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Grief

Chapter:

(p. 43) Grief

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It has been recognized since antiquity that the death of a significant other is not only painful but can devolve into a form of depression. A century ago, Freud characterized this distinction between mourning

and melancholia (Freud, 1917). The death means the loss of a close person, a relationship, a potential social support, and the dissolution of interpersonal bonds. Losing someone close can rip the fabric of an individual's life, creating an interpersonal void. We are supposed to notice such events, and the signal of interpersonal loss comes as a strong emotional reaction.

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Normal Grief

Many of the symptoms that normally follow the death of a loved one resemble depression. In a normal grief reaction, the person feels sad and may lose interest in usual pleasures, have trouble sleeping, lose appetite and energy, and feel distracted even in carrying out routine tasks. These symptoms typically resolve over the course of a few months as the person processes the loss, thinking through remembered experiences with the deceased. This period of grief or mourning is a normal, useful, adaptive process and should be encouraged, not pathologized.

Further, if a patient is markedly dysfunctional or just wants to talk, the therapist need not discourage this. The availability of friends, family, and religious supports surrounding death can be comforting, but some patients lack these supports or feel isolated from them and want help during the period. As IPT benefits patients with major depression–level complicated grief, it is also likely to benefit patients with milder symptoms, including painful normal grief.

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Complicated Grief

Grief is a painful emotional experience, and some individuals find their emotional response too overwhelming to deal with. The death of a significant other (p. 44) tops the life event stress scales (e.g., [Holmes & Rahe, 1967](#)). Perceiving the feelings of mourning as dangerous, too painful to contemplate, they try to “keep busy” with other activities, numbing themselves in the hope that the feelings will subside. They may avoid their feelings by occupying themselves with funeral arrangements and taking care of other mourners rather than mourning themselves. The sadness of the loss may feel dangerous. If the relationship has been a conflicted one, for instance the death of a formerly abusive parent, the patient may feel guilty about feeling angry at the deceased (“What a terrible person I am to be angry at the dead, someone who can no longer defend herself!”). These patients suffer from not grieving. Avoiding the emotions leads the person to try to go through life containing them, distancing herself from emotional life, and consuming great emotional energy. This postponing and avoidance of grief is characteristic of complicated bereavement, a long-recognized form of major depression.

Less commonly, you may encounter a patient who has become in essence a professional mourner, whose entire life is devoted to the remembrance of the dead. A child's room may have been left as it was when he committed suicide years before, the pizza still rotting in its cardboard box. Such patients have adopted a mourner's role and feel any deviation, any indulgence in personal pleasure, as a betrayal of the memory of the deceased. These patients, too, will meet criteria for major depressive disorder, although their presentation is more typically an agitated depression than the constricted state of patients who are attempting to avoid their feelings

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DSM-5 and Grief

The DSM-5 ([American Psychiatric Association, 2013](#)) defines three types of grief: prolonged grief disorder, persistent complex bereavement disorder, and complicated grief. To add to the complexity, DSM-5 also notes traumatic grief as occurring when longing for or preoccupation with the deceased is persistent and the loss is seen as a trauma with intrusive images. The relationship between these different definitions, their similarities, and their predictive validity are open to debate ([Maciejewski et al., 2016](#)). They lie on the cusp of, and to varying degrees overlap with, mood disorders and posttraumatic stress disorders (PTSD).

The IPT manuals have always used “complicated grief” or “complicated bereavement” to define a major depressive episode associated with the death of someone close to the patient. This definition recognizes that some depression-like symptoms often accompany a death (normal mourning), but that if the symptoms reach the diagnostic threshold, or if a patient—often lacking family, religious, and other supports—seeks help for distress even without attaining the diagnosis of depression, IPT may be indicated. Lacking adequate data on the various DSM-5 grief subtypes, we take no other position about when to consider IPT.

