

A Cognitive-Behavioral Conceptualization of Complicated Grief

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A cognitive-behavioral conceptualization of complicated grief (CG) is introduced that offers a framework for the generation of hypotheses about mechanisms that underlie CG and that can be targeted in treatment. Three processes are seen as crucial in the development and maintenance of CG: (a) insufficient integration of the loss into the autobiographical knowledge base, (b) negative global beliefs and misinterpretations of grief reactions, and (c) anxious and depressive avoidance strategies. These processes are offered to account for the occurrence of CG symptoms, whereas the interaction among these processes is postulated to be critical to symptoms becoming marked and persistent. The model recognizes that background variables influence CG, but postulates that this influence is mediated by the model's three core processes.

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Most people who are confronted with the death of a close relative recover without complications (Bonanno, 2004). Nonetheless, some fail to recover and develop symptoms of complicated grief (CG) that, if left untreated, pose risks for persistent impairments in social and occupational functioning (Chen et al., 1999; Prigerson

et al., 1997; Silverman et al., 2000). Many have called for specific treatments for CG (cf. Jacobs, 1999). Until recently, no such treatments existed (Schut, Stroebe, van den Bout, & Terheggen, 2001). “Complicated Grief Treatment” is a novel treatment for CG containing elements of interpersonal psychotherapy (IPT) for depression and cognitive-behavioral therapy (CBT) for posttraumatic stress disorder (PTSD) developed by Shear and colleagues (Harkness, Shear, Frank, & Silberman, 2002; Shear et al., 2001). In a recent randomized controlled trial, Shear, Frank, Houck, and Reynolds (2005) compared Complicated Grief Treatment with standard IPT and found the former treatment to be more effective in terms of response rates and time to response. Encouragingly, although not all patients responded to Complicated Grief Treatment, it yielded effect sizes far beyond those accomplished in earlier bereavement intervention studies (Litterer Allumbaugh & Hoyt, 1999). This study represents an important step toward the availability of an effective treatment for CG.

There is still a need to enhance our knowledge of the mechanisms involved in the development and maintenance of CG. Knowledge is important for the early identification of those at risk for the disorder and for the refinement and development of treatment interventions. This article introduces a cognitive-behavioral conceptualization that can be used as a theoretical framework for the generation of ideas about mechanisms that underlie CG and for the application of cognitive-behavioral interventions that, pending research, are potentially valuable. We first describe clinical characteristics of CG and then discuss the conceptualization and its application to treatment. We close with an overview of related

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hypotheses. The model draws heavily from the work of other theorists, in particular those who have proposed cognitive-behavioral models for PTSD (e.g., Bower & Sivers, 1998; Brewin, Dalgleish, & Joseph, 1996; A. Ehlers & Clark, 2000; A. Ehlers & Steil, 1995; Foa & Kozak, 1986; Foa & Rothbaum, 1998; Horowitz, 1997; Janoff-Bulman, 1992).

CLINICAL CHARACTERISTICS OF COMPLICATED GRIEF

Bereaved individuals may develop symptoms that can be captured within existing diagnostic categories. There is evidence that mourners may, among other things, develop depressive disorders (Zisook, Shuchter, Sledge, Paulus, & Judd, 1994), PTSD (Murphy et al., 1999; Schut, de Keijser, van den Bout, & Dijkhuis, 1991), and other anxiety disorders (Jacobs et al., 1990). In the past decade, it is increasingly recognized that mourners can also experience problematic grief-specific symptoms that are distinct from depressive and anxious symptoms and that, independent of the latter, predict health impairments (Chen et al., 1999; Prigerson et al., 1997).

In the late 1990s, a panel of experts on bereavement proposed standardized diagnostic criteria for CG.¹ These were subsequently validated in a study with widowed elderly individuals (Prigerson, Shear, et al., 1999). CG is defined as present when, after the death of a significant other, the person presents with symptoms from two symptom clusters—separation distress and traumatic distress—that have been causing significant impairments in functioning for at least six months (Prigerson & Jacobs, 2001; Prigerson, Shear, et al., 1999). Symptoms of *separation distress* are at the core of CG and include yearning, searching, preoccupation with memories of the lost person, and loneliness. Symptoms of *traumatic distress* represent the way in which individuals with CG are traumatized by the death and include efforts to avoid reminders of the loss, feelings of purposelessness about the future, numbing, feeling stunned, dazed, or shocked by the loss, difficulties acknowledging the death, feeling that life is empty, difficulties imagining a fulfilling life without the deceased, feeling that a part of oneself died, shattered world view, facsimile illness symptoms, and anger over the loss.²

There is considerable evidence that CG is distinct from depressive and anxious symptoms and syndromes (Lichtenthal, Cruess, & Prigerson, 2004). A matter of

debate still is the distinction from PTSD. Some authors have emphasized similarities between CG and PTSD and have questioned the necessity of establishing CG as a distinct disorder (Fox, Reid, Salmon, Mckillop-Duffy, & Doyle, 1999; M. Stroebe, Schut, & Finkenauer, 2001). However, phenomenologically, overlap between CG and PTSD is not complete (Prigerson, Jacobs, Rosenheck, & Maciejewski, 1999; Raphael & Martinek, 1997). A first important difference between the syndromes is that intrusive images in PTSD often include fragments of the traumatic event or cues that acted as warning signals for the event (A. Ehlers et al., 2002), whereas intrusions in CG are often less circumscribed. Comparable to PTSD patients, many CG patients experience intrusive recollections of emotional events that surrounded the death. Yet, additionally, it is not uncommon for them to have comforting memories of the lost person when he/she was alive (Burnett, Middleton, Raphael, & Martinek, 1997; Horowitz et al., 1997; Raphael & Martinek, 1997). A second key difference is that in PTSD the dominant affect is that of *fear* associated with the traumatic event, whereas in CG the dominant affect is that of *yearning* related to the loved one's absence (Raphael & Martinek, 1997). A third difference (linked with this dominant affect) is that PTSD patients are inclined to avoid reminders of the events that led to their problems, whereas the behavior of CG patients is more strongly characterized by unhealthy approach, in the form of seeking out reminders of the lost person. Altogether, it seems that PTSD patients continue to have involuntary recollections of the traumatic event and, at the same time, experience a sense that the threat is in the present rather than in the past, coinciding with fear and the urge to avoid the reoccurrence of danger (A. Ehlers & Clark, 2000). On the other hand, individuals with CG continue to have involuntary recollections of the death event and the deceased and, at the same time, experience a sense that the loved one is just temporarily rather than permanently gone, coinciding with yearning (a symptom that is not seen in PTSD) and the urge to restore proximity to the lost person.

