in the days to months after the loss of a loved one. Common components of acute grief are feelings of shock and disbelief, yearning for the deceased loved one, waves of sadness and other painful emotions which are intermixed with both positive emotions and tender recollections, feeling disconnected from other people and ongoing life, and desire for a period of respite from customary roles and responsibilities (Bonanno, Moskowitz, Papa, & Folkman, 2005; Zisook, Iglewicz et al., 2014).

All bereaved people benefit from compassionate support. For many people, grief after losing someone very close is among the most intensely painful experience they have had in their lives. Many turn to clinicians because they are discomfited by what they are experiencing and wonder if it is normal. Clinicians can provide compassionate care by accepting and normalizing grief and bearing witness to the pain. An adage utilized in medical education, "When you don't know what to do, just be human," can help guide the approach to providing support.

Questions about important losses are a recommended part of standard diagnostic evaluation, especially for older patients, for whom loss is common (Newson et al., 2011; M. K. Shear, 2015). When a patient shares that a loved one has died, it is important to recognize the significance of this moment. An expression of grief at any time should prompt the clinician to change what is being planned or done in order for the clinician to be fully present for the patient; for example, to stop documenting in the medical record and shift the full attention to the patient (M. K. Shear et al., 2017; Worden, 2018). Clinicians may need to set aside or curtail the agenda, be it medication follow up, diagnostic evaluation, or completion of required annual screens.

Clinicians should show natural human compassion for the loss, indicating this with non-verbal as well as verbal communication. This means paying attention to tone of voice, use of pauses, and body language (M. K. Shear et al., 2017; Worden, 2018). Ideally, clinicians would use a kind, caring tone of voice; pause after making a sympathetic statement about the loss, for example, "I am so sorry to hear that _____ died"; and indicate in body language as well as other behavior that they are not hurried or distracted and are prepared to be fully present and interested in listening to the patient's story (M. K. Shear et al., 2017). A desire to assuage a grieving patient's pain may make clinicians tempted to either offer platitudes, such as "at least he lived a long, full life" or "time heals all wounds" or to try to be reassuring by saying "I understand." If grief is conceptualized as a form of love and therefore unique to each relationship, it is clear that none of us really understands the complexity of thoughts and feelings engendered in someone else by the loss of a loved one. Thus, although well intentioned, such comments are premised on false assumptions and not only miss the mark, but often also make the patient feel more saddened, alone, and even angered (Neimeyer, 2012).

As a small touch, we suggest that clinicians ask the name of the loved one who died as it is warmer and more personal than referring to "your husband," "your wife," "your sister," "your brother," and so forth. Clinicians might document the name of the deceased loved one in the patient's medical chart, allowing for recall of the name in subsequent visits. From our collective experience working with numerous bereaved individuals, we recommend: (a) inviting patients to talk about their relationship with the deceased, to learn about the quality of that relationship; (b) creating a safe, confidential and nonjudgmental space that allows patients to divulge difficulties in the relationship as well as what they cherished; (c) encouraging patients to tell the story of the death; and (d) inquiring about what things have been like for the patient since the death, paying attention to their grief symptoms and to the effectiveness of available support. Who is available to support the patient? Does the patient have a close confidant with whom they can share painful thoughts and feelings? Are there friends, family or a religious community to support the patient? If there is not time for this comprehensive discussion, be sure to express genuine sympathy, learn the name of the deceased, and ask how the patient is doing. Clinicians might schedule a follow-up visit sooner than planned to talk more about the loss.

In any case, clinicians should monitor the response to loss until they and their patient are comfortable that the patient has successfully adapted to the loss. As bereaved people adapt to the many changes that accompany the death of a loved one, the wounds begin to heal, and the bereaved persons find their way back to a fulfilling life. The reality and meaning of the death are assimilated, the relationship with the deceased has a new place in the life of the bereaved who can engage once again in pleasurable and satisfying relationships and activities. The bereaved do not forget lost ones, relinquish their sadness, or stop missing loved ones. Intense grief may reawaken around the time of significant events, such as holidays, birthdays, anniversaries, another loss, or other particularly meaningful or stressful times, however this does not interfere with the ongoing experience of a renewed sense of joy and satisfaction.

4 | ASSESSMENT AND DIAGNOSIS OF CG

A minority of bereaved patients will be stalled or halted in adapting to their loss. For those individuals, maladaptive thoughts, dysfunctional behaviors, inability to manage painful emotions and/or social impediments complicate grief and interfere with adaptation (M. K. Shear et al., 2011; Zisook, Iglewicz et al., 2014). Instead of integrating their grief, they develop CG (M. K. Shear, 2015; Zisook, Iglewicz et al., 2014). The International Classification of Diseases—11th Revision (ICD-11) diagnostic guidelines (see Table 1) describe four core features: (a) history of death of a partner, parent, child, or other loved one; (b) persistent and pervasive yearning or preoccupation with the deceased accompanied by intense emotional pain; (c) lasting at least 6 months and clearly longer than expected social, cultural or religious norms; and (d) clinically significant impairment. See Table 1 for a more complete description of the ICD-11 criteria and Figure 1 for a model of CG.

