The Center for Prolonged Grief

The Big Picture:
Principles and Procedures of Prolonged Grief Disorder Therapy

Agenda – Times are in Eastern Standard Time (New York, USA)

10:00 AM	Background and Overview of PGDT
11:30 AM	**BREAK – 15 minutes**
11:45 AM	Doing a grief therapy assessment
1:00 PM	**BREAK – 1 hour**
2:00 PM	PGDT Early Sessions
3:30 PM	
3:45 PM	PGDT Later Sessions
6:00 PM	Closing

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Loss of loved ones: a very painful consequence of the pandemic

Overall death rate about 2%: total deaths over 6 million

Tracking the reach of COVID-19 kin loss with a bereavement multiplier

"COVID-19 has created a mortality shock throughout the world, and it may yield **a second wave of population health concerns** tied to bereavement ...

"...the burden of **bereavement** from COVID-19 deaths will be **higher than the death toll by nearly an order-of-magnitude..**

Each death leaving roughly nine times as many bereaved of a grandparent, parent, sibling, spouse, or child."

Ashton Verderay and colleagues PNAS 2021

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Call to Action

- "Having a family member recently die is tied to an elevated risk of physical and mental health decline and broader adverse implications for individuals' social, economic, and relationship well-being."
- Quantifying bereavement burden associated with each death can help clarify the size of a potential second wave of population health issues tied to bereavement.

Ashton Verderay and colleagues PNAS 2021

Ellis, 2013. Long-term impact of early parental death; Mack, 2004. Effects of early parental death on sibling relationships in later life. Perry, 2006. Understanding social network disruption; Zettel, 2004. Social networks of older widowed women; Elwert, 2008. Effect of widowhood on mortality; Elwert, 2008. Wives and ex-wives; Fletcher, 2013. A sibling death in the family; Fletcher, 2018. Effects of sibling death; Ott, 2003. Impact of complicated grief on health

"The age pattern of bereavement is unlikely to mirror the pattern of mortality; it may have a completely different age gradient"

"**Older adults** experience a **double burden** of COVID-19 as most vulnerable to dying if infected, and also at disproportionate risk of losing a close relation, especially a spouse or sibling.

...for **adolescents and younger adults**, *parental and grandparental death* correspond with **particularly adverse outcomes** due to consequences of bereavement, loss of social support affecting access to economic security and success and timing of transition to adulthood"

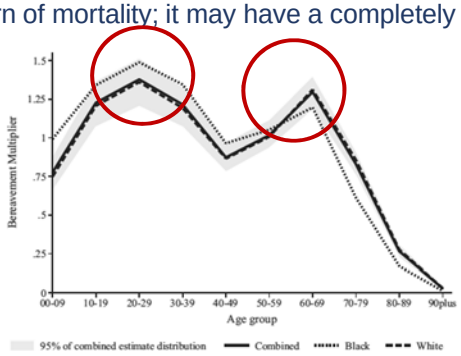

Fig. 1. The age pattern of the bereavement burden, overall and by race: Bereavement multipliers for deaths of any type of kin by age group by different considerations of race. Note: Kin types included in the bereavement burden are grandparent, parent, sibling, spouse, and child. The areas under each curve sum to the "any kin" bereavement multipliers in Table 1. The shaded area contains 95% of the simulated distribution of combined race estimates.

For a hypothetical 100,000 deaths, assuming 40% are White Americans, and a bereavement multiplier of 8.86, about **354, 400 bereaved are White**; assuming 60% of deaths are Black Americans, and a bereavement multiplier of 9.18, about **550, 800 bereaved are Black**.

from Verderay and Greenway-Smith PNAS June 19, 2020

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Tracking the reach of COVID-19 kin loss with a bereavement multiplier applied to the United States

- "Under various scenarios, analyses show that ...**bereavement** from COVID-19 deaths will be **higher than the death toll by nearly an order-of-magnitude**: Each associated death will leave roughly nine times as many Americans bereaved by the death of a grandparent, parent, sibling, spouse, or child.
- If 190,000 Americans die from COVID-19, as some models project by August 2020, this will correspond with about **1.7 million COVID bereaved Americans**.
- If 1,000,000 eventually die from COVID-19 over a longer period, then 8.9 million would be **bereaved**, representing **roughly 3 of every 100 Americans**."

Ashton M. Verdery, Emily Smith Greenaway, Rachel Margolis, and Jonathan Daw PNAS June 19, 2020

Grief is universal… but how we understand it is not

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Share your thoughts

- How do you define grief?
- How do you think about grief?

The definition we use: “Grief is the response to loss”

- A complex experience that is the natural response to loss – the form love takes when someone we love dies
- Permanent after we lose someone close
- Universal, with recognizable features; yet unique to every person and every loss
- Naturally contains a lot of mixed feelings and thoughts

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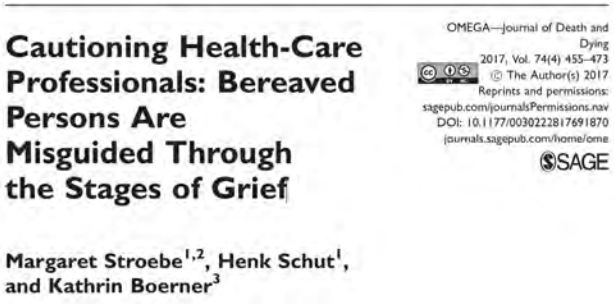
How we understand grief

It does not progress in stages



Cautioning Health-Care Professionals: Bereaved Persons Are Misguided Through the Stages of Grief

Margaret Stroebe[1,2], Henk Schut[1], and Kathrin Boerner[3]

OMEGA—Journal of Death and Dying
2017, Vol. 74(4) 455–473
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DOI: 10.1177/0030222817691870
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SAGE

There are no predictable stages

However...grief does progress; it does have common "pause points" and a wide range of thoughts and feelings are natural and expected

- Grief is messy; it contains thoughts, feelings, behaviors; there are social and spiritual aspects
- It changes – erratically and unpredictably
- It evolves over time as we adapt to the changes brought by a loss.
- It's affected by other people and by things that are unexpected and uncontrollable

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Attachment Theory can help us understand grief

- We're biologically programmed to seek, form and maintain close attachment relationships to promote survival and reproductive success.
- It is intrinsically rewarding, a safe haven and secure base

What happens when a loved one dies?

Meaningful separation	Grief
Attachment Proximity seeking, Separation anxiety/guilt; dysregulation	Yearning, longing, preoccupation, anxiety, physiological dysregulation
Caregiving Proximity seeking, Separation anxiety/guilt	Yearning, longing, preoccupation, anxiety, guilt
Exploration Loss of interest in exploring; loss of confidence	Loss of confidence and motivation to do things

Grief is the form love takes when someone we love dies

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Grief is a Stress Response

Loss of someone close is one of life's most severe stressors and brings many challenges:

A range of stressful losses:

- Companionship
- Sense of protection
- Sense of self
- Aspects of personal and social identity
- Sense of stability

Other restoration-related stresses:

- Challenging family dynamics
- Exclusion from social groups
- Difficulties meeting responsibilities
- Increased uncertainty about the future

The experience of grief adds to the stress

Confusing thoughts and mixed feelings occur naturally, for example...

- Wanting grief to go away and also wanting to hold onto it
- Wanting to be free of pain but also feeling we should be in pain
- Wanting to move on in our life and not wanting to at the same time
- Feeling a need for other people but finding it hard to connect
- Knowing the loss is real but having trouble understanding it
- Craving closeness to the person who died but thinking we need to avoid reminders of the loss
- Not wanting to stop thinking about what we have lost but feeling frustrated because the thoughts are all we have

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In other words, grief is a stress response and also a form of love

– For all pairs of lovers without exception, bereavement is a universal and integral part of our experience of love. It follows marriage as normally as marriage follows courtship or as autumn follows summer. ... It is not a truncation of the process but one of its phases; not the interruption of the dance, but the next figure."

CS Lewis A Grief Observed P. 63.

Giving grief a place in our heart is how we honor our love

Important losses permanently change the world we live in

Adapting…

– is how we adjust to change.
– helps reduce the stress and promote growth
– to change happens naturally if we don't

get in our own way.

We have a **psychological immune system, or implicit processes that protect our psychological wellbeing in the face of threat,** that automatically kicks into action.