As an adequate theory of CG should account for its unique clinical characteristics, in the current conceptualization, we particularly aimed to explain these latter phenomena—the symptoms that fall under the heading of separation distress in the proposed criteria for CG

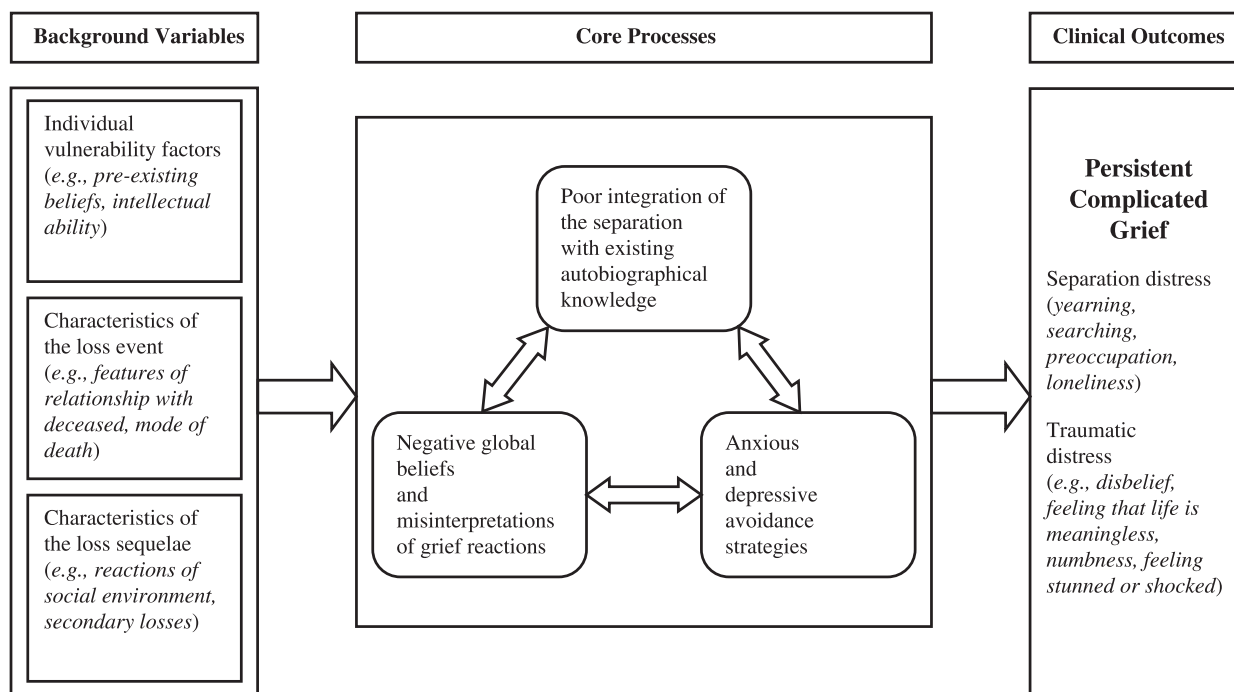


Figure 1. A cognitive-behavioral conceptualization of complicated grief.

(Prigerson, Shear, et al., 1999). However, we also sought to generate ideas about mechanisms underlying traumatic distress symptoms. Taking into account that symptoms of CG occur transiently in many mourners (Bonanno, 2004; Shuchter & Zisook, 1993), another aim was to generate ideas about mechanisms responsible for the fact that, in CG, these symptoms persist and exacerbate.

A COGNITIVE-BEHAVIORAL CONCEPTUALIZATION OF COMPLICATED GRIEF

Within the cognitive-behavioral conceptualization, three processes are crucial in the development and maintenance of CG: (a) poor elaboration and integration of the loss into the database of autobiographical knowledge, (b) negative global beliefs and misinterpretations of grief reactions, and (c) anxious and depressive avoidance strategies.

In succeeding text, we explain the role of these three processes in detail. Henceforth, these processes are referred to as the model's "core processes." Then, we discuss the influence of individual vulnerability factors, characteristics of the loss event, and characteristics of the loss

sequelae on the development of CG. These variables are referred to as "background variables." In the section thereafter, we explain how the background variables and core processes are assumed to work together in causing CG. Key components of the model and their proposed interactions are depicted in Figure 1.

Poor Integration of the Separation with Existing Autobiographical Knowledge

One of the puzzles of CG is that although the mind of CG patients is often bound up with the lost person, the loss continues to feel like an unreal event. That is, on the one hand, CG patients are more often and more easily reminded of the lost person than are individuals without CG (Lichtenthal et al., 2004; Raphael & Martinek, 1997). Numerous stimuli and situations unintentionally trigger memories of how the deceased used to look or act, in a way that eventually everything is a reminder of the deceased. Similarly, all kinds of stimuli have the capacity to evoke intrusive recollections of events surrounding the death. Yet, rather than these recurring memories making the loss more "real," CG patients continue to be

shocked by the loss. Moreover, as manifested in searching behavior, they continue to have great difficulties admitting to the permanence of the separation. We believe that these phenomena can be explained by proposing that, in CG, the separation is insufficiently elaborated and integrated with the autobiographical memory base.

The Role of Poor Integration of the Loss in Intrusive Feelings and Memories. In uncomplicated grief, conceptual (meaning-based) processing takes place. Among other things, this means that the factual knowledge that the separation is irreversible gets linked with information about the relationship with the lost person (i.e., memories, thoughts, feelings) that is represented in long-term memory. Furthermore, elaboration of the meaning and implications of the separation takes place, as a result of which the loss becomes integrated with information about the time frame that the relationship existed, conceptualizations about the self in the past, present, and future, and other abstracted information that is somehow entwined with the relationship with the lost person (cf. Conway & Pleydell-Pearce, 2000). Gradually, this process reduces the ease with which thoughts, feelings, and recollections pertaining to the deceased/death event intrude into consciousness on confrontation with stimuli linked with the loss. At the same time, this process facilitates the formation of more elaborate retrieval routes, with the effect that when information about the deceased/death event comes to awareness, it is increasingly contextualized into other information about the self and the relationship with the lost person (cf. Brewin et al., 1996; A. Ehlers & Clark, 2000). This is in keeping with anecdotal accounts in the literature of how over time, for most bereaved individuals, confrontation with reminders of the loss becomes less disruptive, pangs of grief and despair are replaced by more balanced emotions of sadness and joy, and fragmented memories about the lost person make way for a more coherent story about the relationship with a beginning and an end (Rando, 1993; Shuchter & Zisook, 1993).

The current conceptualization proposes that one of the key problems in persistent CG is that information about the loss as being an irreversible event is poorly elaborated and insufficiently integrated with other knowledge in autobiographical memory. This lack of integration has the consequence that, for CG patients,

the separation continues to be experienced as an event that is very distinct (lacks connection with other information in memory), very consequential (has great significance), and very emotional (triggers strong feelings) (cf. Berntsen, 2001; Bower & Sivers, 1998). This, in turn, has the consequence that thoughts, feelings, and recollections that are linked with the loss in the associative network of memory can be triggered very easily, can be triggered by a wide range of stimuli, and have an intrusive and disruptive quality.