Common CG-related maladaptive thoughts include ruminative second guessing—the "should-have's," "would-have's," "could-have's," and "if only's"; grief-judging; and catastrophizing the future. Intrusive imagery of the death may occur as a symptom of CG or posttraumatic stress disorder (PTSD), especially when the death was by suicide or other violent means (Tal Young, Iglewicz et al., 2012). Excessive avoidance of reminders of the loss (i.e. avoiding thinking about the death or the person who died, avoiding places frequented by the deceased or leaving items of the deceased untouched), escaping the painful reality through excessive proximity seeking to feel close to the deceased (i.e. smelling the unwashed shirt of the deceased, listening to the sounds of their voice), and/or use of alcohol or drugs are common. Emotional dysregulation, such as inability to manage painful emotions including anger and guilt, low positive emotions, and low self-compassion, is often present in CG (M. K. Shear, 2015). Social impediments include absence of supportive companionship, being blamed by others for the deceased's illness and/or death, stigma, homelessness, poverty, or loss of employment (Zisook & Shear, 2009).

Risk factors for difficulty adapting include multiple losses; a history of mood, anxiety, alcohol or drug use disorders; loss of a child or spouse; or loss by suicide or other violent means. Depression early in bereavement increases the likelihood of CG down the road (Guldin et al., 2017). Losing someone very close can also be especially hard if the bereaved person had a difficult upbringing or there are unusually stressful consequences of the death, such as inadequate social supports, serious conflicts with friends or relatives, or major financial problems after the death (M. K. Shear, 2015).

Screening questionnaires can be helpful in identifying CG. The Brief Grief Questionnaire (BGQ) is a 5-item self-report questionnaire

TABLE 1 Guidelines for the diagnosis of prolonged grief disorder in the international classification of diseases, 11th revision

Essential features
History of bereavement after the death of a partner, parent, child, or other loved one
A persistent and pervasive grief response characterized by longing for or persistent preoccupation with the deceased, accompanied by intense emotional pain (e.g., sadness, guilt, anger, denial, blame, difficulty accepting the death, feeling one has lost a part of one's self, an inability to have a positive mood, emotional numbness, or difficulty in engaging with social or other activities)
A grief response that has persisted for an abnormally long period of time after the loss, clearly exceeding expected social, cultural, or religious norms; this category excludes grief responses within 6 months after the death and for longer periods in some cultural contexts
A disturbance that causes clinically significant impairment in personal, family, social, educational, occupational, or other important areas of functioning; if functioning is maintained only through substantial additional effort or is very impaired as compared with the person's prior functioning or what would be expected, then he or she would be considered to have impairment due to the disturbance