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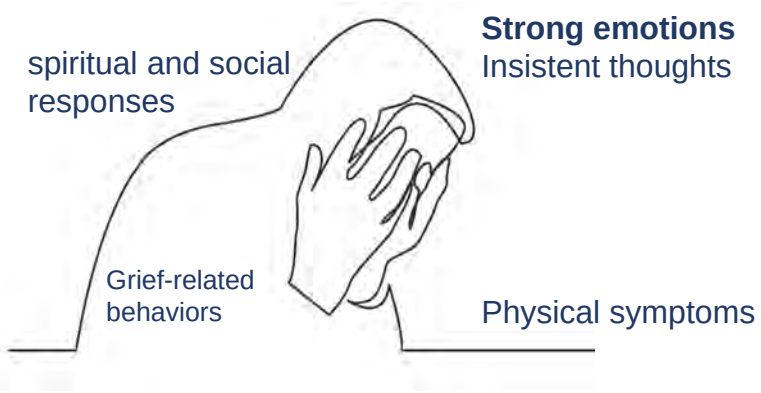
We almost always react strongly to losing someone close

Grief emerges in an acute form



Yet we still adapt to this most unwanted reality

Coping with stress of the loss

A dual process model

Avoidant coping: efforts to keep the stress at bay

Active coping: efforts to change the stressor or how one thinks about it

Problem-solving: used when stress is potentially controllable

Emotion-focused: used when stress does not seem controllable

Loss-focused
directly involves the loss

Restoration-focused
involves ongoing life without the deceased

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Attachment system and other instinctive responses – early forms of coping

The need to replace natural early responses makes them "pause points" in the healing process that can promote learning and personal growth

- A natural human **"righting reflex"** - to try to set things right when reality is different from how we want it to be
- "When a situation occurs which we evaluate as damaging to our interests or to those of persons we care for, our first impulse is to try to rectify the situation." Bowlby Loss p. 229
- Righting reflex responses might give us respite which can be adaptive in the short run. However, they need to be replaced by strategies associated with acceptance of the reality and effective ways to move forward

Common early loss-focused coping "righting reflex" responses, or "defensive processes"

- Disbelief, protest
- Imagining alternative scenarios
- Caregiver self-blame or anger
- Believing there are right & wrong ways to grieve
- Avoiding grief triggers
- Survivor guilt
- Resistance to moving forward
- Inability to connect with others
- Worry about grief

These can be helpful initially (buying time) but they can derail the process of adapting to the loss

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Coping and Adapting Are Different

We cope with stress

- Short term, time-limited
- Oriented toward reducing stress
- Ends when the stress is removed
- Motivated by a threat or a problem
- Uses resources

We adapt to change

- Long term, ongoing
- Oriented toward adjusting to change
- Ends when adjustments are optimized
- Motivated by change
- Builds new resources

Adapting to loss

Changing our expectations and automatic behaviors to fit a changed world

Accept new realities

- Finality of the loss and permanence of grief
- A changed relationship to the person who died
- Other changes that accompany the loss

Restore capacity for wellbeing

- Possibilities for purpose and meaning, joy and satisfaction
- Sense of competence
- The promise of satisfying, meaningful relationships

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Healing Milestones: A way to facilitate adaptation

- Understand and accept grief
- Manage emotions
- See a promising future
- Strengthen relationships
- Narrate the story of the death
- Learn to live with reminders
- Connect with memories of the person who died

When we accept the reality and restore capacity to thrive:

Grief is transformed and integrated

- It **finds a place** in our life
- Physiology is **re-regulated**
- Thoughts and memories recede, more distant yet still accessible
- Emotions become bittersweet, better regulated
- We r**econnect** with others

It's important to know that even when it's integrated, **grief is not always quiet**

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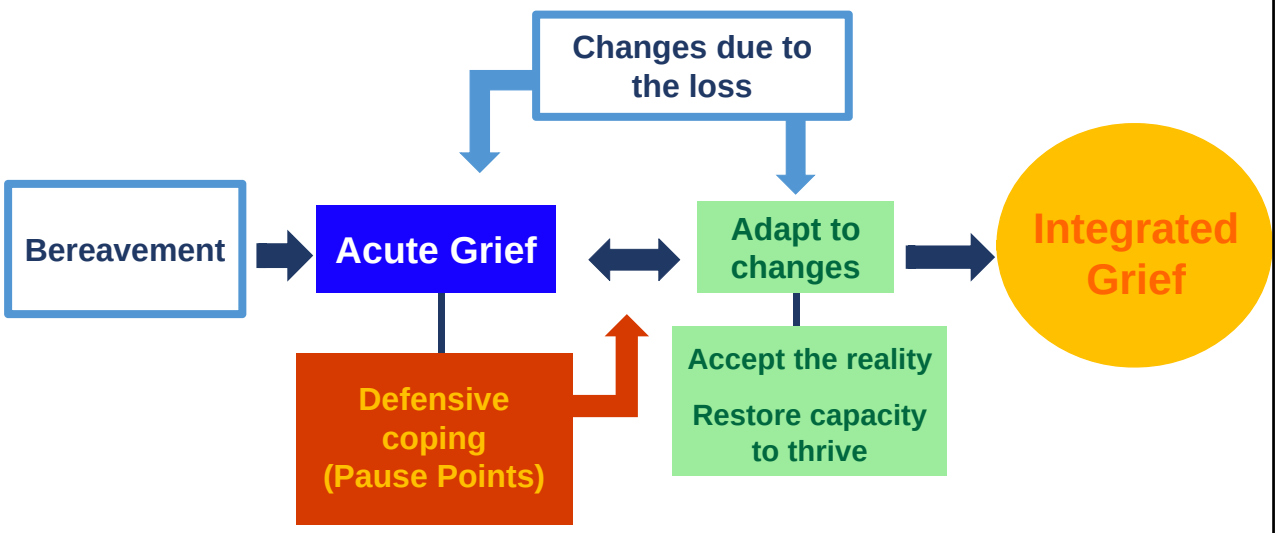
Grief Infographic



DSM-5TR Prolonged grief disorder diagnostic criteria

- Death of a person close to the bereaved at least 12 months ago
- Persistent pervasive yearning, longing or preoccupation with the deceased
- Since the death, at least 3 of the following present most days to a clinically significant degree and nearly every day for at least the past month:

- Disrupted Identity	- Difficulty engaging in ongoing life
- Marked sense of disbelief	- Emotional numbness
- Avoidance of reminders	- Feeling that life is meaningless
- Intense emotional pain	- Intense loneliness

- Significant distress or impairment in personal, family, social, educational, occupational or other important areas of functioning
- Duration and severity clearly exceeds expected norms in the individual's social, cultural or religious context

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Bowlby: Defensive Coping is Natural

"...defensive processes can all be understood as defensive exclusion of unwelcome information; ...Many are found in both healthy and disordered variants of [grief].

"The criteria that most clearly distinguishes healthy forms of defensive processes from pathological ones are the **length of time during which they persist** and the extent to which they influence a **part only of mental functioning or come to dominate it** completely."

Loss p. 140

Risk factors that increase the chances that adaptation may get derailed

- Individual variables
  history of depression, prior loss/trauma, difficult relationship with early caregivers
- Relationship to the deceased
  who died, closeness, identity-defining; secure relationship in the context of general insecurity
- Circumstances of the death
  age of the person who died, how they died
- Context for grief
  what else is going on in the bereaved person's life; loss of income, need to move, loss of social connections, change of lifestyle

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Examples of risk factors associated with covid-19 deaths

Circumstances of the death

- Sudden, unexpected, seemingly preventable, seemingly random
- People are dying alone; Loved ones are unable to visit

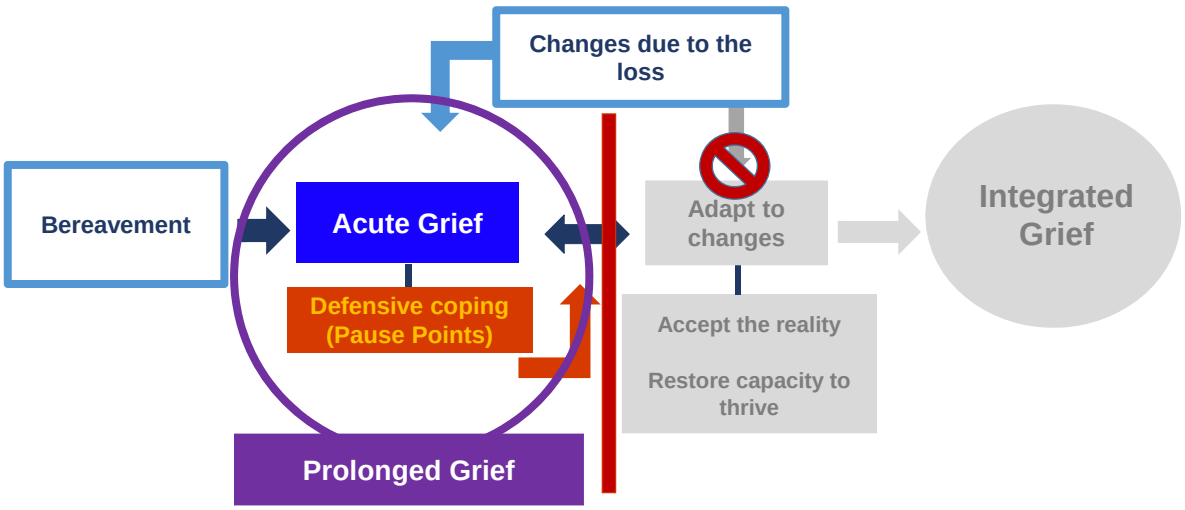
Context of the death

- Need for physical distancing
- Consequences of the death
- Increased social stress; no funerals
- Financial losses

Consequences of the death

- Feeling unsafe
- experiencing multiple losses
- having others to care for
- financial worries
- loneliness

Prolonged Grief Infographic



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Prolonged Grief Disorder Treatment