The notion that, in CG, the loss is insufficiently linked with extant knowledge explains why CG patients continue to feel shocked by the loss. Furthermore, it helps to understand why many stimuli have the capacity to evoke fond memories of the deceased. That is, stimuli that are associated with the *presence* of the lost person and previously elicited no response because his/her presence was a normal thing are now associated with his/her *absence* that is still very unusual and consequential. It is therefore that these stimuli evoke strong yearnings accompanied by memory images of what is missed. The lack of integration of the loss with other knowledge is also assumed to account for the occurrence of intrusive recollections of the death event. That is, these recollections are closely tied with the poorly integrated information about the loss in memory and are therefore likely among the recollections that enter awareness when this information is activated.

Generally, thoughts and memories that come to mind when confronted with loss-related cues are assumed to mirror information about the separation represented in memory. As the content of this information differs from person to person (dependent on the circumstances and meaning of the loss), the content of dominant intrusive experiences differs as well and is not always restricted to the actual moment the loved one passed away. When the events that caused the death were traumatic, unbidden recollections of these events may be dominant. Yet, when the death itself occurred relatively tranquilly, other emotional memories or fond recollections may be dominant. This notion matches with findings of Kaltman and Bonanno (2003) that intrusions about the death event were more common in mourners confronted with violent loss (due to accident, suicide, or homicide) than in those confronted with other deaths. The content of intrusions also depends on the type of stimuli mourners are

confronted with. It is conceivable that fond recollections are easily elicited by stimuli linked with the loved one's presence (e.g., places he/she used to come), whereas recollections of the death event are easily triggered by reminders of the situational context in which the death event took place (e.g., the road where the fatal accident took place).

The Role of Poor Integration of the Loss in Persistent Attachment Reactions. Another consequence of insufficient integration of the loss with extant knowledge (apart from causing information about the deceased/death event to continue to intrude into awareness) is that attachment reactions persist. As described in attachment theory, individuals form mental representations of relationships with important others as part of their autobiographical knowledge base. The “set goals” of these representations are to retain proximity to these others (Bowlby, 1980, 1982; Marvin & Britner, 1999). Therefore, these representations contain information about *emotional responses* (e.g., despair) and *behavioral responses* (e.g., searching) that are activated when the relationship is threatened (e.g., when separation occurs) and that serve to maintain proximity and a sense of “felt security” (cf. Kobak, 1999; Shaver & Tancredy, 2001). In uncomplicated grief, these reactions are present but gradually subside as the information that the loss is irreversible gets increasingly connected with other information in memory. It is proposed that, in CG, poor connectivity between these types of information causes patients to continue to engage in automatic responses aimed at restoring proximity to the lost person.

This notion helps to understand why CG patients continue to experience sorrow, despair, and distress without a sense of reduction in intensity (Horowitz, Bonanno, & Holen, 1993). Furthermore, it explains why they continue to engage in reflexive searching behaviors (e.g., looking out for the deceased in familiar places, feeling drawn to places associated with him/her) that would indeed result in restoration of proximity if the loved one were to still be alive. Finally, poor integration of the loss is assumed to account for the fact that many patients have a sense that the loved one is still alive or bound to return soon—a phenomenon that has been found to be predictive of persistent emotional problems after bereavement (Horowitz et al., 1993; Vachon et al., 1982).

Notice that this first core process within our conceptualization is directly descended from cognitive theories of PTSD. These theories propose that a key mechanism in persistent PTSD is that the memory of the traumatic event is insufficiently integrated into the existing autobiographical database. This is assumed to account for the fact that PTSD patients continue to relive fragments of the traumatic event and, at the same time, continue to anticipate the reoccurrence of danger, rather than seeing the danger as something from the past (Bower & Sivers, 1998; A. Ehlers & Clark, 2000; for reviews see Brewin & Holmes, 2003; Dalgleish, 2004). Comparably, we postulate that one of the key problems in CG is that the separation is poorly elaborated and connected with extant autobiographical knowledge. In terms of the proposed criteria for CG (Prigerson, Shear, et al., 1999), this lack of connectivity is assumed to account for the fact that CG patients continue to suffer “intrusive preoccupation with recollections of the deceased” that may involve fond as well as painful memories. These intrusive phenomena are conceptualized as resulting from the activation of insufficiently processed memory information about the loss via cuing. At the same time, it is the same poor integration of the loss that causes CG patients to continue to feel “stunned, dazed, or shocked” by the loss and to have a sense that the separation is temporary rather than permanent, which is manifested in the hallmark symptoms of “searching behavior” and “difficulties acknowledging the loss” (Prigerson, Shear, et al., 1999).

Negative Global Beliefs and Misinterpretations of Grief Reactions

The model further proposes that, unlike people who recover from loss, CG patients have negative beliefs and misinterpretations that (a) directly generate symptoms of CG, (b) strengthen the inclination to engage in unhelpful avoidance strategies, and (c) interfere with the adjustment of the autobiographical database (see Figure 1). Negative global beliefs about the self, life, and the future, and catastrophic misinterpretations of grief reactions are postulated to be particularly critical.

Negative Global Beliefs. In accordance with cognitive theories of PTSD (Foa & Rothbaum, 1998; Janoff-Bulman, 1992) and earlier theoretical approaches to grief (Horowitz, Wilner, Marmar, & Krupnick, 1980; Parkes,

1988), it is assumed that a loss may present mourners with information that violates previously held global beliefs. The death of a spouse may shatter expectations for the future. Similarly, the death of a child may disrupt ideas about life's meaning. Successful adjustment occurs when the person is able to form new functional beliefs that take into account the loss event. Problems can arise when the person fails to do so and global beliefs are adjusted in a negative direction to bring these into accord with the loss experience. In these instances, negative global beliefs that can have a disabling effect on everyday functioning (cf. Beck, 1976) may come to dominate thought content. Importantly, such beliefs can also arise when the loss confirms or reactivates negative beliefs that were present before the loss (cf. Foa & Rothbaum, 1998). The death of a loving partner may reactivate negative views of the self that were dormant when the partner was alive (Horowitz et al., 1980).

In keeping with earlier writings on cognitions in grief (Gluhoski, 1995; Neimeyer, Prigerson, & Davies, 2002; Schwartzberg & Janoff-Bulman, 1991) and preliminary empirical evidence (Boelen, van den Bout, & van den Hout, 2003a), global negative beliefs about the self, life, and the future are assumed to be particularly critical. Beliefs that "the self is worthless," "life is meaningless," and "the future is hopeless" are likely to strengthen the propensity of mourners to keep attention away from the present and future, and to dwell on what was lost. As such, they are likely to fuel yearning and to interfere with healthy behaviors that facilitate adjustment (e.g., setting new goals, continuing usual activities). Moreover, processing the loss is probably hindered when elaborating on its implications brings to mind negative thoughts about the self, life, and the future. That "purposelessness or feelings of futility about the future" and "feeling that life is empty or meaningless" are among the proposed CG criteria (Prigerson, Shear, et al., 1999) underscores the importance of these belief themes. Yet, rather than being part of the symptom picture of CG, these beliefs are assumed to have a key role in driving the disorder.