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(p. 45) Grief as a Problem Area in IPT

Therapists select grief as an IPT problem area when the onset of depressive symptoms is associated with the death of a significant other and the patient is struggling to come to terms with that loss. The loss of a close attachment is emotionally hard to bear. The significant other might be a spouse, partner, child, parent, other relative, friend, or even a dear pet. Note that in IPT, grief means complicated bereavement postmortem; life losses that are not deaths are defined as role transitions. It is important to take a careful history to see whether the onset of depressive symptoms relates to a death, as some patients may not make this connection. Some patients may also present with physical symptoms rather than sadness, which may connect to the illness from which the deceased died.

A complicated grief reaction may be diagnosed when grief is severe and the severe phase lasts longer than two months, or when a loved one has died and the patient has not experienced the normal mourning process. Telltale signs include the patient’s failure to mention the dead person or to discuss the circumstances around the death. Depressive symptoms such as excessive guilt and suicidal ideation are not usually seen in normal grief and suggest the presence of complicated grief.

Signs of complicated grief present in patients who have suffered multiple losses and have not gone through a grieving period, who have avoided circumstances around the death such as mourning at the funeral or going to the grave, who fear developing the same illness as the deceased, who try to preserve the environment of the dead person, who lacked family or other social support during the period of bereavement, and who are still not functioning at work or with family at least two to three months after the death. The death has often brought their life to a halt: patients feel adrift, lost, and hopeless.

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Goals in Treating a Grief Reaction

It is important to convey to the patient that complicated grief is a form of depression that can and should be treated. Treatment is not a sign of disrespect for the deceased. The two goals of treating a complicated grief are:

- **To facilitate mourning** (catharsis). You can facilitate the mourning process by encouraging the patient to think and feel about the loss in detail, and by discussing the sequence and consequences of events

prior to, during, in the immediate aftermath of, and since the death. What does the patient miss about the deceased? About their relationship?

- **To (re)establish interests and relationships** that can to some degree substitute for the person and the relationship that have been lost. The death has often left a vacuum in the patient's life, a loss of relationship and of direction that the patient may not feel capable of filling.

(p. 46) Overall Strategies

IPT provides three strategies for working with patients with complicated grief:

1. **1.** Educate about grief and depression.
2. **2.** Facilitate catharsis through letting the patient experience her feelings about the loss. Elicit the feelings through detailed discussions about the deceased, the death, and the relationship.
3. **3.** Find new activities and relationships to substitute for the loss and provide a direction forward in life.

Taking the History

Chapter 4 describes the opening phase of IPT, including diagnosing the target disorder, taking an interpersonally focused history, and providing a formulation. To collect the data from which to provide a formulation of complicated bereavement or grief, when assembling an interpersonal inventory, it is important to ask:

Has anyone close to you died?

If so:

I'm sorry to hear that. How did you handle that loss? What feelings did you have?

Did you attend the funeral? What was it like?

Where were you when you found out about X's death? (Did you feel you did something wrong?)

Do you feel you've been able to mourn that loss?

It may be difficult for the patient to answer these questions or painful to recall details. In treating grief, encouraging the patient to review picture albums and memorabilia, visit familiar places that evoke memories, go to a place of worship (where appropriate), or call friends or family and talk with them about the deceased can help. The goal is to elicit discrete vignettes that evoke feelings and to give the patient a chance to reflect on the feelings and what they meant, and to realize that—however powerful—they are tolerable.

Recalling the deceased and the lost relationship will likely evoke strong feelings. Many patients fear that the power of their grief might overwhelm them: that they will crumble, that if they once begin to cry they will never be able to stop. The IPT therapist's role is to encourage patients to tolerate their feelings, which feel powerful but are not as dangerous as they imagine, and are likely to subside if accepted.

Feelings are powerful but not dangerous. In fact, they may do the most harm if you try to hold them in.

(p. 47) Because many depressed individuals feel overly guilty, the therapist should inquire into the circumstances of the death. Many patients will feel they did something wrong, or should have done something differently: "If only I had stayed in the hospital room just then ..." or "If only I had left the hospital room to give him some space ..."—a circumstance now too late to rectify. Giving the patient a chance to air these feelings may help. Whereas in CBT, a therapist might ask a patient to weigh the evidence about a guilty belief, an IPT therapist lets the patient sit with and reflect on the feelings, eventually pointing out that guilt is a depressive symptom. (If the patient has more complex, potentially

more justified feelings of guilt, after having truly neglected someone in need, or participating in an assisted suicide, you and your patient should explore guilt more fully.)