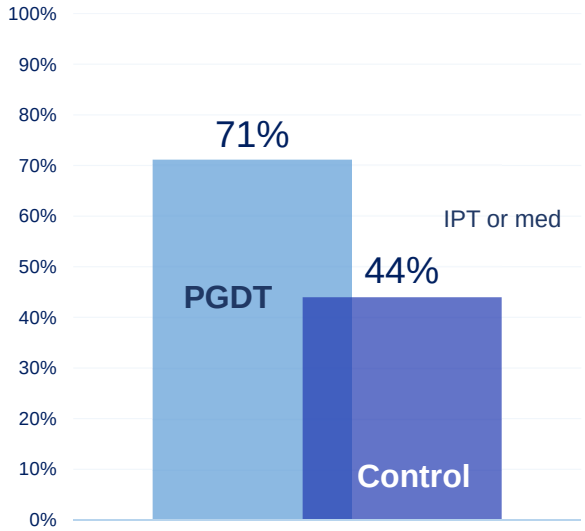
- A 16-session treatment model
- 7 milestones/themes introduced sequentially
- Each associated with a specific procedure
- Themes/milestones guide us to achieve our goals

NIMH-funded Research

Study 1: Shear et al JAMA 2005; N=95
Study 2: Shear et al JAMA Psych 2014; N=151
Study 3: Shear et al JAMA Psych 2016; n=395

4-site study; The HEAL collaborative:
New York: M. Katherine Shear, Overall PI
Boston: Naomi Simon, PI
Pittsburgh: Charles Reynolds, PI
San Diego: Sidney Zisook, PI

Participants were **ages 20 to 93, bereaved of a range of losses by natural and by violent causes**. Many had already received grief counseling and/or mental health treatment



Results of all 3 studies
(N= 641)

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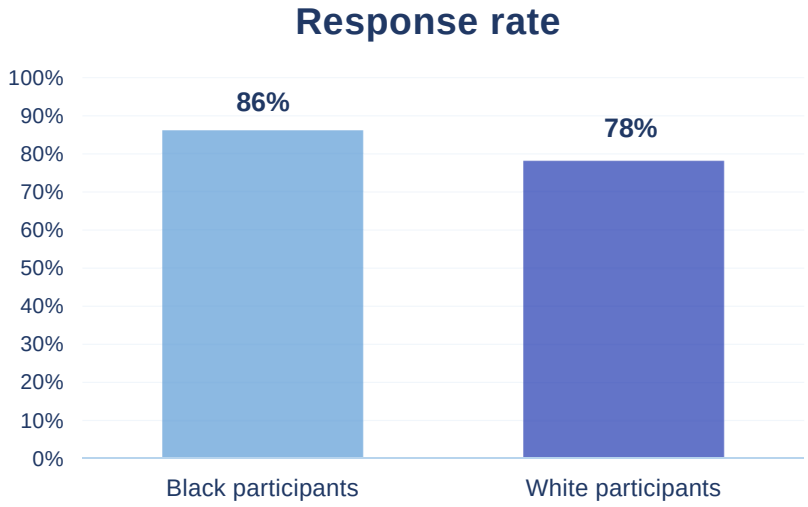
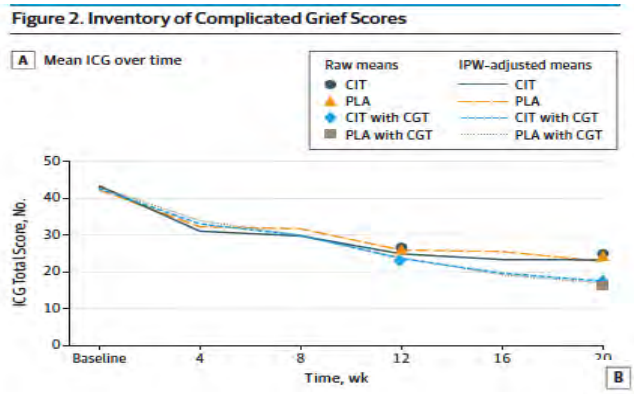
Therapy Outcome did not differ by race



Data provided by Margaret Gacheru (PhD student) and Christine Mauro PhD

Role of medication

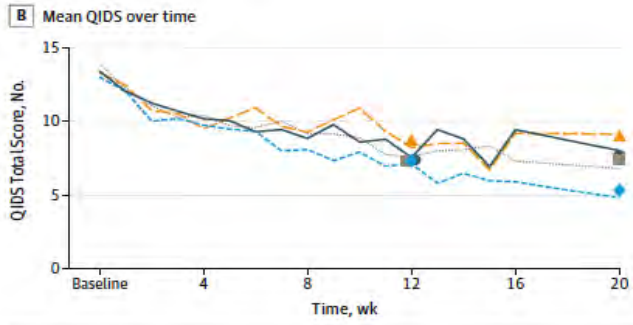


Complicated Grief Symptoms

- No difference between citalopram & placebo
- Significant difference between CGT and no CGT

Depression Symptoms

- No difference between citalopram and placebo
- However, there is a significant difference between CGT with citalopram and CGT with placebo



Shear et al Jama Psychiatry 2016 73:7 685

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Covid-19 & Prolonged Grief Disorder Therapy

GOALS

- Provide effective support
- Facilitate adapting to the loss
- Identify and address stuck points

Doing PGDT: Underlying premises

- Grief is a form of love that emerges naturally and finds a place in our life
- Adapting to loss is progresses naturally if it is not impeded
- Grief is stressful and early grief elements can derail adaptation
- Everyone grieves, copes and adapts in their own way
- We don't grieve well alone

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Active listening is the centerpiece of PGDT

Bereaved people need to feel heard and we need to listen

- with unconditional acceptance; refraining from judgment
- conveying interest and a willingness to share pain
- maintaining a focus on ways to promote adaptation and address stuckpoints

Personalized Interventions

Validation

– e.g. of grief itself, insensitive social experiences, stuck points that can derail adapting normalized

Support

– e.g. being present, empathic listening, unconditional acceptance, shared problem solving, judicious self disclosure

Guidance

– e.g. psychoeducation, helpful suggestions; relevant information; focused questioning to foster Healing milestones and/or address stuck points

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Healing Milestones: A way to facilitate adaptation

- Understand and accept grief
- Manage emotions
- See a promising future
- Strengthen relationships
- Narrate the story of the death
- Learn to live with reminders
- Connect with memories of the person who died

Find and address “derailers”-persistent, overly influential defensive coping

Early responses that need to be replaced by more effective coping strategies.

- Avoiding grief triggers
- Survivor guilt
- Separation anxiety: difficulty moving forward
- Inability to connect with others
- Disbelief or protest
- Counter-factual thinking
- Caregiver self-blame or anger
- Believing there are right and wrong ways to grieve

Listen for these. Provide validation, support or guidance as indicated

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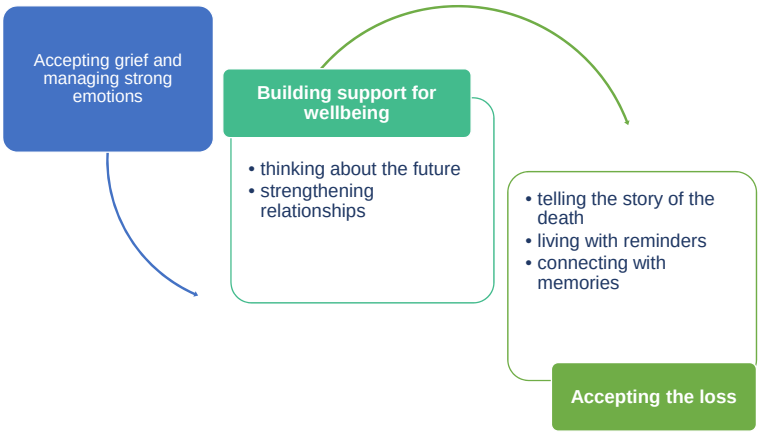
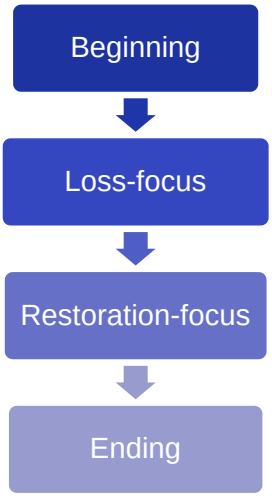
The 7 milestones are introduced sequentially in the first 6 sessions

- We meet the client where they are – concerned about grief and strong emotions
- We build a foundation for restoring wellbeing, instilling a bit of energy, enthusiasm and warmth
- We do the hard part last – coming to terms with the loss and all it means



We sequence sessions to deal first with a loss focus and then with restoration

- Predictability is reassuring when we are highly emotionally activated
- Planned sequence ensures a focus on both loss and restoration
- Sequence so that emotional activation lessens as the session progresses



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Healing Milestones
Understand and accept grief

Grief is natural after loss; it's a form of love; accept it; don't judge it; observe it – monitor it; get to know it: allow it a place in your life

Grief naturally waxes and wanes providing some time to process and some respite from the pain; this oscillation is natural and helpful

Monitoring grief can be helpful; see how it waxes and wanes, notice when it's triggered and when it subsides

Common stuck points

Protesting or imagining alternative scenarios are natural; it's important not to judge this, but recognize it as futile, pause and consider; resolve or gently set it aside