Catastrophic Misinterpretations of Grief Reactions. Negative interpretations of one's own grief reactions are assumed to be important (cf. A. Ehlers & Steil, 1995). Mourners may interpret their emotional pain as intolerable. Likewise, they may label the intensity of their

sadness as signaling loss of control, view their numbness as depression, and interpret vivid intrusions as reflecting insanity. Such catastrophic misinterpretations of reactions that occur transiently in most mourners are deemed important because they are likely to contribute to feelings of distress and discomfort. Moreover, they are likely to fuel the inclination of mourners to engage in attempts to minimize feelings and thoughts over the loss. As such, it is hypothesized that these misinterpretations contribute to anxious avoidance strategies that mourners can adopt. These are part of the third of the model's three core processes. Two recent cross-sectional studies confirmed that catastrophic misinterpretations of grief reactions are important in CG (Boelen, van den Bout, & van den Hout, 2003b; Boelen, Kip, Voorsluijs, & van den Bout, 2004).

Negative global beliefs and misinterpretations have in common that they both are conceptualized as cognitive concepts that can be deliberately accessed by mourners and are open for editing. In this respect, the second core process of the model (negative global beliefs and misinterpretations of grief reactions) differs from the first core process (poor integration of the separation within existing autobiographical knowledge) that is conceptualized as being less directly accessible and open for manipulation (cf. Brewin et al., 1996; Dalgleish, 2004). Global negative beliefs and misinterpretations do, however, differ in their level of abstraction. Global beliefs represent assumptions about general themes, and misinterpretations represent evaluations of one's own reactions. Moreover, although this hypothesis still needs to be tested, they are thought to differ in their link with the third core process of the model (anxious and depressive avoidance strategies), with global beliefs being more strongly linked with depressive avoidance and misinterpretations being more strongly related to anxious avoidance. Importantly, that negative global beliefs and misinterpretations are brought under the heading of one process does not mean that they always co-occur. Patients may be wrapped up in a search for what life is still worth without the lost person without assigning catastrophic meanings to their feelings. Conversely, patients may be afraid of their own reactions without being plagued by negative views of themselves or their lives.

Other Beliefs and Interpretations. That the aforementioned cognitive variables are considered crucial does not

mean that other beliefs are not important. Research has shown that emotional problems after bereavement are also influenced by, among other things, thoughts about self-blame (e.g., Field & Bonanno, 2001; Fleming & Robinson, 2001) and negative views of responses of the social environment (Boelen et al., 2003a). Yet, more than causing CG symptoms, these cognitions are assumed to lead to other emotional reactions. For instance, in line with cognitive theorizing (Beck, 1976), cognitions about self-blame (e.g., “It was my fault that he died”) are likely to generate feelings of guilt, cognitions about danger (e.g., the idea that “Nowhere is safe” after confrontation with a violent loss) can generate fear, and negative thoughts about the responses of others (“People have let me down after the loss”) can cause anger.

Anxious and Depressive Avoidance Strategies

As a third core maintaining process, the model proposes that, in comparison with individuals with uncomplicated grief, CG patients are more inclined to engage in maladaptive strategies that have the common effect of (a) directly causing symptoms of CG, (b) interfering with the alteration of negative beliefs and interpretations, and (c) interfering with the integration of the separation with existing knowledge (see Figure 1). We make a distinction between *anxious avoidance strategies* and *depressive avoidance strategies*.

Anxious Avoidance Strategies. Anxious avoidance strategies occur when mourners believe that confronting the reality of the loss—that is, confronting feelings, thoughts, or memories linked with it—will lead to “madness,” “loss of control,” or otherwise “unbearable” consequences, and they consequently engage in attempts to avoid confrontation with this reality to ward off this threat. They may engage in avoidance of situations (places the deceased used to come), people (who might ask about the deceased), or objects (pictures of the deceased) that all might elicit feelings or thoughts about the loss (cf. Horowitz et al., 1997; Ramsay, 1977). In addition, they may engage in counterproductive cognitive strategies to deflect from unwished feelings and thoughts. They may anxiously suppress painful memories about the events leading up to the death. They may also engage in continuous rumination about their own reactions or reasons why the loss occurred as a means to

escape from having to admit to the loss and the emotions linked with it (compare the findings of Nolen-Hoeksema, McBride, & Larson, 1997, of a positive prospective association between ruminative coping and emotional distress in bereaved gay men).

With the similar function of avoiding confrontation with the reality of the loss, CG patients may also attempt to maintain a strong connection to the deceased (cf. Field & Friedrichs, 2004). In doing so, they may constantly talk about the lost person as if he/she were still alive, cherish objects related to him/her, cultivate particular mourning rituals, or engage in cognitive strategies such as having inner conversations with the deceased or seeking comfort through memories.³ At first sight, mourners who engage in these strategies seemingly approach rather than avoid reminders of the loss. Importantly, however, attempts to maintain a strong connection to the deceased can be regarded as a form of anxious avoidance in case mourners are afraid to confront the reality of the loss and engage in such attempts to escape from this reality. Stated otherwise, mourners may well approach reminders of their loved one but at the same time avoid confrontation with the fact that he/she is dead and gone.

It is important to emphasize that instrumental and cognitive efforts to escape from thoughts, feelings, and memories about the loss are not considered maladaptive *by definition*. In fact, various theorists have pointed at the protective function of maintaining ties and escaping from one’s sorrow at times (M. Stroebe & Schut, 1999), and research has confirmed that avoidance is not always detrimental (Bonanno, Keltner, Holen, & Horowitz, 1995). Yet, the current model hypothesizes that turning away from the reality of the loss *does* contribute to CG when (and *to the degree that*) mourners fear that the opposite (confronting this reality) will have disastrous consequences. That is because it is in these instances that avoidance prevents the correction of (and thus maintains) catastrophic meanings linked with confronting the loss and the habituation of fear that accompanies confrontation. Moreover, when thoughts, feelings, and memories are averted for reasons other than that they are linked with danger (e.g., because the mourner has to support relatives), their occurrence will likely be accepted at other moments. Conversely, when these experiences are linked with danger, they will continue

to elicit distress and will continue to be avoided. As internal and external loss-related cues are ubiquitous, the persistent urge to avoid them is likely to interfere with the process of adjustment. In terms of the proposed CG criteria (Prigerson, Shear, et al., 1999), anxious avoidance is likely to contribute to the traumatic distress symptoms “numbing,” “detachment from others,” and “absence of emotional responsiveness.”