Some patients feel guilty about improving, seeing it as a betrayal of the deceased. They fear that if they recover from the grief (i.e., the depressive episode), it means they did not love the deceased as much as they had believed. To their way of thinking, if they really loved the person, the loss would be so great that they could never recover.

The interpersonal formulation, delivered within the first three sessions of treatment, should link the depressive disorder to the interpersonal problem area:

You have suffered the death of someone close to you, which we know is the most painful kind of loss there is. You've understandably had some difficulty getting over it, and you've developed the symptoms of what we call complicated grief, which is a form of depression. It's a treatable problem, and it's not your fault. I suggest we spend the next X weeks working on what Michelle's death meant to you, what you miss about her, and how you can find a way to go on from there. To some degree this means coming to terms with the strong feelings you understandably have about her death. They feel powerful, but they're not really dangerous, and they should subside a good deal as you handle them. Does that make sense to you?

The principal techniques to use here are nondirective exploration and direct elicitation of affect (see Chapter [10](#)).

Treatment Strategies

The early sessions of treatment for complicated grief focus on affect. Many patients will present an idealized version of what was a complicated or fraught relationship. A goal of treatment is therefore to gently elicit the patient's feelings, to give her a chance to reflect upon them, and to normalize them. The goal is to take the narrowly idealized, distanced and abstracted, two-dimensional view of the deceased and the lost relationship, and expand it into a more nuanced, balanced picture so that the patient can fully integrate the loss.

When first reviewing the patient's lost relationship with the deceased person, patients commonly recall their pleasant times together; they usually feel most (p. 48) comfortable (if sad) discussing these. Yet clearly patients also will have felt angry, disappointed, hurt, or unhappy about some characteristics of the deceased and their relationship. The patient may feel abandoned by the loved one or guilty about some aspect of the relationship, particularly about something the patient did or failed to do near the time of the death. At the same time, many patients with complicated bereavement fear the strength of their feelings and so try to avoid them. Strong negative emotions may include not only sadness but anger—and yet patients often feel that hating a dead person is a terrible thing and makes them a terrible person. How the therapist handles negative emotions toward the deceased may vary by culture (see Chapter [24](#)).

Thus, you may start by inquiring about what was good about the relationship:

What do you miss about your mother? What were some of her good qualities? What do you miss about your relationship with her?

Once the patient begins to reminisce, avoid the temptation to change the subject if emotions become powerful. Let the patient sit with and reflect on her feelings.

After exploring the positive aspects of the relationship (which may take a session or more), encourage the patient to openly express her less positive feelings, as they are normal: “No two people get along all of the time. You must have a complex range of feelings about someone you cared so much about.”

You can tell the patient that negative feelings may be followed by positive emotions and attitudes toward the loved one. This is no different from what would happen if the person were still alive: one would generally discuss upsetting things with that person, and that would make both of them feel better.

Patients with severe grief reactions may get irritated at any hints to discuss ambivalent feelings about the deceased, especially those patients with early caretaking deficits (insecure attachments) for whom the deceased provided an adult secure attachment. Tell the patient:

It's normal to feel upset and confused when you talk about the loss, but you will feel better again. I will be encouraging you to talk about your life with [the person], how your life has changed since the loss, and what the ups and downs have been. I will be encouraging you to talk about the things you did not like, as well as those you did like, about the relationship.

Gradually, you will be able to sort through these emerging feelings and build a three-dimensional picture of your relationship with [the person you lost] that includes [the person's] good and bad points, as there are in all relationships.

If you have difficulty in going through this grieving process, it might be helpful to discuss memories with friends or family. You might want to review picture albums or revisit places that were meaningful in your relationship. This can help you recollect the past. If you have old friends you have not seen since [the person] died, you might meet these people and review your past times together or even go over the albums with them. We can then discuss how those events go.