Strong unregulated emotions, especially judging emotions, e.g. guilt, anger, shame –consider ways to resolve these feelings and/or let them go

Healing Milestones
Manage emotional pain

- ✓ Accept emotions and name them; refrain from judging them
- ✓ Find triggers of emotional pain and reflect on them
- ✓ Encourage experiencing and savoring positive emotions
- ✓ Plan to do something pleasant each day – make it a kind of ritual.
- ✓ Start to think about what's important, meaningful or interesting

Common stuck points

- ✓ Avoiding grief triggers – behavioral and experiential avoidance in general
- ✓ Judging grief intensity or emotions, feeling ashamed
- ✓ Caregiver self-blame or anger
- ✓ Survivor guilt

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Grief Monitoring

Take 5 minutes at the end of the day to record grief intensity. Using a scale from 1-10 record when grief was at its highest and at its lowest each day and what was happening at that time

Date	HIGHEST grief	What was happening at the time?	LOWEST Grief	What was happening at the time?	Overall Level for the day
Mon					
Tues					
Wed					

Healing Milestones
See a promising future

- ✓ Take time to consider what's important and meaningful
- ✓ Encourage experiencing and savoring positive emotions
- ✓ Think about a big, long-term project that could be interesting, meaningful or satisfying
- ✓ Begin to plan and move forward on a meaningful project

Common stuck points

- ✓ Survivor guilt
- ✓ Conviction that the world is empty and life meaningless without a loved one present

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Healing Milestones
Strengthen relationships

- ✓ Nurture social connections, at least one close confidant
- ✓ Help others understand grief and adaptation to loss
- ✓ Allow others in, share stories, accept their support and comfort, honor the deceased person together
- ✓ Lower expectations for reciprocity; understand the difficulty in being fully present with others during acute grief

Common stuck points

- ✓ Persistent feelings of distance and mistrustfulness of others
- ✓ Experiences of insensitivity of others
- ✓ Strong feelings of not belonging or mattering

Healing Milestones
Talk about the death

- ✓ Don't be afraid to share the story knowing it's painful, understanding it might be too difficult in the beginning – do it in parts, piecemeal, if necessary
- ✓ Develop ability to narrate a meaningful story, make the unthinkable "thinkable"
- ✓ Understand death as a very important part of loved one's life, but not all of it
- ✓ Voice and deal with what cannot be changed

Common stuck points

- ✓ Persistent strong feelings of protest, disbelief,
- ✓ Incessant counterfactual thinking; strong focus us alternative scenarios
- ✓ Persistent Self-blame or anger
- ✓ Avoiding grief triggers

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Healing Milestones
Live in a world of reminders

- ✓ Gradually return to a world of absence
- ✓ Turn toward reminders; discover meaningful and/or comforting memories
- ✓ Look at photos and share memories
- ✓ Respect the need to balance confronting pain and avoiding it
- ✓ Create new experiences with others

Common stuck points

- ✓ Avoiding grief triggers
- ✓ Judging grief or trying to control it, feelings of shame
- ✓ Resisting moving forward
- ✓ Inability to connect with others

Healing Milestones
Connect with memories of the person who died

- ✓ Understand memories as a living connection to the deceased
- ✓ Think about the person who died, access and enjoy positive memories,
- ✓ Learn to experience a changed relationship with the person who died
- ✓ Allow them to be a part of ongoing life that can contribute to learning and growing

Common stuck points

- ✓ Survivor guilt
- ✓ Persistent protest or disbelief
- ✓ Caregiver self-blame or anger
- ✓ Resistance to moving forward

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The way we will think about grief therapy

Active listening guided by a big picture model of grief and adaptation to loss, and respect for the uniqueness of each client

We seek to

Warm things up

Turn on a light

Open a door to the outside world

Grief is a common human experience, and we have an innate capacity to adapt

"Like tiny seeds with potent power to push through tough ground and become mighty trees, we hold innate reserves of unimaginable strength. We are resilient."

—Catherine DeVrye, The Gift of Nature, 2018

"Although the world is full of suffering, it is also full of overcoming it."
Helen Keller

Slide from Christy Denkla Ph.D

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Doing a grief therapy assessment

Conducting a Grief Therapy Assessment

- Start with a thorough initial assessment
- Include diagnostic measures
- Review history and learn about relationships and history of relationship with deceased

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Important current and past relationships

- Brief history of early upbringing, quality of early relationships
- Important people across the lifespan; any losses; social identities and context
- other important stresses or life changes, interpersonal stressors, including racism experiences or systemic maltreatment
- How have they faced challenges?

Learn about interests, values and accomplishments

- Education/employment and achievements
- Hobbies, leisure activities, interests, achievements
- Interests, dreams, goals,
- Religious or spiritual beliefs

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The Loss Story

Relationship with the deceased loved one

The story of the death

What's happened since the death

Connect with genuine interest in their loss and grief

- Listen to stories about the person who died
- Most people with PGD will talk freely about this person and their relationship with her or him.
- Listen to begin to understand what it is the client has lost.
- Listen for the quality of the relationship and what this person means to the client

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The story of the death

- This is a more difficult conversation
- Ask where and how the patient learned of the death
- Be alert to possible derailers as you listen to their story

Ask about the client's grief and listen actively to learn about …..

- What things have been like since the death
- Thoughts and feelings about the loss
- Listen for how person is feeling about herself and self-compassion.
- If they have religious or spiritual beliefs or practices that have been comforting or not so helpful?
- Learn how they are functioning
- Open-ended discussion
- How the person spends their time?
- Who they spend time with?
- How the loss is affecting functioning in the world?
- How their life was changed by this loss?

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Meet Frank

Frank is a 65 year old recently retired police officer, married to Deborah, with two children, Lisa and Jack. Frank was always hard working, popular with his colleagues, neighbors and friends. Jack was 33 and recently married when a tragic accident took his life 18 months ago. During his son's adolescence, Frank had some difficulty with Jack's behavior and they had some conflicts, but in the 5 years before Jack died they became quite close.

Frank thinks he will never again hear the sound of a phone without feeling the ring in his whole body. In a way Frank feels like he died that night too. He knows he will never be the same. He often feels waves of intense longing and sadness or he is overcome with rage.

Frank is convinced that his life has ended. Suddenly it seems like wherever he goes there are reminders of Jack. He can break down unexpectedly in the most ordinary places so he has become wary of going out. He carries so much sadness that he finds it hard to smile or laugh and when he does, it feels strange – almost like it's wrong to feel happy. Frank feels most like himself when he's talking about Jack. He thinks about Jack constantly, sometimes about the period when he was angry at him. Then he regrets the time they lost. More often, he remembers how good everything turned out, how wonderful Jack is, and the bright future he and his wife Amy were supposed to have together. When he is not caught up in thinking things should have been different, he reproaches himself for his inability to control his emotions. Frank is not eager to see a therapist but Deborah tells him he has to do something or she doesn't know if she can stay with him.

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Using a clinical interview to diagnose PGD

Elicit information to determine if the following are present:

1. Persistent pervasive and intense yearning, longing or preoccupation with the deceased
2. Other evidence of intense emotional pain, manifested by experiences such as sadness, guilt, anger, disbelief, protest, blame, difficulty accepting the death, feeling of having lost a part of one's self, emotional numbness
3. Substantial impairment in one or more areas of functioning

Two instruments you can use to screen for PGD

Positive Screen

Inventory of Complicated Grief (ICG)
Prigerson et al., 1995
Score $\geq$ 30 on 19-item questionnaire

Brief Grief Questionnaire (BGQ)
Shear et al, 2006
Score $\geq$ 5 on 5-item questionnaire

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Instruments you can use to further characterize PGD symptoms

- Typical Beliefs Questionnaire
- Grief-Related Avoidance Questionnaire (GRAQ)
- Structured Clinical Interview for PGD (SCI-PGD)
- Grief-related Work and Social Adjustment Scale (WSAS)

Differential Diagnosis

MDD	PGD
– Sadness and anhedonia	– Yearning, longing
– Persistent dysphoric mood	– Painful waves of emotion
– Guilt pervasive and wide ranging	– Guilt focused on survival and/or caregiving
– Rumination related to feelings of worthlessness	– Rumination related to the loss: counterfactual thinking and/or self blame or anger
– Suicidal ideation motivated by low self worth and/or hopelessness	– Suicidal ideation motivated by not wanting to be here without them and/or wanting to join them

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Differential Diagnosis

PTSD	PGD
– Triggering event: danger	– Triggering event: loss
– Primary emotion: fear	– Primary emotion: yearning/longing
– Thoughts: intrusive, event-related, flashbacks	– Thoughts: person-related, not intrusive or frightening
– Avoidance: threat/fear-based	– Avoidance: loss/grief-based
– Reminders linked to danger activate fear or anger	– Reminders linked to the person (pervasive) - activate grief

Differential Diagnosis

PTSD	PGD
– Nightmares common	– Nightmares rare
– Guilt sometimes present	– Survivor guilt; Caregiver self blame
– Proximity seeking is not prominent, yearning, positive reminiscing not common	– Proximity seeking is prominent, yearning, positive reminiscing is common
– Healing entails remodeling of fear system	– Healing entails remodeling of reward system