Depressive Avoidance Strategies. Depressive avoidance occurs when mourners engage in behavioral patterns of inactivity and withdrawal, and refrain from social, occupational, and recreational activities that could provide positive reinforcement and were important prior to the loss. Depressive avoidance can have various sources (Abrahms, 1981; Kavanagh, 1990; Ramsay, 1977). It can occur when the loss coincides with a considerable reduction of reinforcers for healthy behavior or when mourners lack the skills needed to achieve desired outcomes. In addition, it can occur when mourners think that making adjustments and engaging in activities without the lost person is disrespectful to him/her and they therefore refrain from doing so. Negative expectations are assumed to be important in depressive avoidance as well, especially those concerning the *effects* of engaging in potentially helpful behaviors (e.g., “Meeting friends will not make me feel better”) and *one’s abilities* to do so (e.g., “I am unable to take up new responsibilities”) (cf. Benight, Flores, & Tashiro, 2001).

In keeping with its role in maintaining major depression (Jacobson, Martell, & Dimidjian, 2001), depressive avoidance is hypothesized to play a key role in persistent CG. A first debilitating effect is that it likely contributes to yearning and feelings of purposelessness about the future—phenomena that are key symptoms of CG (Prigerson, Shear, et al., 1999). Moreover, the disruption of daily routines that depressive avoidance coincides with can cause biological deregulation that contributes to emotional instability (C. L. Ehlers, Frank, & Kupfer, 1988). Debilitating too is that depressive avoidance blocks access to experiences that run counter to global negative beliefs about the self and life. Finally, it prevents mourners from gaining experiences in the absence of the lost person and thus interferes with the incorporation of the loss into abstracted knowledge about the self in the present and future.

Anxious avoidance and depressive avoidance have in common that they both represent maladaptive strategies CG patients can engage in to avoid particular demands the loss brings. Yet, they are distinct in that anxious avoidance primarily represents a maladaptive way of dealing with internal, emotional experiences related to the loss (thoughts, feelings, memories), whereas depressive avoidance reflects an attempt to escape from the external, contextual demands of the loss. In the context of bereavement, anxious avoidance can thus also be regarded as past-oriented (or loss-oriented) avoidance and depressive avoidance as future-oriented (or adjustment-oriented) avoidance. It is not always easy to determine whether a particular reaction/strategy is a manifestation of anxious avoidance, depressive avoidance, or a mixture of both. For example, mourners may drug themselves because they wish to escape from the pain that is deemed “unbearable,” because they think that it is useless to engage in more healthy behavior, or because both these reasons hold. Taking into account the complexity of the relationship between anxiety and depression (e.g., Kendall & Watson, 1989) and the many research findings of a temporal link between the two (e.g., Parker et al., 1999), future studies should seek to clarify whether anxious and depressive avoidance strategies, as defined in our model, are indeed distinguishable and, if so, if a temporal relation between the two perhaps exists.

INFLUENCE OF INDIVIDUAL VULNERABILITY FACTORS, EVENT CHARACTERISTICS, AND LOSS SEQUELAE

The present conceptualization takes into account the influence of background variables that are neither necessary nor sufficient factors in the development of CG, but that may influence the conceptualization’s three core processes and, along this pathway, indirectly contribute to CG (see Figure 1). These background variables can roughly be categorized into individual vulnerability factors, characteristics of the loss event, and characteristics of the loss sequelae. Examples of these variables and their hypothesized influence on the core processes of the model are given in succeeding text.

Influence of Background Variables on Integration of the Separation with Existing Autobiographical Knowledge

As an *individual vulnerability factor*, the person’s adult attachment style likely exerts an influence on the easiness

with which the loss is processed. It is conceivable that, for insecurely attached individuals, it is a more complex endeavor to adjust extant knowledge than it is for securely attached persons because their autobiographical knowledge is much more entwined with the deceased (cf. Fraley & Bonanno, 2004). Intellectual ability likely has an influence. Individuals with lower intellectual abilities will have more difficulties with conceptually processing the loss in an organized way (cf. A. Ehlers & Clark, 2000; McNally & Shin, 1995).

Characteristics of the loss event are also assumed to be important. Violent losses (due to accidents, suicide, or homicide) are more distinct than are nonviolent losses and are therefore, by their very nature, more difficult to incorporate with existing autobiographical knowledge (Berntsen, 2001; Bower & Sivers, 1998). Moreover, violent deaths are more likely to generate distressing intrusive memories than nonviolent deaths (Kaltman & Bonanno, 2003). The activation of these memories on confrontation with loss-related cues goes at the expense of cognitive resources necessary to elaborate the meanings of the loss. As such, the ongoing preoccupation with the events leading up to the separation may well interfere with the processing of the separation itself (cf. Raphael & Martinek, 1997).

As an example of *characteristics of the loss sequelae*, reactions of people in the social environment can have an influence. The integration of the loss with conceptualizations of the self in the present and the future is promoted when the social environment acknowledges that the loss occurred and, at the same time, encourages the mourner to continue usual roles. Conversely, when the environment does not recognize the loss, processing may get blocked.

Influence of Background Variables on Negative Global Beliefs and Misinterpretations of Grief Reactions

As an *individual vulnerability factor*, neuroticism—the predisposition to see the world and oneself in a negative way (Clark, Watson, & Mineka, 1994)—is likely to predispose to a pattern of negative thinking after bereavement. Prior experiences with loss may have an influence in that they may be linked with the current loss and increase its negative meaning.

Characteristics of the loss event potentially exert an influence on beliefs coming to the fore in its aftermath. For instance, in keeping with schema-based theories of

PTSD (Horowitz, 1997; Janoff-Bulman, 1992), unpredictable, traumatic death events are more likely to disrupt preexisting positive beliefs or to reinforce preexisting negative beliefs than are losses with a more natural cause. As another characteristic of the loss event, the nature of the relationship can impact thinking patterns, in that, for instance, the death of a strongly supporting partner may be highly disruptive to one's self-image, whereas the loss of a child is likely to violate certainties about life that previously went unquestioned.

With respect to *characteristics of the loss sequelae*, secondary losses can exert an influence. Losses that have major financial or social consequences are more likely to generate negative beliefs about life and the future than are losses with relatively minor implications. Similarly, when a loss causes great emotional problems in close relatives, this can have debilitating effects on how one looks at life and the future. Responses of people in the environment may have an influence in that uncaring or overtly unsympathetic responses may strengthen negative ideas about the self.

Influence of Background Variables on Anxious and Depressive Avoidance Strategies

With respect to *individual vulnerability factors*, it is conceivable that strategies that are used to deal with the loss are influenced by preexisting beliefs, in that mourners with a preexisting lack of self-confidence will probably be more inclined to depressively withdraw than mourners who have more positive views of themselves.