(p. 49) Try not to be overly directive or didactic in relating this. The less you say in steering the patient in this direction of grieving, the better.

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Catharsis

Many patients fear that if they begin to cry or mourn, they will not be able to stop and that the wave of grief will overwhelm them. It is important to reassure them that this will not happen. Once the patient begins to focus on the deceased person, the positive and negative aspects of their relationship and of that person, the hitherto controlled patient often begins to cry. A wave of affect rolls through the office. This makes many therapists anxious and raises the temptation to interrupt the patient. *Don't do it!* Your role as therapist is to help the patient learn that *emotions, while powerful, are not dangerous*. As the feelings are expressed, their force will diminish. Patients are then likely to feel calmer and more in control—sad, but less depressed. Once patients express strong emotion about the deceased, it is important to be calmly quiet and let them talk out their feelings. The main techniques used here are encouragement of affect and clarification.

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Reestablishing Interests and Relationships

Once the patient has begun to process the grief, you can help her to fill the emptiness the death has often created. It is important not to proceed to this step until the patient has had a chance to deal with the grief feelings and to address the loss. You can say:

Social supports are important and protect against depression. It's often good to feel connected rather than carrying around your feelings all alone. Later in the therapy, when you're feeling a little better, you

may want to try to call or go out to dinner with a friend, just to see how it goes. Your discussion of these experiences, good and bad, and your feelings around them are things we can discuss.

As you begin to talk and think about the person who has died and to relive some of the experiences of the relationship and the loss, you are likely to feel better and should gradually begin to take on some of the old activities that gave you pleasure before the death. Although it may be hard to imagine this now, you may begin to look for ways to resume relationships and meet new friends who can also bring happiness to your life. We can talk about the practical efforts you are making and the feelings that surround these new steps.

Sometimes a patient will have given up her social life or job in order to care for a dying family member. This may stir an uncomfortable resentment that the patient feels guilty for having: what a terrible person I am to be angry at a dying mother! After the death, the patient not only has lost the loved one but finds that her broader life has atrophied. The loss thus often leaves a patient feeling lost and (p. 50) directionless. Although one can't replace a parent or a best friend, it is possible to find new relationships and activities that provide satisfaction and give life a new sense of purpose. Sometimes the patient might volunteer at a hospital or cancer society in honor of the deceased.

If the patient undertakes a new activity or relationship, it is helpful to review afterward:

- *What did you do?*
- *What parts did you enjoy?*
- *What parts were difficult?*
- *Would you do it again?*
- *What else might you like to do?*
- *If some part of the activity, some interaction, was difficult, how else could you handle that in the future?*

Depressed patients who have an unresolved grief reaction may fear abandonment in new relationships. Any prospective new (or revived) relationships deserve discussion, including fears about them. Similarly, discuss activities that make the patient feel comfortable and those she fears. Encourage the patient to risk undertaking new activities and to use the therapy to discuss experience and reactions. Exploring interpersonal options ("*What might help you to feel better during this time?*") and role playing them ("*How would you approach her? What might you say?*") often facilitate this process.

As therapy progresses, the sessions will gradually shift from discussions of the deceased to issues surrounding these new efforts. The deceased person will be seen in a less emotionally charged way. Mourning continues for years: *the goal of IPT is not to end mourning but to ease it and to get the patient on the right path.* The patient will of course continue to remember the deceased but may feel less preoccupied with the loss.

Some patients present with chronic complicated bereavement: they have become professional mourners, dressed in black, their lives dedicated to the memory of the deceased. Any potentially pleasurable activity feels like a betrayal of the memory of their loved one. Friends and family who tell them to "get over it" simply don't understand their plight.

For such patients, the IPT therapist needs to underscore the severity of the loss:

This has been such a terrible loss to you that it's taken over your life for the last seven years. You feel like you'll never get over it.