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Distinguishing Forms of Grief

	Acute	Integrated	Prolonged
Symptoms	**Normative Grief in the first 6 months after death of a loved one**	**Normative Grief after the first 6 months after death of a loved one**	**at least 6 months after the death of a loved one**
Yearning/longing	✔✔✔	✔	✔✔✔
Sadness	✔✔✔	✔	✔✔✔
Anxiety/anger/guilt	✔✔	✔	✔✔✔
Difficulty engaging with other people or activities of ongoing life	✔		✔✔✔
Heightened physiological and/or emotional reactivity to reminders of the loss	✔✔	✔	✔✔✔
Prominent thoughts or memories of the deceased	✔✔	✔	✔✔✔

Symptoms	Normative Grief in the first 6 months after death of a loved one	Normative Grief after the first 6 months after death of a loved one	Prolonged Grief (at least six months after the death of a loved one)
Changes in sense of self	✔✔	✔	✔✔
Rumination over troubling thoughts related to the death or the loss	✔✔	✔	✔✔✔
Avoidance of reminders that the person is gone	✔- ✔✔	✔	✔✔✔
High levels of emotionality with difficulty regulating emotions	✔ - ✔✔		✔✔✔
Sleep disturbance	✔✔		✔
Physical pain and other distressing somatic symptoms	✔		✔✔

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Marion is a 68-year-old woman who presented to her primary care doctor 6 weeks after the death of her husband from cardiovascular disease. Her physician knew her as a gentle, quiet person whom they looked forward to seeing; they had treated her for episodes of major depression after the birth of her 2nd child and at the time of her husband's first heart attack, 10 years earlier. On both occasions, she responded well to antidepressant medication.

Now, she appeared listless and withdrawn; she explained that her spirit was broken. Feelings of deep sadness began about a week after her husband's death, and had not lifted even when her third grandchild was born 2 weeks ago. She said she misses her husband but mostly she feels empty and numb.

Marion described her thoughts as "boring" and said when she thinks about her husband, she mostly wonders why he stayed with her so long; she was troubled by guilty feelings, including thoughts that she had never been a good wife or mother and a feeling that she was not a good person; she described a frightening sense of inadequacy and worries about how she would manage on her own.

Marion was having trouble sleeping, showed evidence of psychomotor retardation and severe difficulty concentrating. Starting a week after the death, she refused to see her friends and only sporadically socialized with her 2 grown children, 1 of whom was a new parent and needed her. When questioned about this Marion said she could not help her daughter and would just be more of a burden. She felt a strong sense of hopelessness, with a return of ideas she had experienced before that life was not worth living. She kept thinking it would have been better if she had died instead of him.

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Marion is clearly depressed. However, because her depressive symptoms are occurring after the loss of her husband, Marion saw this as different from her prior depressions and believed her feelings were normal after losing someone so beloved.

The PCP is uncertain if this is grief or depression. They wonder if they should initiate treatment for depression at this time or if it would be best to agree with Marion that her grief is the natural response to loss and not an episode of MDD.

Tony is a 33-year-old man who was referred to a community mental health clinic by his company's employee assistance program. He is married and has a four-year old son. Tony was reluctant to seek help, but his wife insisted that he had not been himself since his father died. Tony is a manager in the billing department of a healthcare consortium. Until recently he has been an excellent employee and loving husband who is devoted to his young son. Tony feels that until this past year he led a "charmed life."

During his intake interview, he reports has been having difficulty concentrating and completing tasks at work since the sudden death of his father, who was struck by a car while riding his bicycle 10 months ago. "I still can't believe it. He was not my favorite person, but I hate the way he died. It was horrible." Tony and his mother had raced to keep up with the ambulance that took his father to the hospital, but by the time they arrived, he had already passed away. Tony seems tense as he recounts the story but otherwise shows little feeling. He says he is sorry that his father won't be there to see his son grow up, but provides few additional details regarding his father's death or his relationship with his father.

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Tony is having frequent nightmares of his father being hit by the car. Sometimes the dreams seem so realistic that he feels like he was actually there to witness the accident. At work, he has been having intrusive images of his father's mutilated body, whenever he has to process claims for the hospital where his father died and when he hears a car break suddenly or when he sees older man on a bicycle. He startles easily at the sound of any sudden noise. Tony reports trouble sleeping, partly because of the nightmares; he has started to drink at night, with the hope that it will help him "chill out and go to sleep." He says he feels tense and "edgy" all the time. It's not like him and he hates feeling this way.

Tony used to see himself as a strong person who could handle anything. Now he is always worried that something bad will happen to him or to his wife or his son. The family used to spend weekends doing outdoor activities together, but now Tony makes excuses to keep them from going out. He's annoyed with himself because he can't handle this and he is feeling weak and out of control.

These feelings sometimes cause him to start arguments with his wife and to lose patience with his son. He has started to think that it's better to withdraw from them – he doesn't want to lash out and make things worse.

Tony says that he's here because his wife wants him to get help, but he's not a big one for talking about himself, and he really doesn't want to talk about his father. They never got along very well and they had gotten to a place where they tolerated each other and kept their distance. He wants to do that again now. He just wants to forget all this - or put it aside and move on.

The intake interviewer is uncertain whether Tony's main problem is PTSD or "traumatic" grief . They also wonder if the poor concentration, irritability, lack of energy and sleep disturbance might be a manifestation of depression.

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Kate is a pleasant 62-year-old woman who came for an evaluation at the insistence of her daughter who thought her mother should be getting past her intense grief over her deceased husband, Jim. Kate has 3 grown children and works as a manager for a local fast food store. She has a lifelong history of moderate claustrophobia, never treated. She sees her children regularly but does not feel close to them. She is somewhat reserved, but appears calm and friendly until the therapist asks about her marriage.

Kate immediately becomes tearful, recalling how wonderful her husband was, how Jim was her soul-mate, and how devastated she was by his death 4 years ago from an unusual form of cancer. Her emotions quickly escalate and she begins to sob, "why did he have to die? Why did he get cancer? I just can't understand." Struggling to regain control, she is angry. Her husband died a horrible, senseless death. She asks the interviewer if they are married and then challenges them to consider how they would feel if this happened to their partner or someone they loved.

Kate has kept Jim's office and tool room intact. She refuses to let anyone sit in his favorite arm chair. She socializes minimally as she feels strangely incomplete when with other people, and experiences painful feelings of sadness, anger and envy. She spends hours daydreaming about being with Jim and remembering how perfect their life was. When not day dreaming, she often ruminates, feeling angry and bitter about the fact that his cancer wasn't diagnosed early enough. She has intrusive images of his body, ravaged by the illness. She asks herself why she didn't figure out what was wrong with him before it was too late. She still can't believe this really happened.

Kate avoids reminders of Jim - places they enjoyed together, shopping at a store she likes that is across the street from his office. Since his death, she's refused to go near the hospital where he died. She thinks the doctor could have saved him if they had tried harder. She visits the cemetery infrequently because she can't bear to think of him lying in the cold ground. Kate wishes she would have died with Jim.

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She sometimes skips her hypertension medication knowing this could be dangerous. Her religious upbringing is all that keeps her from trying to take her own life. She and Jim attended church regularly, but she lost her faith after Jim died. She gets little comfort from religion now. What good is it to attend church if this is what you get? What kind of God would allow Jim to die when people who are bad continue to live?

Friends and family have told Kate she needs to move on but Kate thinks this is not possible. A month ago, after the 4th anniversary of Jim's death, her daughter insisted that she get some help. Kate made an appointment reluctantly and tells the therapist that no one can help her since no one can bring Jim back.

Kate's therapist is puzzled. They note there are symptoms of depression and PTSD along with grief. Its been a long time since Jim died, but they know that everyone grieves in their own way. They are not sure how best to understand and help Kate.

PGDT: Early Sessions

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Healing milestones on the pathway to adapting

- Understanding and accepting grief
- Managing emotions
- Imagining possibilities for a promising future
- Strengthening relationships
- Telling the story of the death
- Living with reminders of the loss
- Connecting with memories

Emotions are at the heart of grief

- Grief emotions are natural; they might be painful or disconcerting but they aren't wrong or bad.
- Emotional pain is among the most difficult things about acute grief.
- Emotions might be triggered easily; seem sudden, random and uncontrollable.

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Common sources of grief emotions

- Separation : yearning, longing, sadness, anger, anxiety, guilt
- Facing a world of absence: anxiety, sadness, guilt, anger
- Lost sense of personal and social identity: sadness, anxiety, anger, shame
- Lost sense of future possibilities and/or fear of the future: anxiety, dread, sadness
- Sense of disconnection: sadness, anxiety, guilt, anger

Managing emotions is a core theme in PGDT

- We use active listening to help clients feel safe to experience and express emotions
- We help clients understand and name their emotions

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Managing emotions means attending to both painful and pleasant emotions

Grief Monitoring

the PGDT procedure used to work on managing emotions

- Monitoring is a simple tool that encourages people to get to know their grief.
- We want them to observe and reflect on their grief, see the different forms it takes and observe how it waxes and wanes in intensity.