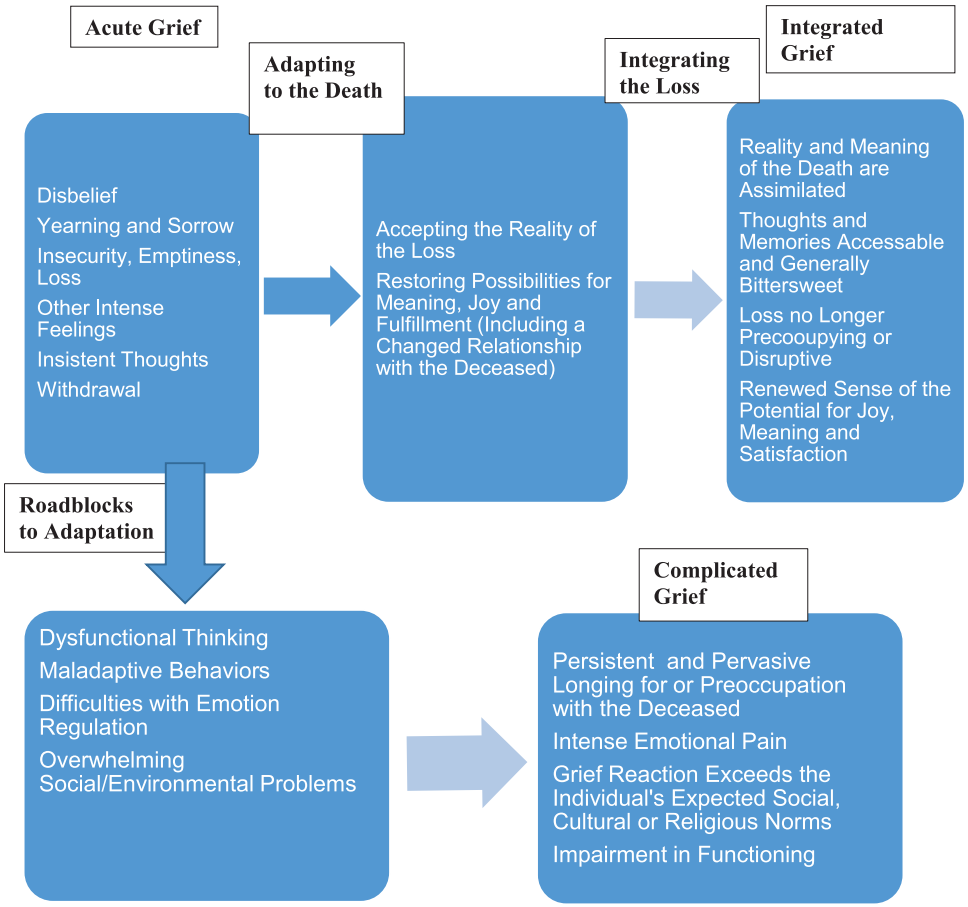

FIGURE 1 Pathways to integrated and complicated grief

(Ito, Nakajima et al., 2012; K. M. Shear, Jackson, Essock, Donahue, & Felton, 2006) (Table 2). A score of five or higher is a positive screen. The inventory of complicated grief (ICG) is a 19-item self-rated scale measuring affects, thoughts, and behaviors related to the loss of a loved one. Each item is scored from 0 = never to 4 = always. A cut off of >25 is suggestive of CG (Prigerson, Maciejewski et al., 1995). We recommend a clinical diagnostic assessment following a positive screen with either of these instruments.

Diagnosing CG entails the differential diagnoses of major depressive disorder (MDD) and posttraumatic stress disorder. In contrast to MDD and PTSD, all of the symptoms of CG—even those which overlap with MDD and PTSD—center around the loss of a loved one. CG's core symptoms of yearning and sorrow, preoccupying thoughts of the deceased and difficulty accepting the painful reality of the death are not typically seen in MDD or PTSD. A detailed discussion of the differential diagnoses is described elsewhere (M. K. Shear et al., 2011; Zisook & Shear, 2009). CG often co-occurs with MDD, PTSD, or other DSM5 conditions (Simon et al., 2007) and it is important to understand when the co-occurring conditions require additional clinical attention.

If a patient is already receiving effective medication treatment for a co-occurring condition, there is no need to stop the pharmacotherapy that is helping. Clinicians can integrate aspects of complicated grief therapy (CGT) into clinical management. If a psychological approach for a co-occurring condition is effective, clinicians might complete that treatment and then shift gears and focus on the CG. We generally recommend focusing on problems sequentially. However, how this is done—sequencing within sessions,

TABLE 2 The brief grief questionnaire (BGQ) (Ito, Nakajima et al., 2012; K. M. Shear et al., 2006)

Has anyone important to you died? If so,
1. How much are you having trouble accepting the death of _____?
2. How much does your grief still interfere with your life?
3. How much are you having images or thoughts of _____ when s/he died or other thoughts about the death that really bother you?
4. Are there things you used to do when _____ was alive that you don't feel comfortable doing anymore, that you avoid? Like going somewhere you went with him/her, or doing things you used to enjoy together? Or avoiding looking at pictures or talking about _____? How much are you avoiding these things?
5. How much are you feeling cut off or distant from other people since _____ died, even people you used to be close to like family or friends?
Answers rated as 0, not at all; 1, somewhat; or 2, a lot.
A score of 5 or more may be suggestive of the presence of the syndrome of Complicated Grief, but full evaluation by a clinician is necessary to make this diagnosis.

across sessions or across series of sessions—is best-answered case-by-case. Clinicians would need to take into account the severity of each condition, the patient's preferences, past history and past treatment trajectories. Of course, any life-threatening condition, such as an impending or actual suicide crisis or serious substance use disorder requiring inpatient detoxification, takes precedence.

5 | EVIDENCE-BASED TREATMENT FOR CG

We developed the first targeted short-term complicated grief treatment (CGT; M. K. Shear et al., 2001) and this treatment remains the most extensively tested treatment to date (K. Shear, Frank, Houck, & Reynolds, 2005; M. K. Shear et al., 2016). CGT is based on the premise that grief emerges naturally after a loss and finds a place in our lives as we adapt to the loss. The treatment is designed to remove impediments to adaptation and facilitate natural adaptive processes. Adaptation is considered to have both a loss focus and a restoration focus, as delineated in the dual-process model of grief (Stroebe & Schut, 2010). The loss focus requires acceptance of the reality of loss, grief, and stress and a changed relationship to the person who died. The restoration focus requires a renewed sense of autonomy, competence and relatedness in a changed world. Sequenced work on seven core themes is used to accomplish these goals (Table 3). Clinicians practice active empathic listening as they work through these themes, primarily contributing by introducing tools and/or asking clarifying questions.

Results of our trials show CGT is markedly more effective for CG than are proven efficacious treatments for depression, including citalopram (M. K. Shear et al., 2016) and interpersonal therapy (K. Shear et al., 2005; M. K. Shear et al., 2014). CGT has been used successfully in a group therapy model (Supiano & Luptak, 2014). Additionally, several individual, group, and internet-based cognitive behavioral treatments have been found to be effective in small randomized controlled trials (Boelen, de Keijser, van den Hout, & van den Bout, 2007; Bryant et al., 2014; Kersting et al., 2013; M. K. Shear, 2015; M. K. Shear et al., 2005). A number of other authors have proposed various strategies and techniques to use in work with bereaved patients (Acierno et al., 2012; Asukai, Tsuruta, & Saito, 2011; Boelen et al., 2007; Neimeyer, 2000; Rosner, Pfoh, & Kotoucova, 2011; Rynearson, 1987; Wagner, Knaevelsrud, & Maercker, 2006; Worden, 2018). Strategies or procedures used by these authors can be used in working with the core themes described below.