While recognizing this dedication to the deceased, you need to find a way to reassure the patient that it's possible to honor the memory and to live one's life. Thus the treatment would begin as with the other form of complicated grief, asking about the death, what the patient loved about the deceased and the relationship, and gradually proceeding to less wonderful aspects of the relationship. As (p. 51) the patient tolerates the feelings and they diminish somewhat in intensity, you can gradually move into finding other activities and relationships:

You seem to feel guilty if you catch yourself enjoying an activity. But does that mean you'll ever forget your lost Jimmy? It is possible to have more than one feeling at a time, to honor his memory and to live your life.

The techniques used here include communication analysis, decision analysis, and role play.

An adaptation of IPT for prolonged acute grief disorder, with or without depression, has been developed. This classification of grief is similar to a new diagnostic category of traumatic grief. The adaptation has been used when the longing and preoccupation with the deceased are persistent. The loss of the attachment figure is seen as a traumatic loss with intrusion images. Shear and colleagues have added elements of exposure-based PTSD treatment to IPT, including structured revision exercises and motivational enhancement to help patients reengage with their lives without the deceased (Shear et al., 2005, [2016](#)).

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Case Example: A Husband's Death

Mitzi is a 56-year-old schoolteacher and the mother of two grown children. Her life collapsed when her 60-year-old husband, Roy, died suddenly of a stroke. Their marriage had suffered some rockiness over finances and Roy's past extramarital affair. Nevertheless, the two were looking forward to enjoying their lives together now that their children were grown and they had finally saved enough money for vacations and relaxation. Mitzi, in her usual way, handled the funeral arrangements, comforted the children, consoled her husband's aged mother, and carried on as the backbone of the family. Although her husband's death occurred just before Thanksgiving, in the interest of family unity she decided to continue their Thanksgiving traditions. Two weeks after Roy's death, she returned to her teaching job and resumed playing tennis. She missed Roy and was weepy, but she felt that she had to carry on and to keep busy, both for her elderly mother-in-law and for the children.

A year later, the one problem that had developed after her husband's death, Mitzi's inability to get a full night's sleep, worsened. She also began to lose interest in teaching and felt that she could not go on. Convinced that she had an underlying medical problem (maybe cancer or heart disease), she consulted doctors and began to miss work. She could no longer carry through with Thanksgiving plans. She started to lose weight. Her friends felt she had aged five years in the past twelve months.

Mitzi entered IPT after a fourth medical checkup failed to find anything physically wrong with her. Her doctor noted that her loss of sleep, weight, energy, and interest in her work and family were symptoms of depression. Although she entered treatment, she denied that she was depressed and remained convinced that she had an undetected physical illness. In the initial sessions, it became clear that Mitzi fit the criteria for major depression despite her interpretation of her symptoms as physical (p. 52) illness. The therapist did not dispute this with her but began to inquire what had been going on in Mitzi's life and when her symptoms began. The therapist assessed her symptoms using the Hamilton Rating Scale for Depression ([Hamilton, 1960](#)) and found that her score was 27—in the severely depressed range.

Her husband's death immediately became the focus of attention: the sudden, unforeseen circumstances of his death, her inability to mourn, and her immediate resumption of activities to avoid mourning. It was also clear that Mitzi's symptoms had worsened around the anniversary of Roy's death—several weeks before Thanksgiving—when her mild sleep disturbance worsened and resulted in fatigue, failure to go to work, and, finally, inability to organize the family's Thanksgiving.

The therapist diagnosed major depression associated with complicated bereavement, emphasizing that depression was an illness with prominent physical as well as emotional and cognitive symptoms. Mitzi was able to agree with this diagnosis. Therapy progressed with a detailed discussion of the life she and her husband had shared. Each session began with details of her daily activities, usually a discussion of

how she used to do the same things with her husband and how his loss felt to her. With the therapist's encouragement, Mitzi began to go through the picture albums of their shared life, which she had buried in a closet after Roy died. She cried frequently and acknowledged that she was really focusing on his death now, a year later, for the first time.