Characteristics of the loss event can also affect strategies used. Violent deaths will likely lead to more PTSD-like intrusions than nonviolent deaths. The occurrence of these intrusions may strengthen the inclination to avoid reminders of the loss, as a means to prevent these intrusions from entering awareness (cf. Bower & Sivers, 1998). Features of the lost relationship can also influence strategies used. A mourner who was very dependent on his/her loved one for the filling in of daily life will probably have more difficulties in making active adjustments than a mourner who was less dependent on the deceased.

With respect to *characteristics of the loss sequelae*, reactions of people in the environment again can have an influence. For example, the presence of friends who encourage the mourner to engage in pleasurable activities likely counteracts inactivity. Conversely, when the environment fails

to give support, the propensity to withdraw may grow (compare the findings of Lepore, Silver, Wortman, & Wayment, 1996, of an association between social constraints and persistent depression in bereaved mothers).

RELATIONSHIPS AMONG COMPONENTS OF THE MODEL

The current conceptualization posits that three processes are crucial in the development of CG: one that reflects a disturbance of memory, a second process representing relatively easily accessible assumptions, and a third process that represents strategies to handle the internal and external demands the loss brings. All three processes are important as they contribute to the occurrence of various clinical outcomes observed in CG patients (Prigerson, Shear, et al., 1999). Poor connectivity between information about the separation and abstracted autobiographical knowledge is assumed to directly generate key symptoms such as disbelief, involuntary recollections, and searching behavior. Negative global beliefs fuel yearning and anger, and a range of emotions that can accompany CG (e.g., depression, guilt), whereas misinterpretations of grief reactions generate discomfort and fear. Finally, anxious and depressive avoidance strategies contribute to numbness, detachment, and difficulties imagining a fulfilling life and future.

Apart from directly contributing to CG symptoms, the three processes inevitably influence each other (see Figure 1). Examples of these reciprocal relationships have already been described. Other examples are the following. Negative beliefs may influence the integration of the loss into existing autobiographical knowledge in that, as noted earlier, this integration is likely blocked when reviewing the implications of the loss brings to mind negative beliefs (e.g., that the self is unworthy). Conversely, experiencing a sense of presence of the deceased resulting from insufficient integration may strengthen the catastrophic idea that one is “going insane,” whereas preoccupation with memories of the lost person may go at the expense of resources necessary to alter negative beliefs. Reciprocal relationships between the avoidance strategies and adjustment of the autobiographical database exist as well. Both anxious and depressive avoidance strategies are likely to interfere with the elaboration and integration of the loss. Conversely, the occurrence of vivid intrusions may fuel anxious avoidance, whereas disbelief over the permanence of the separation may block

active adjustment and strengthen depressive withdrawal. Finally, the second and third core processes in the conceptualization (i.e., negative beliefs and avoidance behaviors) are assumed to influence each other. For instance, beliefs about self-incompetence may strengthen inactivity, whereas catastrophic misinterpretations of grief reactions can lead to anxious avoidance. Conversely, avoidance strategies have a maintaining influence on negative beliefs as they prevent mourners from gaining experiences that can help to alter negative thoughts about the consequences of the loss and one’s own reactions to it.

A key assumption within the current conceptualization is that the three processes in themselves are assumed to be responsible for the *occurrence* of symptoms that can be observed in CG patients, whereas it is the interaction among the processes that causes these symptoms to become *marked* and *persistent* and to move from being normal to being indicative of disturbance. For example, experiencing a sense of presence of the deceased (resulting from poor integration of the loss with extant knowledge) may in itself well provide the mourner with a comforting sense of security (cf. Field & Friedrichs, 2004). Yet, this experience can become problematic when it is interpreted as a sign of impending insanity, or when it is accompanied by the belief that life is no good without the loved one and hence fuels the mourner’s propensity to cling to the past, rather than adjust to the loss. Another example is that negative beliefs may cause negative emotions, but it is only when these beliefs are accompanied by anxious and depressive avoidance that these emotions will persist and exacerbate. Thus, in its current form, the conceptualization implies that, pending future research that shows otherwise, all three components are important, with each of them accounting for the occurrence of particular symptoms of CG and the interaction among the processes impacting the severity of the symptoms.⁴

The model acknowledges that various background variables may contribute to emotional problems after bereavement. Yet, more than exerting a direct influence on CG, the influence of these variables is assumed to be mediated by the three core processes. That research thus far has failed to identify background variables that unequivocally predict emotional problems after bereavement (Bonanno, 1999; W. Stroebe & Schut, 2001) concurs with our hypothesis that the influence of these variables

is indirect more than it is direct. The idea of mediation implies that, in the complex interplay of mechanisms and variables that eventually leads to CG, background variables temporally precede the three core processes and exert a direct influence on (and thus are correlated with) the three core processes. Moreover, mediation implies that the three core processes play a crucial role in explaining how the background variables operate to influence CG severity (i.e., by affecting the three core processes) (cf. Baron & Kenny, 1986; Kraemer, Stice, Kazdin, Offord, & Kupfer, 2001).⁵

So, for instance, characteristics of the loss event are thought to influence clinical outcomes because, among other things, they will affect the beliefs and cognitions mourners have after the loss, which, in turn, influence the intensity and nature of the emotional responses. In line with this, W. Stroebe, Stroebe, and Domittner (1988) found mode of death to interact with negative views about personal control in predicting emotional and somatic problems after bereavement. Furthermore, consistent with evidence that neuroticism influences the effect of stressful life events on postevent psychopathology (Kendler, Kuhn, & Prescott, 2004), it is conceivable that neuroticism plays a role in CG. Yet, from the model, we would predict that it does so by affecting the speed of integration of the loss and the nature of postloss assumptions and avoidance strategies. A final example is that the person's adult attachment style is recognized as important in CG. But again, we would expect this influence to be mediated by the three processes. This corresponds to Field and Sundin's (2001) findings that the relationship between an anxious attachment style and difficulties recovering from conjugal loss was mediated by negative appraisals about one's coping abilities. Pertinent to the notion of mediation too is that Hankin, Kassel, and Abela (2005) found the association between insecure attachment and prospective elevations in depression to be mediated by negative self-esteem and maladaptive interpersonal behaviors.

The model does not specify the relative importance of the three core processes in mediating between background variables and postloss psychopathology. For example, as we saw in the previous section of this article, it may be that victims of a violent loss or insecurely attached persons are more prone to CG (a) because, for them, it is a more complex endeavor to incorporate

the loss into existing autobiographical knowledge, (b) because, for them, it will be more difficult to maintain a positive view of themselves or life, (c) because they will be more prone to anxious avoidance, or (d) because any combination of reasons holds. An important challenge for future research is to elucidate the extent to which each of the three core processes mediate between background variables and CG.