TABLE 3 Seven core themes of complicated grief therapy

1.	Understanding and accepting grief
2.	Managing emotional pain
3.	Thinking about the future
4.	Strengthening ongoing relationships
5.	Telling the story of the death
6.	Living with reminders
7.	Connecting to memories

Licensed therapists from different backgrounds provided CGT in our randomized trials. They learned CGT easily and provided it in a reliable manner while personalizing the treatment for each patient. We have since learned that practicing clinicians can easily learn to use CGT in a manner that their patients find very helpful. The ease at which therapists can learn CGT does not discount the challenges inherent in this work. Appropriate supervision and peer support are recommended to help mitigate against the development of compassion fatigue and secondary trauma in therapists learning CGT considering the heavy nature of the work with sad, often traumatized, chronically grieving individuals. Importantly though, as all authors can attest, helping to transform the lives of those frozen in the throes of CG through CGT serves to prevent burnout, rather than cause it, leading to inspiration and engagement in clinical work. The study treatment manual can be purchased, and we offer a range of possible training experiences both in person and online (https://complicatedgrief.columbia.edu). However, you can also help bereaved patients by simply using the principles and goals of CGT. Below we outline ways to do this in different practice settings, ranging from a pharmacotherapy practice with briefer, spaced appointments to a psychotherapy practice in which sessions may be longer and more frequent.

6 | CGT: PRINCIPLES AND GOALS

Each close relationship is unique, and so too is each person's grief. Loss of a loved one is a complex and profound experience that brings many associated changes in physical, psychological and social spheres. Our close relationships provide us with a sense of safety and a feeling that we belong and matter in the world. Our loved ones help regulate a wide range of psychological (K. Shear & Shair, 2005) and physiological functions (i.e. social zeitgeibers such as sleeping, eating, and socializing on a regular schedule) (Diamond, Hicks, & Otter-Henderson, 2008). They give us confidence to pursue intrinsic goals and interests and support our sense of competence in doing so. Our personal and social identities are tied to our loved ones (Feeney & Collins, 2003). It is not surprising that the death of someone close is like an earthquake that shakes the very foundation of our lives. Given this disruption, it is remarkable that most people find pathways to adaptation and personal growth after bereavement. CGT is based on the premise that we do so because a natural adaptive process is triggered by a loss, side by side with grief. Adapting entails coping with problems as well as envisioning and finding new ways to bring joy and satisfaction into ongoing life. When doing CGT, grief is not an intervention target. Rather we seek to facilitate coping and personal growth and to resolve any impediments to this process.

With CGT, adaptation to a loved one's death is conceptualized as having two main components. One is focused on acceptance of the reality of the loss, including its finality. The other component entails coping with bereavement-related stresses while finding a way forward that has possibilities for happiness and a remodeled and

enduring relationship with the deceased. CGT is a short-term approach that facilitates both components, clearing away obstacles that might be standing in the way.

Creating a place for patients to share thoughts and feelings is the cornerstone of any effective psychotherapy. Our patients must see us as trustworthy and genuine, having necessary expertise and ability to take time and effort to understand their problems and context (Frank & Frank, 1991). We need to acknowledge a patient's deep pain without offering platitudes or creating expectations. We want to establish a safe relational "container" wherein the bereaved person feels they will not be judged. Some clinicians find it helpful to ask patients to describe their hopes, wishes and fears regarding the therapeutic process as an entrée into therapy.

It is important to learn something about the patient's own background, including their early upbringing and experience with caregivers, their progress through school and occupational activities, their history of psychiatric and medical illness and also their dreams, accomplishments and talents. We often ask about philosophic or religious beliefs they have relied on to deal with difficult times. We also invite the patient to tell us about the person who died. This might include a discussion of what the bereaved patient and the deceased loved one meant to one another. Then we ask about their personal grief experience, exploring what they have been feeling, thinking and doing since their loved one died.

Clinicians might find that hearing stories of loss and grief is emotionally activating. Additionally, as Bowlby pointed out, both bereaved patients and the treating clinician might believe that nothing can help except bringing the deceased person back (Bowlby, 1980). It is natural in this situation to want to soothe the pain or find something related to the death that can be fixed. However, this is not likely to be helpful. In CGT, clinicians contribute primarily by asking clarifying questions that emerge during active empathic listening, providing psychoeducation about grief, and using the tools described below.