Over time, she revealed her anger at Roy for not taking vacations, which had cost them the chance to relax and have fun together. They had now missed any chance to vacation together. Toward the end of treatment, Mitzi arrived with a brochure. She and a close female friend were planning a cruise to the Bahamas. The end of therapy included a discussion of what it would be like to be a single woman on a cruise, as well as her enthusiasm for the trip and her guilt that her husband would not be able to share this activity. Her final Ham-D score was 5—within the normal range.

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Case Example: Hidden Death

Linda, a 30-year-old college-educated and very attractive woman, had run through several therapies and therapists. Her affect shifted between bland and confrontational. She seemed out to challenge any help to prove it useless. When she presented for IPT she was mildly depressed (Ham-D = 15) and had been taking antidepressant medication for several months. Linda described her life as empty and meaningless. She had recently taken a new job as an administrative chief, a slight promotion from her previous position, but she said her main motivation for the move was to meet new people and feel less socially isolated. Her depression had increased when she found no improvement in her social life after two months at the new job. She came home and ate alone after work. Weekends were long and painful.

Linda described her previous therapists as unhelpful and poorly trained, and it seemed clear after two sessions that she would soon add her IPT therapist to that category. Her interpersonal inventory revealed no current close friends, few acquaintances, and no disputes. Her father was dead, her mother lived across the country, (p. 53) and she had limited contact with her and her younger sister, who lived near the mother. They were not estranged, Linda said; they just didn't keep in touch. Linda's current situation sharply contrasted with the rich life, full of social activities, she reported having had about four years before.

Finding a problem area proved difficult. At first it seemed that her transition into the new work situation might be a focus, but that proved a dead end: Linda found little difficulty in the change other than its failure to restart her social life. In the absence of other life events, interpersonal deficits (loneliness) seemed the next alternative: an absence of life events and problem areas. The therapist tried again to understand the onset of symptoms and the social context, in other words to find a life event.

She again asked Linda about the time four years before when she had friends, eliciting the friends' names and the nature of their relationships. During this third session, with some reluctance, Linda described her former boyfriend John. They were planning a four-week summer trip to Europe to hike and bike. They were both about to take on new jobs and wanted to use this interlude to rest, relax, and get to know each other better. They planned to get engaged after the trip and tell their families. Then one day, John and Linda spent time at her apartment. He was planning to drive back to his own apartment 20 miles away to pack, and they were to meet again at the airport the next afternoon. The next day, however, John never appeared. After frantic calls, Linda learned that John had been hit in a head-on collision, had been taken by ambulance to a hospital, and had died that night.

Linda met John's family for the first time at the funeral. She described the subsequent days as a blank blur. She began her new job as planned and said her life changed. She would wake in the middle of the night in terror. She stopped seeing friends. She couldn't cry. She felt that she wished she could join John. Although she had made a determined effort to block out the pain and any memories of this event, the focus of complicated grief had now become apparent.

With the therapist's gentle encouragement that it was better to process than to try to ignore the feelings of this terrible loss, Linda reluctantly and increasingly tearfully began to describe John, how they met, their relationship, and how they designed their planned vacation. She described the terrible meeting with the parents at the funeral. They knew little about her and blamed her for the accident. Had she given him something to drink at dinner? Why was she encouraging him to take a month-long vacation when he could have been working? She also noted that their mutual friends had drifted away with his death. She feared what his parents might be saying about her. They evidently needed someone to blame for this senseless accident.

Linda's emotions during the session ranged from wailing to fury to sadness. She was well into the grieving process that she had never undergone. After four more sessions, she decided to call some of their closest mutual friends and was surprised and pleased to learn they were happy to hear from her and didn't understand why she had turned away from them. At week eight she decided she could visit her mother and sister, whom she had not seen or returned calls from since John's death.

Acute treatment terminated at twelve weeks as planned. The quality of the interactions with the therapist had changed remarkably. Linda was no longer (p. 54) confrontational and began to consider new ways to meet people with similar interests, hiking and biking, and had begun to see one or two old friends. She expressed sadness at termination and thanked the (competent) therapist for her expertise. She was asymptomatic (Ham-D = 4). Linda decided to continue monthly maintenance for six months to help consolidate the gains she had made in her mood and social life.