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We introduce grief monitoring at the end of the first treatment session and continue it daily throughout the treatment

- **Rationale:** Monitoring grief can help by
- Shows a client that their grief is not always the same
- Helps clients to observe low as well as high grief
- A way of seeing what's happening; what they are thinking and feeling

Slide credit Dr. Katherine Shear

How we introduce grief monitoring

Each evening, think back over the day

- identify a time when your grief was at its highest level for that day; rate the intensity on a scale of 0-10, where 0= none and 10 is the most grief you have ever felt; make a note about what was happening at the time
- identify a time when your grief was at its lowest level for that day; rate the intensity on a scale of 1-10; make a note about what was happening at the time
- Think back over the day, as a whole – estimate the overall grief level for the day

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Grief Monitoring

Take 5 minutes at the end of the day to record grief intensity. Using a scale from 1-10 record when grief was at its highest and at its lowest each day and what was happening at that time

Date	HIGHEST grief	What was happening at the time?	LOWEST Grief	What was happening at the time?	Overall Level for the day
Mon					
Tues					
Wed					

We use daily grief monitoring to work with accepting grief and managing emotional pain

Using a scale where 1=the least intense, and 10=the most intense grief you can imagine, please record the minimum and the maximum intensity of your grief each day and tell us when these **lowest** and **highest** points occurred. Then, at the end of the day, rate the average intensity for that day.

DAY	HIGHEST GRIEF	NOTES	LOWEST GRIEF	NOTES	AVERAGE GRIEF
Thurs	8	Had dinner with friends I haven's seen since I died	3	Spent time with 4 year old grand niece. She is very cute and funny	6
Fri	9	Before I went to bed. Missing I so much	7	Trying to watch tv (this was a bad day. home alone all day. no one called)	8

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Psychoeducation in PGDT: 5 main topics

1. The nature of close relationships and grief as a form of love
2. Grief as a stress response
3. The process of adapting to loss and healing milestones
4. Pause points in grief with the potential to derail the healing process
5. Prolonged grief disorder and Prolonged Grief Therapy

Goals for psychoeducation

- Impart information about PGD in a non-judgmental way
- Demonstrate respect and appreciation for the patient's strengths/resources and foster open communication
- Motivate clients to engage and actively participate in therapy
- Engender a belief that the treatment is relevant and promising
- Gain agreement on treatment goals

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Psychoeducation: a discussion not a lecture

Confirm the client's interest and attention

- *e.g. ask if the client would like to hear how you think; ask if they would like to hear more*

Check in regularly - confirm understanding

- *e.g. ask if what you are explaining makes sense; answer questions directly; "listen" actively to verbal and nonverbal communication*

Stay present and connected; watch for signs of confusion

Psychoeducation

Close relationships as part of our biology

Attachment: we resist separation from **people we love**

- They help us feel better when we are feeling stressed, threatened or upset
- They make us feel even better when we are feeling good
- They are mapped in a special way in our brains
- They affect us physically and psychologically
- They are part of how we define ourselves and our sense of mattering and belonging.

Caregiving: the reciprocal of attachment

- We make others feel better when they are stressed or upset and feel even better when they are feeling good

Exploration: motivates us to explore the world

- To learn and grow and to use our skills and talents; a threat to an attachment relationship shuts down the exploratory system

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Psychoeducation

Key Terms for thinking about grief

Grief: the complex, variable response to loss

Acute grief: the initial form of grief that is often intense, dominating the mind of a bereaved person

Integrated grief: a quieter form of grief that has a place in the life of the bereaved - a reminder of their humanity and capacity for love

Prolonged grief disorder: a form of grief that is persistent, preoccupying and impairing

Psychoeducation

Explain the process of adapting to loss

- Adapting is a process of adjusting to a world of absence
- Adapting entails
  - Accepting the reality
  - Restoring capacity for wellbeing
- Things that help people adapt
  - Managing emotional pain and experiencing positive emotions
  - Support of friends and family
  - Effective coping with day-to-day stresses

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Psychoeducation

Common pause points in the healing process can be painful and also places to grow and learn

- Disbelief or protest
- alternative scenarios: “if onlys” or “what ifs”
- Negative reactions to grief
- Caregiver self-blame or anger
- Survivor guilt
- Avoidance of grief triggers
- Resistance to moving forward
- Inability to connect to others

…or can become derailers

Psychoeducation: Describe PGDT

People with PGD need a targeted treatment. PGT is based on the model of grief just described (see map) The goal is to facilitate adapting to loss and address derailers of this process.

The treatment is designed to help people achieve the 7 Healing milestones and includes at least one procedure for each of these.

PGT procedures are simple, but two of them can be pretty emotionally activating so you want to tell the patient about these.

The first is called imaginal revisiting. It includes telling the story of the death in a special way and the spending time talking about this. Then you put the story away and plan something rewarding to do.

The second emotionally activating procedure is called situational revisiting. In this procedure you help the patient plan to gradually revisit places and things they are avoiding because they don’t want to trigger their grief. You will do this very gradually, gently guiding the patient to move forward at their own pace.

You ask the patient if they would like examples of this and be prepared to provide them.

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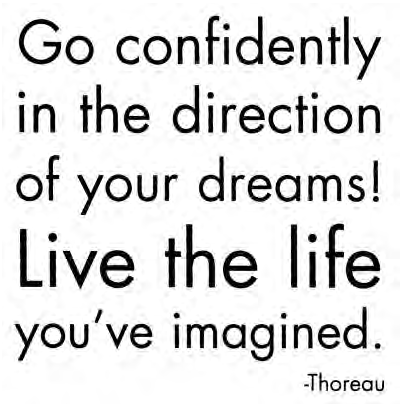
An important focus of PGT is fostering the ability to envision a future that has possibilities for purpose and meaning, joy and satisfaction



Two ways we foster the ability to see the future in a promising way

We encourage clients to plan and do simple everyday rewarding activities

We work with clients to plan and work toward accomplishing long-term aspirational goals

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How to introduce aspirational goals work

- "Imagine your grief was at a manageable level, what would you want for yourself?
- Note: acknowledge that you know the client is not at that place right now

Aspirational goals work is introduced early and continues throughout the treatment

- It can feel awkward to both therapist and client to introduce this topic early in the treatment.
- However, many people with PGD can still connect to what matters to them.
- Initiating this work early communicates your faith in the client; it's a way of saying you know they matter.

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Why it's hard to talk about the future during acute grief

- The past seems more interesting than the future
- It can be difficult for a grieving person to connect with what they are interested in or what they care about.
- Yet it's difficult to move forward in life without some sense of purpose and/or some possibilities for happiness.

When the client identifies an aspirational goal

A motivational interviewing strategy:

"How would you know you were working toward this goal?"

"How committed are you to doing something to work toward the goal right now?"

"What might stand in your way?"

"Who could help you?"

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Examples of aspirational goals

Learn to play the piano

Open an antique store

Swim with dolphins

Buy a little green VW bug

Learn computer programming

Go parasailing

- No idea of anything that could be satisfying
- This is the most common response to the aspirational goals question

Sometimes a client might become activated or defensive after even being asked the question

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What then?

Don’t be discouraged as the therapist!

Your goal is to help clients connect to their own deepest interests and values

Just talking about interests and values can generate positive feelings and hope.

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Some things you can do if a client is stymied

- Ask about childhood dreams, satisfaction or fun
- Talk about things others have done
- Brainstorm creative things to do; encourage trial and error
- Do a values card sort (MI procedure)
- Do a Aspirational goals questionnaire
- Use an occupational counseling approach

Use your imagination

Have fun!!

Alert!

There is no expectation that an identified aspiration will be fulfilled by the end of your treatment

(in fact – you don't even want to achieve the goal during the treatment)

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We introduce the idea of simple rewarding daily activities as a natural way to balance emotional pain

Most people do this naturally when adapting to a loss.

People with PGD don't

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We invite the client to make a list of a simple things that could bring some small pleasure or satisfaction

- Decide on something to do each day
- Turn this into a small daily ritual

EXAMPLES OF SIMPLE REWARDING ACTIVITIES – SHORT LIST

SELF-PAMPERING Drinking tea in the garden Having a latte in a favorite coffee shop Sitting in the garden reading Taking a spa-like hot bath Getting a manicure Making a special meal	HAVING FUN Someone who makes you laugh Playing with children Dancing Playing a game Playing with a dog or cat Going to a carnival
STIMULATING OR INTERESTING Watch a movie or TV program Read a good book Go to a lecture, concert, museum, sports event Draw, paint or play a musical instrument	CAREGIVING Volunteer at a park or shelter Babysit, read to children at a library A special meal for loved ones Help an elderly person Work on a fund-raising campaign
SKILL-BUILDING Learn to cook, garden, knit Learn to dance, play piano, woodwork Learning to play a new game Work on athletic skills	EXPLORATION Go on a hike, climb a mountain Explore a new neighborhood Surf on the internet Collect seashells, fossils, rocks

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Strengthening Relationships

Feeling of belonging and mattering is a basic human need

Bereavement robs us of a sense of belonging

Most people don't grieve well all alone

We help clients strengthen their relationships
We help them build strong connections

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Family and friends may disappoint

"Stop wallowing in your grief"

Their advice might be insensitive and not helpful

Most of the time people with complicated grief have exhausted their support system

PGT session 3: meet with a significant other

Ideally someone who…

- Knew the person well before the death
- Is a close family member or lives with the person
- Has tried to be helpful, though may now be frustrated

Can be anyone the bereaved person is willing to invite

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Four simple goals

- Discuss the relationship between the visitor and the client
- Get the visitor's perspective on the person who died and the client's life since the death
- Provide an overview of PGD and PGT
- Discuss how friends and family can support the client

Strengthening relationships in PGT

Look for opportunities to encourage interactions during…

- Review of grief monitoring
- Managing painful emotions – letting others comfort
- Thinking about the future – who can help
- Telling the story of the death - having a confidant
- Living with reminders – sharing with others
- Sharing memories

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Prolonged Grief Disorder Therapy Later Sessions

The imaginal revisiting procedure in PGT

The story of the death is told repeatedly over 3-6 sessions, in a ritualistic way

Step one: Client tells the story of the death in a ritualized manner (10 minutes)

Step two: Discussion of the client's experience of telling the story and what they noticed about it (10 minutes)

Step three: Client sets the story aside (2-5 minutes)

Step four: Client plans a rewarding activity (2-5 minutes)

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Why do imaginal revisiting?