7 | CGT: SEVEN CORE THEMES

1. *Providing information to help patients understand and accept grief*: CGT is a collaborative approach, in which information is shared with the patient in an interactive way. Patients are encouraged to comment and ask questions as the model of grief and adaptation is explained. Structure can thus be introduced into a seemingly disorganized world. This introduction also provides an explanation that normalizes their grief, counters the notion that they are alone, and gives the bereaved hope that effective treatment exists. Key information to relay includes why people grieve, examples of symptoms and variability of "natural, adaptive grief," what adapting to loss generally entails, factors that might "complicate" grief and impede its healing potential, what CG is, and how the therapist plans to help. Often, the diagnosis of CG, especially when combined with a treatment plan, provides some hope and relief. When a patient's ideas about their symptoms differ from the CGT therapist's, an attempt is made to reconcile the differences, enacting the active listening and collaborative approach used throughout the treatment. An explanation of the patient's symptoms that incorporates their perspective can help them problem solve ways to overcome roadblocks to adaptation.
2. *Managing emotional pain and monitoring symptoms:* Patients are encouraged to accept their grief as the natural response to their loss. Accepting grief also means accepting and managing painful grief-related emotions. Patients are instructed to monitor their grief as a way to help them learn more about their grief and accept it, including the pain. They also see the natural oscillation in confronting the pain and setting it aside. In CGT, people are asked to take just 5 minutes at the end of each day to think back over their day, identify a time when their grief was at its highest, rate its intensity on a scale of 1–10 and make a note about what was happening at the time. This is repeated for the lowest grief of the day and patients are then asked for an overall rating for the day. At the next session, patient and therapist briefly discuss just one day when the grief was highest for the week and one day when grief was lowest. The process of monitoring is often quite helpful and requires minimal time and discussion.
3. *Thinking about the future:* Individuals with CG are "stuck" in acute grief and have difficulty envisioning a promising future. In CGT, the idea of thinking about the future is introduced in session 2. This is done using a modification of the personal goals procedure from motivational interviewing—asking the patient to imagine that their grief is at a manageable level and consider what they would want for themselves. If the patient does not know, they are asked to think about this question during the week. Once they have an answer, they are asked to formulate steps towards meeting these goals. They are asked how committed they are to these plans, what obstacles they foresee and who can help them.

   Ideally a personal goal is something that is truly interesting and potentially satisfying. If the patient has trouble with this, an alternative might be to ask that the patient think of what they would want if the deceased were still alive. Notably, this can be challenging for a patient with CG. Another possibility is to start with a simple rewarding activity; for example, engaging in better health care, learning to balance a checking account, or even going for a walk in the park. During each clinical visit, a few minutes are reserved for discussing this plan.
4. *Reconnecting with others:* In addition to making plans for interesting or fulfilling goals, CGT clinicians talk with patients about their ongoing relationships. Patients are encouraged to find at least one person who can be a confidant. Patients are also encouraged to re-engage in different social activities as they feel ready to do so. Clinicians keep this social side of their patients' adaptation in mind throughout each session and use opportunities to clarify who can help or who they can share things with and encourage them to do so. For some bereaved spouses, something as adventuresome as finding a new mate might be a focus of rebuilding relationships.
5. *Telling the story of the death:* Sharing the story of a loved one's death is one way to help patients come to accept the reality of the

loss. Most cultures and mourning rituals include a period in which relatives, friends and neighbors get together to talk about what happened, to recount stories about the person who died and share connections and remembrances. Over time, friends and relatives start to feel that conversation should focus on other topics. They often feel that continuing to talk about the deceased is counter-productive and they may become harsh in their insistence that the bereaved person refrain from doing so. As a result, many individuals with CG avoid such discussions. They may also fear that reminders will only trigger more pain. In CGT, it is very helpful to invite the patient to tell the story of the death repeatedly over several sessions. Restorative retelling (Rheingold et al., 2015; Saindon et al., 2014) is another way to do this.

In CGT, clinicians approach the telling of the story of the death in a ritualized manner (Wetherell, 2012), building in emotion regulation strategies as telling this story is usually emotionally activating. The bereaved patient is invited to report what happened beginning with first learning of the death. They reflect on the story, put it away and plan a rewarding activity. This procedure is repeated on multiple occasions allowing the patient to fill in details and gain greater mastery of the painful narrative. The goal is to help the patient come to accept the painful reality. Ultimately, across several sessions, the patient will be able to revisit the story with less avoidant coping, less emotional reactivity, and a greater sense of coherence.