IMPLICATIONS OF THE MODEL FOR TREATMENT

Cognitive-behavioral therapy for CG is aimed at the alleviation of CG symptoms. The following changes are needed for this to be accomplished:

- (1) The loss needs to be conceptually processed and integrated with existing autobiographical knowledge.
- (2) Problematic beliefs and interpretations need to be identified and changed.
- (3) Anxious and depressive avoidance strategies need to be replaced by more helpful strategies that facilitate adjustment.

Treatment has the following general format. The initial phase focuses on conceptualizing the patient's problems in terms of the variables in the model. Psychoeducation is given and the rationale for treatment is introduced. Care is taken to establish a therapeutic relationship and to develop realistic treatment goals. The second and main part of treatment focuses on reversing the processes that maintain CG. In the third phase (the closing phase), attention is paid to treatment evaluation and relapse prevention.

Issues concerning the initial treatment phase are discussed. Next, interventions that can be used to target maintaining processes are considered (e.g., exposure, cognitive restructuring, behavioral activation). This section closes with notes on how the interventions can be combined. No studies have yet examined the effectiveness of an integrated CBT, but Complicated Grief Treatment (Shear et al., 2005) which was recently found to be effective, includes several cognitive-behavioral interventions.

Assessment and Case Conceptualization

The initial sessions are used to gather information about the various components of the model. The therapist uses

this information to formulate an individualized conceptualization of the patient's problems, and working hypotheses about the processes that are most critical in maintaining the problems and the relationship among them. The degree to which the separation is integrated with existing knowledge can be judged by examining the extent to which the patient feels and behaves as if the loss is reversible rather than definite, as well as by the presence of intrusive feelings, thoughts, and recollections. Intrusive recollections give information about aspects of the loss that need to be addressed in treatment. The presence of distressing intrusions of the death event indicates that the circumstances of the loss require additional processing. To identify potentially problematic global beliefs and misinterpretations, patients can be asked to describe how the loss has changed their views of themselves, life, and the future, and how they appraise their reactions to the loss. Completion of the Grief Cognitions Questionnaire (GCQ; Boelen & Lensvelt-Mulders, 2005) can be useful as well. Dominant emotions also give clues, with guilt feelings pointing at the presence of thoughts about self-blame and fear pointing at thoughts about threats and danger. Asking how patients are currently handling the consequences of the loss provides insight into helpful strategies that should be expended (e.g., asking friends for support) and unhelpful ones that should be terminated (e.g., anxiously avoiding reminders of the loss).

To complete the individualized conceptualization, the therapist should also identify background variables that possibly have influenced the problems by exerting an influence on the three maintaining processes. Key issues include earlier experiences with loss, potential strengths and weaknesses in the patient's repertoire of coping skills, preexisting beliefs about the self and the world, and features of the death event and its aftermath that have been most difficult and distressing.

Psychoeducation and Normalizing

The therapist should explain that many of the symptoms the patient has (e.g., yearning, disbelief, sense of disrupted future) are understandable reactions to the loss he/she suffered and that these occur transiently in most victims of loss. This helps to counteract negative interpretations the patient may have assigned to his/her reactions and may facilitate some initial acceptance of these reactions. To provide patients with a framework for understanding

the process they are going through, information could be given about the tasks people stand for when trying to come to terms with loss, the most important of which are accepting and fully realizing that the loved one is forever absent and confronting and adjusting to the implications of this reality (Worden, 2001).

It is important for the therapist to explain how separation distress, disbelief, and other CG symptoms may be maintained by negative beliefs (e.g., that one is unable to handle the consequences of the loss, that life is meaningless) and unhelpful strategies mourners can adopt to deal with the demands of the loss (e.g., anxious avoidance, giving up activities that were pleasurable before the loss). This explanation should be tailored to the patient's circumstances and illustrated with examples of how some of his/her beliefs and strategies may have interfered with recovery. All this should gradually enhance the patient's understanding of his/her problems. As part of the treatment rationale, the therapist emphasizes that altering unhelpful thinking patterns and terminating unhelpful behavioral and cognitive strategies will pave the way towards more detailed discussion of the implications of the loss and ways the patient can functionally adapt to these implications—things that are crucial in coming to terms with the loss.

Facilitating Integration of the Loss into Existing Autobiographical Knowledge

Facilitating integration of the loss is one of the leading targets of treatment. Thus, in order for the loss to get more "real" and to increase its connectivity with abstracted knowledge of the patient about himself, his life, and the relationship with the lost person, many interventions are more or less explicitly focused on reviewing and elaborating the meanings and implications of the loss and helping the patient to rearrange his/her internal and external world in a way that takes into account the loss event. It is important for the therapist to use subtle means throughout treatment to promote integration (e.g., zooming in on how it feels that the loss is permanent whenever patients tend to dwell on what is missed, calling the lost person by name when patients avoid doing so). In addition, it is considered useful to increasingly encourage the patient to reengage in healthy behaviors as treatment progresses. As described in more detail in succeeding text, this serves to reverse depressive

avoidance but also helps the patient to recognize and adjust to the demands of the loss.

Exposure is one of the key interventions of the current proposed treatment. It is specifically aimed at targeting the conceptualization's first core process. The procedure that we have tended to follow parallels Ramsay's (1977) modified flooding technique and is comparable to exposure as applied in PTSD treatment (cf. Foa & Rothbaum, 1998; Harkness et al., 2002). At the beginning of the procedure, patients are invited to tell the story of their loss, beginning with the events that led up to the death and moving on to the death itself, the moments of the leave taking and funeral, and the immediate aftermath of the loss. During this phase, the therapist identifies "hot spots"—recollections of moments that represent the most painful aspects of the loss. Examples are recollections of the moment one first heard about the unexpected death of one's loved one, memories of the physical deterioration of the lost person, and recollections of the moment one took leave of the loved one just before he/she died. Next, these hot spots are addressed more exclusively. The therapist encourages the patient to articulate the painful aspect of the loss the hot spots are related to, to face these aspects, and to fully connect with the feelings linked with these aspects. Problematic thoughts linked with key features of the loss are identified and discussed. This procedure is continued over the course of therapy, until symptoms indicative of poor integration of the loss (e.g., disbelief) have reduced considerably and the patient is capable of admitting to the most painful feelings, thoughts, and memories linked with the loss. If necessary, repeated imaginal reliving of circumscribed traumatic events surrounding the death can be used to promote processing of these events (compare the application of imaginal reliving in PTSD treatment, cf. Foa & Rothbaum, 1998).

As part of the exposure procedure, it is considered useful to discuss what is missed most now that the relative is dead and to systematically review the implications of the loss for one's everyday life. This forces the patient to fully connect with the reality of the loss. As such an explicit focus on what is lost may evoke intense emotions, care should be taken that the patient has social support during this part of treatment.