Telling and reflecting on the story has beneficial effects

- The narrative deepens and develops as its meaning matures
- A story line emerges and makes the unthinkable "thinkable"
- Repetition helps the client face and comprehend the reality
- Emotional pain lessens with repetition, increased self-compassion and alternation between confronting the pain and setting it aside
- "Pause points" are identified and carefully considered
- Sharing this story and thoughts about it allows the client to feel heard and fosters a meaningful human connection which helps with adaptation to loss

Therapist's role

Imaginal revisiting procedure

Scripted	Personalized
Describe the exercise Step 1: Tell the story Step 2: Encourage reflection Step 3: Set the story aside Step 4: Plan rewarding activity	– Active listening – Connect with client – identify derailers – Facilitate adapting – Track alliance

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When we listen closely to what they say, clients start to reconsider troubling ideas on their own

- *From Lipton: "It wasn't my judgment that solved the problem. What solved it was listening to their entire stories."*
- "While we can listen to the stories of others, and they can listen to ours, perhaps the most healing feature is that we, the storyteller, get to hear our own story. While we may have an idea about what the story is whenever we tell it, it usually comes out different from what we thought." —Charles L. Whitfield

From Lipton "Story Listening as a Transformative Process"

"

Step 1: Doing the revisiting exercise

- Eyes closed, client visualizes themselves at the time when they first learned of the death and tells the story of what happened from that point forward.
- Therapist asks for distress* level before starting and periodically as they tell the story.
- The story is recorded so the client can take it home and listen to it.
- The first time – the client tells the story in whatever way they choose.

*distress level is standard in exposure exercises like this one; in the case of PGDT it is considered to be equivalent to a grief level

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Emotion regulation during STEP 1

- The procedure is a predictable ritual
- There is a specified timeframe
- Distress levels are monitored
- Therapist shares the pain. provides encouragement, acceptance and compassion

The therapist's role during STEP 1

Do's	Don'ts
– Listen closely, stay present – Create a safe place for the client to share their experience – Bear witness to the story – including it's pain – Comment only to ask for distress level, note they are doing a good job or gently ask them to continue	– Don't offer guidance, comments or suggestions during this exercise – other than explaining how to do the revisiting exercise – Don't offer comfort or try to relieve pain during this exercise

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STEP 2

- After 10 minutes the therapist asks the client to open their eyes and report their distress level.
- Comment on the exercise, e.g. “you did a good job”
- Ask: “what was it like for you to tell this story?”
- Ask, “did you notice anything or observe anything as you were telling the story?”
- Repeat this question as needed.
- Facilitate reflection on the story for 10 minutes

Emotion regulation during STEP 2

- Self-observation and reflection is an emotion regulation strategy.
- Reflection provides opportunities to foster self-compassion.
- Resolving troubling thoughts can reduce emotional pain

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The therapist's role during STEP 2

Dos	Don'ts
– Use active listening to decide when and how to intervene	– Comment on your own observations
– Focus on alliance, derailers and healing milestones	– Focus the discussion on a topic you think is important
– Validate, support and/or guide as indicated	– Try to problem solve or fix troubling thoughts or feelings

STEP 3

- At the conclusion of the reflection period you check the distress level.
- Then invite the client to set the story aside, with a plan to revisit it daily during the upcoming week.
- Provide assistance with a visualization or grounding exercise as indicated

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STEP 4: Plan a rewarding activity

A way to balance the emotional pain

– Positive emotions are helpful in coping with stress, general health and wellbeing, building strong social resources and adapting to the loss

Ask client to commit to doing a rewarding activity today after they leave the session

Emotion regulation during STEPS 3 and 4

– Inviting the client to set the story aside gives them permission to do so and demonstrates their capacity to move in and out of the story
– Planning a rewarding activity directly invokes pleasant emotions; doing these positive activities is an excellent emotion regulation strategy

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Summary: Imaginal Revisiting

- Imaginal revisiting begins in session 4 and is repeated for 3-6 sessions during which the story usually evolves
- Doing this exercise lightens the burden of experiential avoidance and fosters acceptance of the reality of the death
- Results in a meaningful narrative of a loved one's death
- Helps clients feel less alone with their sorrow and their grief and helps clarify and rethink troubling aspects of the death

Imaginal Revisiting

- **Video**

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Situational revisiting

- The procedure is very similar to in vivo exposure for phobias
- Client develops a list of reminders of the loss that might include people, places or things
- We ask them to rate the intensity of grief they expect to feel at each item on the list and then to select one that they want to address.

Living with reminders as an emotion regulation exercise

- Reminders confronted in a graded way, beginning with a moderate level of grief intensity.
- Opportunity to practice acceptance of grief emotions, self-observation and reflection regarding the grief experience and self compassion
- Can include a supportive companion
- Reflection includes a focus on the positive memories as well as emotional pain

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Painful reminders in daily life

- Grieving people cannot avoid reminders of the deceased
- Often reminders are extremely painful
- PGDT seeks to help reduce intensity of painful emotions and free memories to "live" and grow
- Strategies for this make use of daily life reminders
  - Planned revisiting of avoided activities, places and people
  - In-office work with pictures and other mementos
  - Difficult times

Working with avoidance

Target

- Activities, places and people who evoke painful reminders of the loss

Goals

- Decrease avoidance of reminders of the loss
- Reduce painful emotions associated with avoided situations and release positive ones
- Help with understanding the finality and consequences of the death
- Help bring memories to life
- Discover pleasure (if bittersweet) in activities
- Reduce survivor guilt

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Introducing situational revisiting

- Discuss avoidance
  - What is being avoided and why
  - Problems with avoidance
    - *Interferes with learning about the finality and consequences of the death*
    - *An important source of functional impairment*
- Explain situational revisiting as exercise
- Develop hierarchy
- Get agreement to engage in activities

Daily activities revisiting exercises

- Target situations that are practical and that elicit painful reminders
- Collect information about what these are
- Discuss the importance of starting to resume doing avoided activities
  - Important in understanding what the loss means
  - Important to minimize any constriction of activities
    - Places, activities patient would like to go or do
    - Places, activities that the person needs to be free to go or do(e.g. failure to get medical care because the doctor or hospital is a reminder)

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Examples of typical kinds of activities that people with PGD avoid

- Spending time in rooms of home
- Visiting the cemetery
- Reading obituaries or condolence cards
- Visiting places where time was spent with the deceased
- Visiting hospital or place where the person died
- Listening to favorite music
- Going out with old friends
- Disposing of personal items

Planned practice helps with resuming activities

Procedure:

- Repeatedly revisit actual places
- Pay attention to feelings and thoughts

Results:

- Repetition tends to reduce the emotionality
- Doing things that are reminders of the loss helps explore the meaning of the relationship and its loss
- Revisiting places and doing things helps promote access to memories
- In some cases, doing things or going places provides an opportunity to enjoy places in a new way

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Working with pictures in PGDT

- Pictures of the deceased are a powerful tool in PGDT
- Pictures are used as a revisiting activity practice
- Pictures are used in session to bring out positive (and occasionally) painful memories

Pictures as a revisiting exercise

- Looking at pictures is almost always a good early activity for revisiting exercises
- Pictures are often difficult to look at
- Often people avoid certain pictures
- The balance of comfort and sadness usually shifts in the positive direction fairly quickly with pictures

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Use of pictures in session

- Patients often bring in pictures spontaneously before session 6
- If they have not done so, the therapist invites them to bring in some pictures
- Pictures are reviewed and discussed in the session
- Pictures give the therapist more insight into the relationship to the deceased and an opening for story telling
- Reviewing pictures can be used to review the revisiting procedure and results

Difficult times: anticipated unavoidable revisiting

- Anniversary of the death
- Birthday (deceased)
- Birthday (bereaved)
- Other birthday
- Wedding anniversary
- Holiday
- Other day(s)

- Date
- How upsetting
  - 0 (not at all)
  - 1 (a little)
  - 2 (moderately)
  - 3 (severely)
  - 4 (very severely)

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Doing Situational Revisiting

Reminders confronted in a graded way, beginning with a moderate level of grief intensity