6. *Learning to live with reminders:* Many people with CG believe that avoiding events, thoughts, people, places and activities that remind them of their loved ones is the best strategy for managing emotional pain. (Baker et al., 2016). However, in so doing, their lives become narrow and circumscribed. CGT clinicians want patients to accept grief as a natural part of life rather than treat it as something which should be avoided. Avoidance is discussed as only one possible coping strategy. Excessive use of avoidance can interfere with adapting to a loss. For some patients, simple encouragement to approach reminders is sufficient for them to begin to do so. Often, once patients start to confront these reminders, they realize that the memories they evoke are bittersweet and they hold benefits as well as pain. They begin to feel free to move about the world without the restrictions they had been placing on themselves. In CGT, a procedure called "situational revisiting" is utilized to encourage patients to learn to live with reminders rather than avoid them. One way to do this is to ask them to rank-list activities and places they have been avoiding. Then, beginning with those the patient considers somewhat difficult, but still doable, to plan to face them despite the discomfort. If patients desire, they can bring a trusted friend along as they do these revisiting exercises. Patients are asked to observe and record their grief levels and any relevant thoughts or feelings, before, during, and after the encounter and to bring this report to the next appointment.
7. *Connecting with memories:* Bereaved people often feel like they lost their loved one and don't know where they've gone. CGT clinicians help patients understand that their relationship with the person who died continues, albeit in a changed way. CGT clinicians discuss how memories are an important part of our relationships with people we love, even when our loved ones are alive. Clinicians describe how memories grow and change as living parts of us. We have different kinds of memories, both in and out of awareness and, together, they create a rich and meaningful internalized representation of the person who died. Bereaved persons are helped to feel the deep sense of connection to their loved one that their memories can afford. In CGT, a series of questionnaires are given to patients after they have told the story of the death several times and have started to deal with reminders of the loss. These are available from the Complicated Grief Center (https://complicatedgrief.columbia.edu/), or clinicians can create their own versions. Patients are asked to bring in pictures and videos and share them with their clinician. Patients can discuss memories in whatever way they wish with the goal of helping them feel their connection to their now deceased loved one.

8 | IMPLEMENTING CGT IN DIFFERENT PRACTICE SETTINGS

When clinicians have diagnosed a patient with CG, we strongly recommend either referring to a CGT specialist or the clinicians initiating treatment themselves. Time limitations and frequency of appointments vary in different practice settings. Clinicians also vary in their preferred way to work with patients. We suggest each clinician adapts the principles and procedures of complicated grief therapy in the way that fits their work best. Our experience suggests that patients can benefit greatly from a simple intervention that includes the seven core themes described above. For clinicians who are interested, the strong, well specified approach we used in our research studies is readily available (https://complicatedgrief.columbia.edu/). For those who prefer to use a modified approach, it may still be helpful to learn the specifics of what we did, but these clinicians may prefer to weave these themes into their own way of working. Still others, such as primary care physicians and some pharmacotherapists, may work in settings in which effective psychotherapies like CGT cannot be implemented. In these instances, a referral to a clinician who can provide an effective targeted psychotherapy is indicated. In the meantime, the recommended approach includes (a) recognizing when CG is present, (b) discussing this diagnosis with the patient, (c) empathically eliciting the narrative of the patient's relationship with the deceased loved one and the death, and (d) regularly "checking in" regarding patient's grief experience. This is in addition to assessing for suicide risk and

both screening for and treating frequently comorbid conditions, such as MDD, PTSD, and substance use disorders.

9 | SUMMARY

This paper summarizes an evidence-based approach to working with bereaved patients based on the premise that grief emerges naturally and finds a place in our lives as we adapt to a loss. We recommend working to help patients understand and accept grief, manage painful emotions, think about a meaningful and fulfilling future, strengthen ongoing relationships, tell the story of the death, learn to live with reminders and establish an enduring connection with memories of the person who died. This work can be done in a variety of mental health settings, taking into consideration the needs of the patient, the limitations of the setting, and the skills and experiences of each clinician. We believe the grief therapy proposed in this paper is learnable, can be integrated into mental health treatments, and is thus scalable. Availability of this evidence-based grief treatment would have important benefits for individuals caught up in intense, persistent and impairing grief who feel isolated and hopeless.

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REFERENCES

Acierno, R., Rheingold, A., Amstadter, A., Kurent, J., Amella, E., Resnick, H., … Lejuez, C. (2012). Behavioral activation and therapeutic exposure for bereavement in older adults. *The American Journal of Hospice & Palliative Care*, *29*(1), 13–25.

Asukai, N., Tsuruta, N., & Saito, A. (2011). Pilot study on traumatic grief treatment program for Japanese women bereaved by violent death. *Journal of Traumatic Stress*, *24*(4), 470–473.

Baker, A. W., Keshaviah, A., Horenstein, A., Goetter, E. M., Mauro, C., Reynolds, C. F., 3rd, … Simon, N. M. (2016). The role of avoidance in complicated grief: A detailed examination of the Grief-Related Avoidance Questionnaire (GRAQ) in a large sample of individuals with complicated grief. *Journal of Loss and Trauma*, *21*(6), 533–547.

Boelen, P. A., de Keijser, J., van den Hout, M. A., & van den Bout, J. (2007). Treatment of complicated grief: A comparison between cognitive-behavioral therapy and supportive counseling. *Journal of Consulting and Clinical Psychology*, *75*(2), 277–284.

Bonanno, G. A., Moskowitz, J. T., Papa, A., & Folkman, S. (2005). Resilience to loss in bereaved spouses, bereaved parents, and bereaved gay men. *Journal of Personality and Social Psychology*, *88*(5), 827–843.

Bowlby, J. (1980). *Loss: Sadness and depression*. New York: Basic Books.