- "challenging but doable"
- SUDS level 50-60
- Opportunity to practice
- acceptance of grief – with its complexity
- self-observation and reflection regarding the grief experience
- self compassion

The complexity of grief is stressful

- Wanting to it to go away – and also wanting to hold onto it
- Wanting to be free of pain – and also feeling we should be in pain
- Wanting to go on in our life - and not wanting to go on without the person who died
- Knowing the loss is real – and not understanding or wanting to accept it
- Craving connection to the person – and thinking we need to avoid reminders
- Wanting to think about the person – and frustrated that thoughts are all we have

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Situational Revisiting

a simple procedure for addressing avoidant coping that is similar to exposure for phobias

- However, there are some important differences:
- Phobias are fear-based and entails irrational, maladaptive expectations of danger; Grief-related avoidance is based on fear of a natural reaction and is not irrational
- Exposure is a natural way of learning that a situation is not actually dangerous; Exposure does not naturally teach clients that the reminder is not very painful
- Exposure is helpful for grief related avoidance in a different way
  - An opportunity to find ways to manage grief-related emotional pain and practice them
  - An opportunity to learn that meaningful and/or comforting memories are also evoked by these activities
  - An opportunity to explore the pros and cons of continuing to do the activity

Situational revisiting is a simple procedure

- Make a list and assign distress levels to different situations
- Choose an activity that is challenging but doable and do it repeatedly
- Observe and reflect on feelings and thoughts and try out ways to deal with them
- Write down distress levels before, highest during and after the activity

... but it can go wrong

- Difficult to make a list; inaccurate estimation of distress levels
- The activity is either too challenging or not challenging enough; the client doesn't do it
- The client doesn't observe or reflect or they don't try to deal with their thoughts or feelings
- The client doesn't use the revisiting record or the therapist doesn't review it

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We use our different kinds of memory in everyday life

– Episodic memory
  specific facts and personal experiences

– Semantic memory
  general information about the world

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Implicit memory

How we store information about how to do things like…

ride a bike knit or react emotionally to cues

Implicit memory can't be put into words

- Our brains arrange information about loved ones in a network that we call a "working model" - a way of mapping a version of the person we love. This is a way we use our relationship in everyday life.
- The working model of a loved one makes us feel connected to our loved ones when they are alive.
- This is how we feel secure in our relationship with them even when we are apart.

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Information about people we love is stored in all kinds of memory.

We couldn't erase them even if we wanted to.

- When someone dies, the working model – a vast network of memories of them - becomes more active as we notice their absence and want to find them. This activity can create a feeling- even when we know it is irrational - that they might reappear. This hopeful feeling is one way we get some respite from grief but in the end it only adds to painful longing.
- It takes time to generate memories of what their death means and what it's like to live in a world without them.

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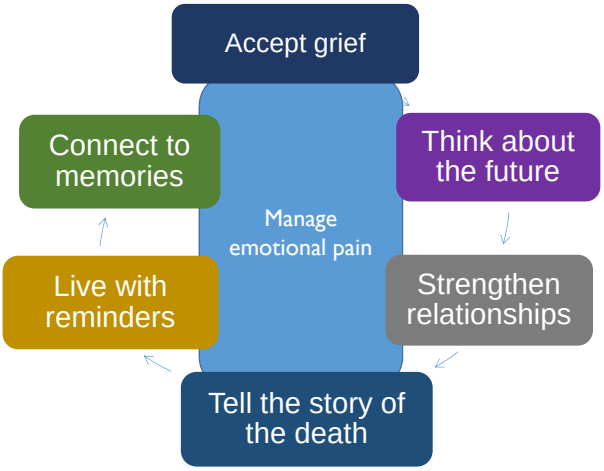
- Accessing memories and allowing them to grow and change is a way to feel connected to a person who died, to honor the person and to experience positive emotions even during acute grief.
- Memories provide a way to have an ongoing, realistic connection to a deceased person. It's not the same as when they are alive, and of course it's not what a client really wants, but it is still an important connection that can make a meaningful difference in a client's life.

Connecting with memories: last of the 7 milestones

- Questionnaires
- Imaginal conversation
- A series of different lenses on memory…
- grief monitoring, thinking about the future, strengthening relationships, telling the story of the death, living with reminders



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Accessing and using memory

The other six milestones

- Understanding grief as a form of love means that memories of a deceased loved one remain a part of the attachment working model
- Memories of a deceased loved one can both provoke and relieve emotional pain
- Memories of a loved one can play a role in envisioning life moving forward into a future without their loved one's physical presence
- Sharing memories with friends and family helps strengthen these relationships
- The story of the death is created from memories
- Living with reminders is accessing memories

Remembering a person who died

- Death changes our relationship to the person who died but it does not end it.
- A relationship can still provide comfort and hope even after a loved one has died.
- Memories are also living parts of us, and they can and should change and grow as we change and learn new things.
- Our sense of connection is strengthened when our memory system is revised to accurately reflect the reality of the death.

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- It is natural to remember mostly positive things when someone we love dies.
- In some cultures it is prohibited to say anything negative and it might even be considered wrong to think negative things.
- We tend to think mostly about what we loved and admired about a person who died.
- The tendency to idealize someone who died is natural even if it's not the only way to feel about a deceased family member. It can be helpful in adapting to their los

- Everyone has good and bad qualities, strengths and weaknesses, things we admire and love about them and things we dislike.
- If our relationship with the person who died was mixed, conflicted or difficult we might have negative feelings about them.
- This is natural but people feel guilty or ashamed of negative thoughts or feelings.
- We help clients allow themselves to have whatever feelings and thoughts they have without judging what thethey should think or feel.

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- We encourage clients to refrain from judging or second guessing their thoughts or feelings or memories.
- We encourage them to stay open to different kinds of memories as a way they can learn and grow, a way their loved ones can continue to play a role in their life and continue to teach them things even after they die.

We created a series of memories questionnaires to use in PGDT

- We use them after the client has made progress accepting the reality of the death
- Three questionnaires are about positive experiences.
- A fourth one includes not so positive memories
- A fifth includes both positive and negative memories.

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Positive memories

- most likeable characteristics
- most enjoyable times
- things you loved about them
- important thing they added to your life
- your favorite pictures
- other memories if you feel like it
- additional likeable characteristics
- additional enjoyable
- additional things you loved about them
- other things they added to your life
- additional pictures you liked
- more memories if you feel like it

Most favorite memories

1. Some most favorite memories of their best traits?
2. What you loved most
3. what you miss most
4. How you comfort yourself
5. more memories or comments

Least favorite memories

1. Least favorite memories
2. most annoying traits
3. What you wished was different
4. What you don't really miss
5. ways that life is easier
6. more memories or comments

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Mixed memories questionnaire

1. What are some of your most favorite memories?
2. What are some of your least favorite memories?
3. What were some of their endearing traits?
4. What did you admire about _____?
5. What were some of their annoying traits?
6. What did you love most about _____?
7. What did you love least about _____?
8. What do you miss most?
9. What do you miss least?
10. How do you comfort yourself when you missing them?

Imaginal conversation

- The client imagines they can talk with the deceased after the death, that they can be heard, and then take the part of the deceased person, and imagine they are responding.
- Draws on complex memory systems of the deceased
- Creates a strong sense of connection
- a different and very powerful way to access memory

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Ending Grief Therapy

- Thoughts and feelings
- Review of therapy and plans for the future
- Difficult times

Example of a Grief Therapy Final Session

Review therapy you have done together, the client's present situation and plans for the future including:

- Review of the Healing Milestones model
- Discuss what you shared and what remains unfinished
- Discuss plans
- Review client's strengths and vulnerabilities
- Discuss any remaining thoughts or feelings about ending
- Say good-bye and end the session

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Discuss difficult times and how to manage them

- One component of the future focus is a discussion of difficult times, i.e. calendar dates that trigger surges in grief intensity
- Most bereaved people react to certain times of the year that serve as reminders of the deceased
- Surges can be especially intense for people with PGD

Discussion of Difficult Times

Examples of common difficult times

- Holidays
  - Eg. Winter Holidays – the period between Thanksgiving and New Year
  - Typically, a time when families gather and a stark reminder of the loved one's absence for traditions
- Birthdays
- Weddings or Anniversaries
- Anniversary of the death
- Life milestones: first day of school, graduation, moving into university and more

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Managing difficult times

- Might just want the day to be over; try to hide and hope for the best
- Our approach to managing difficult times includes:
  - planning
  - self care, positive emotions
  - help and support from others
  - honor the deceased person
- Termination sessions include planning for future difficult times

Learn more about Prolonged Grief Disorder and its treatment

- Workshops
  - The Big Picture - today's workshop
  - Practice-Focused Training – 2 day workshop, 13 CEs
- Monthly webinars- 1 CE per webinar; join us live or access on demand recording.
- Treatment Manual
- Research projects
- **NEW! PGDT*Web***
  - Online, asynchronous tutorial in PGDT
- Training Video Self Study (4 CEs)
- Invited speakers
- Individual case consultation
- Special events
- Assessment Tools (included in your registration)

Stay in touch with us by signing up for our updates for professionals

visit our website: prolongedgrief.columbia.edu

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