Bryant, R. A., Kenny, L., Joscelyne, A., Rawson, N., Maccallum, F., Cahill, C., … Nickerson, A. (2014). Treating prolonged grief disorder: A randomized clinical trial. *JAMA Psychiatry*, *71*(12), 1332–1339.

Diamond, L. M., Hicks, A. M., & Otter-Henderson, K. D. (2008). Every time you go away: Changes in affect, behavior, and physiology associated with travel-related separations from romantic partners. *Journal of Personality and Social Psychology*, *95*(2), 385–403.

Feeney, B. C., & Collins, N. L. (2003). Motivations for caregiving in adult intimate relationships: Influences on caregiving behavior and relationship functioning. *Personality and Social Psychology Bulletin*, *29*(8), 950–968.

Frank, J., & Frank, J. B. (1991). *Persuasion and healing: A comparative study of psychotherapy*. Baltimore: Johns Hopkins University Press.

Guldin, M. B., Ina Siegismund Kjaersgaard, M., Fenger-Grøn, M., Thorlund Parner, E., Li, J., Prior, A., & Vestergaard, M. (2017). Risk of suicide, deliberate self-harm and psychiatric illness after the loss of a close relative: A nationwide cohort study. *World Psychiatry*, *16*(2), 193–199.

Ito, M., Nakajima, S., Fujisawa, D., Miyashita, M., Kim, Y., Shear, M. K., … Wall, M. M. (2012). Brief measure for screening complicated grief: Reliability and discriminant validity. *PLOS One*, *7*(2):e31209.

Kersting, A., Brähler, E., Glaesmer, H., & Wagner, B. (2011). Prevalence of complicated grief in a representative population-based sample. *Journal of Affective Disorders*, *131*(1–3), 339–343.

Kersting, A., Dölemeyer, R., Steinig, J., Walter, F., Kroker, K., Baust, K., & Wagner, B. (2013). Brief Internet-based intervention reduces post-traumatic stress and prolonged grief in parents after the loss of a child during pregnancy: A randomized controlled trial. *Psychotherapy and Psychosomatics*, *82*(6), 372–381.

Latham, A. E., & Prigerson, H. G. (2004). Suicidality and bereavement: Complicated grief as psychiatric disorder presenting greatest risk for suicidality. *Suicide & Life-Threatening Behavior*, *34*(4), 350–362.

Lundorff, M., Holmgren, H., Zachariae, R., Farver-Vestergaard, I., & O'Connor, M. (2017). Prevalence of prolonged grief disorder in adult bereavement: A systematic review and meta-analysis. *Journal of Affective Disorders*, *212*, 138–149.

Mauro, C., Reynolds, C. F., Maercker, A., Skritskaya, N., Simon, N., Zisook, S., … Shear, M. K. (2018). Prolonged grief disorder: Clinical utility of ICD-11 diagnostic guidelines. *Psychological Medicine*, 1–7.

Middleton, W., Raphael, B., Martinek, N., & Burnett, P. (1998). A longitudinal study comparing bereavement phenomena in recently bereaved spouses, adult children and parents. *Australian and New Zealand Journal of Psychiatry*, *32*(2), 235–241.

Mitchell, A. M., Kim, Y., Prigerson, H. G., & Mortimer, M. K. (2005). Complicated grief and suicidal ideation in adult survivors of suicide *Suicide & Life-Threatening Behavior*, *35*(5), 498–506.

Monk, T. H., Houck, P. R., & Katherine Shear, M. (2006). The daily life of complicated grief patients—What gets missed, what gets added? *Death Studies*, *30*(1), 77–85.

Murphy, S. L., Xu, J., Kochanek, K. D., & Arias, E. (2018). Mortality in the United States, 2017. *NCHS Data Brief*, *328*, 1–8.

Neimeyer, R. A. (2000). Searching for the meaning of meaning: Grief therapy and the process of reconstruction. *Death Studies*, *24*(6), 541–558.

Neimeyer, R. A. (2012). *Techniques of grief therapy: Creative practices for counseling the bereaved*. Routledge.

Newson, R. S., Boelen, P. A., Hek, K., Hofman, A., & Tiemeier, H. (2011). The prevalence and characteristics of complicated grief in older adults. *Journal of Affective Disorders*, *132*(1–2), 231–238.

Prigerson, H. G., Bierhals, A. J., Kasl, S. V., Reynolds, C. F., 3rd, Shear, M. K., Day, N., … Jacobs, S. (1997). Traumatic grief as a risk factor for mental and physical morbidity. *American Journal of Psychiatry*, *154*(5), 616–623.

Prigerson, H. G., Maciejewski, P. K., Reynolds, C. F., 3rd, Bierhals, A. J., Newsom, J. T., Fasiczka, A., … Miller, M. (1995). Inventory of

complicated grief: A scale to measure maladaptive symptoms of loss. *Psychiatry Research*, *59*(1–2), 65–79.

Rheingold, A. A., Baddeley, J. L., Williams, J. L., Brown, C., Wallace, M. M., Correa, F., & Rynearson, E. K. (2015). Restorative retelling for violent death: An investigation of treatment effectiveness, influencing factors, and durability. *Journal of Loss and Trauma*, *20*(6), 541–555.

Rosner, R., Pfoh, G., & Kotoučová, M. (2011). Treatment of complicated grief. *European Journal of Psychotraumatology*, *2*, 7995.

Rynearson, E. K. (1987). Psychotherapy of pathologic grief. *Psychiatric Clinics of North America*, *10*(3), 487–499.

Saindon, C., Rheingold, A. A., Baddeley, J., Wallace, M. M., Brown, C., & Rynearson, E. K. (2014). Restorative retelling for violent loss: An open clinical trial. *Death Studies*, *38*(1–5), 251–258.

Shear, K., Frank, E., Houck, P. R., & Reynolds, C. F., 3rd (2005). Treatment of complicated grief: A randomized controlled trial. *Journal of the American Medical Association*, *293*(21), 2601–2608.

Shear, K., & Shair, H. (2005). Attachment, loss, and complicated grief. *Developmental Psychobiology*, *47*(3), 253–267.

Shear, K. M., Jackson, C. T., Essock, S. M., Donahue, S. A., & Felton, C. J. (2006). Screening for complicated grief among Project Liberty service recipients 18 months after September 11, 2001. *Psychiatric Services*, *57*(9), 1291–1297.

Shear, M. K. (2015). Complicated grief. *New England Journal of Medicine*, *372*(2), 153–160.

Shear, M. K., Reynolds, C. F., 3rd, Simon, N. M., Zisook, S., Wang, Y., Mauro, C., … Skritskaya, N. (2016). Optimizing treatment of complicated grief: A randomized clinical trial. *JAMA Psychiatry*, *73*(7), 685–694.

Shear, M. K., Frank, E., Foa, E., Cherry, C., Reynolds, C. F., 3rd, Vander Bilt, J., & Masters, S. (2001). Traumatic grief treatment: A pilot study. *American Journal of Psychiatry*, *158*(9), 1506–1508.

Shear, M. K., Simon, N., Wall, M., Zisook, S., Neimeyer, R., Duan, N., … Keshaviah, A. (2011). Complicated grief and related bereavement issues for DSM-5. *Depression and Anxiety*, *28*(2), 103–117.

Shear, M. K., Muldberg, S., & Periyakoil, V. (2017). Supporting patients who are bereaved. *British Medical Journal*, *358*, j2854.

Shear, M. K., Wang, Y., Skritskaya, N., Duan, N., Mauro, C., & Ghesquiere, A. (2014). Treatment of complicated grief in elderly persons: A randomized clinical trial. *JAMA Psychiatry*, *71*(11), 1287–1295.

Simon, N. M., Shear, K. M., Thompson, E. H., Zalta, A. K., Perlman, C., Reynolds, C. F., … Silowash, R. (2007). The prevalence and correlates of psychiatric comorbidity in individuals with complicated grief. *Comprehensive Psychiatry*, *48*(5), 395–399.

Stroebe, M., & Schut, H. (2010). The dual process model of coping with bereavement: A decade on. *Omega (Westport)*, *61*(4), 273–289.

Supiano, K. P., & Luptak, M. (2014). Complicated grief in older adults: A randomized controlled trial of complicated grief group therapy. *Gerontologist*, *54*(5), 840–856.

Szanto, K., Shear, M. K., Houck, P. R., Reynolds, C. F., 3rd, Frank, E., Caroff, K., & Silowash, R. (2006). Indirect self-destructive behavior and overt suicidality in patients with complicated grief. *Journal of Clinical Psychiatry*, *67*(2), 233–239.

Tal Young, I., Iglewicz, A., Glorioso, D., Lanouette, N., Seay, K., Ilapakurti, M., & Zisook, S. (2012). Suicide bereavement and complicated grief. *Dialogues in Clinical Neuroscience*, *14*(2), 177–186.

Wagner, B., Knaevelsrud, C., & Maercker, A. (2006). Internet-based cognitive-behavioral therapy for complicated grief: A randomized controlled trial. *Death Studies*, *30*(5), 429–453.

Wetherell, J. L. (2012). Complicated grief therapy as a new treatment approach. *Dialogues in Clinical Neuroscience*, *14*(2), 159–166.

Worden, J. W. (2018). *Grief counseling and grief therapy: A handbook for the mental health practitioner*. Springer Publishing Company.

Zisook, S., Iglewicz, A., Avanzino, J., Maglione, J., Glorioso, D., Zetumer, S., … Shear, M. K. (2014). Bereavement: Course, consequences, and care. *Current Psychiatry Reports*, *16*(10), 482.

Zisook, S., & Shear, K. (2009). Grief and bereavement: What psychiatrists need to know. *World Psychiatry*, *8*(2), 67–74.

Zisook, S., Shuchter, S. R., & Lyons, L. E. (1987). Predictors of psychological reactions during the early stages of widowhood. *Psychiatric Clinics of North America*, *10*(3), 355–368.

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