The exposure procedure as described here (which is mostly imaginal) could be combined with in vivo

exposure to situations/stimuli that are associated with the death. Visiting the hospital the loved one died at, talking to people who saw the accident happening in which one's child died, or visiting places the lost person always used to come may all help to accept that the loss occurred and to put it in the past. When directive confrontation is possibly overwhelming to the patient, exposure should be graded, starting with confronting the least troubling aspects and reminders of the loss and gradually proceeding toward exposure to more distressing ones. In a gradual format, a first step could consist of merely talking about the lost person. An intermediate step could be to visit the place the loved one died. A further step could involve reviewing the implications of the loss for one's present and future life.

The present exposure procedure should coincide with, or be preceded by, interventions that target the processes that have thus far kept the patient from fully acknowledging and elaborating the loss. For example, if negative global beliefs (e.g., "Life has got nothing to offer anymore") have thus far prevented the patient from facing the loss, exposure should coincide with methods to change these beliefs (e.g., cognitive restructuring). Likewise, if efforts to maintain an unchanged tie to the lost person or other anxious avoidance strategies have thus far blocked confrontation, these avoidance strategies should be addressed before the patient is encouraged to confront the loss.

Changing Negative Beliefs and Catastrophic Misinterpretations of Grief Reactions

Changing global negative beliefs and misinterpretations of grief reactions is another key target of the current approach. Imaginal exposure can play an important role with this target in that working through hot spots affords the opportunity to identify problematic cognitions about, for instance, the events leading up to the death and one's capability to cope with the loss. These can subsequently be discussed in treatment (cf. A. Ehlers & Clark, 2000; Malkinson, 1996). In addition, exposure to reminders of the loss can be used as a behavioral experiment to test catastrophic misinterpretations of grief reactions. In the current treatment, exposure procedures can thus fulfill two functions. First, they can be used to enhance the connectivity between information about the separation and other information in memory (as

described in the previous section). In this case, elaboration of the meanings and implication of the loss is emphasized during exposure to reminders of the loss. Second, they can be applied to test the validity of catastrophic misinterpretations. In this case, a key aim is to give patients the opportunity to experience that the things that they are afraid of (e.g., getting crazy, losing control) do not happen when they confront the reality of the loss.

Many conventional cognitive restructuring techniques as described in CBT literature may be used to change unhelpful beliefs and misinterpretations as well (cf. Beck, Rush, Shaw, & Emery, 1979). Examples are testing the logical consistency of beliefs through Socratic dialoguing, examining their consistency with empirical reality, and identifying and curbing recurrent thinking errors. When discussing global negative beliefs, it is our experience that it is useful to emphasize the functionality of these views. Yet, when doing so, it is important that the therapist shows acceptance for the negative views of the patient. The patient has experienced an event that likely has violated basic certainties and not “merely” suffers the consequences of easily changeable misinterpretations. Therefore, it would be a pitfall to dispute the validity of negative beliefs (“What evidence do you have that life is futile?”) without acknowledging that the loss likely has disrupted old certainties.

The more “intellectual” cognitive restructuring interventions and “behavioral” interventions such as exposure and behavioral activation (described in succeeding text) play complementary roles in altering maladaptive cognitions. Thus, a Socratic debate about an unhelpful belief is ideally followed by a behavioral assignment in which the validity of this belief is tested. For instance, pleasant event scheduling can be used to test that one is “no longer capable of experiencing pleasure.” Conversely, a behavioral assignment should be followed by a discussion on how the assignment altered negative cognition or strengthened positive thought.

Reducing Anxious and Depressive Avoidance

Exposure procedures are important in reducing anxious avoidance. They can help to correct misinterpretations of grief reactions and to diminish anxious attempts to keep away from internal and external reminders of the loss. Other interventions are considered useful as well in reducing anxious avoidance. For example, the *thought*

suppression experiment (A. Ehlers & Clark, 2000; Wegner, 1989) may be useful to curb the urge to suppress unwanted recollections or thoughts about the loss. The patient is encouraged to deliberately keep an unwanted thought or image out of awareness for some time, as a means to experience that this is impossible and that thought suppression increases rather than decreases the frequency of unwished thoughts.

When anxious avoidance manifests itself in attempts to maintain an unchanged connection to the deceased, it is considered useful to apply *response prevention*. Together with the patient, the therapist first identifies the short-term effects of these attempts (e.g., they help to escape from the pain that is felt when thinking about the irreversibility of the loss) and their long-term effects (e.g., they prevent the mourner from adjusting his/her internal and external world to the new situation). Next, thoughts that go behind the fear of confronting the loss are discussed. Finally, the patient is encouraged to reduce the compulsive behavior in a step-by-step manner. The procedure resembles response prevention as applied in the treatment of obsessive-compulsive disorder (OCD). Yet, an important difference is that (if all goes well) in OCD, the intentional nonuse of compulsive behavior has the effect that patients discover that the things they are afraid of do not happen. With CG patients, reducing efforts to maintain an unchanged connection with the lost person likely brings about painful thoughts and emotions that have to be dealt with in treatment.

Behavioral activation strategies—structured attempts to increase activities that improve mood and quality of life—can be used to diminish depressive avoidance (cf. Hopko, Lejuez, Ruggiero, & Eifert, 2003; Jacobson, Martell, & Dimidjian, 2001). An example is pleasant event scheduling. With this intervention, the patient is helped to schedule activities he/she previously enjoyed and that will likely give a sense of achievement (Beck et al., 1979). To facilitate a continued sense of self, emphasis should be placed on helping the patient to reclaim activities that were pleasurable and meaningful before the loss. Another presumably helpful intervention is systematic activation (Hopko et al., 2003). With this intervention, specific needs and goals of the patient concerning occupational, recreational, and social functioning are identified. For every selected goal, steps toward accomplishing the goal are explicated and ordered from

easiest to most difficult. Then, these steps are systematically worked through (see also Hayes, Stroschal, & Wilson, 1999). Sometimes new skills need to be learned to be able to achieve particular goals. For instance, learning assertiveness or communication skills may be necessary for patients who lack such skills and wish to give an impulse to their social life. Notice that systematically increasing healthy behavior targets all three core processes of the model as it facilitates recognition of (and thus integration of) the irreversibility of the separation, generates experiences that run counter to negative global beliefs, and stops the downward spiral of depressive avoidance.

General Course of the Treatment Phase

In its current form, the conceptualization posits that the three processes that are central to the present model interact in maintaining problems. Strictly speaking, this implies that targeting any of these processes can be expected to influence the other processes and that all three processes can be chosen as a focus of treatment. However, choosing a focus does not occur randomly but is based on a conceptualization of the patient's problems and working hypotheses that are checked and (if necessary) adjusted throughout treatment. As noted, in the initial phase of treatment, the therapist makes an individualized conceptualization of the presenting problems that includes information about the patient's idiosyncratic beliefs/interpretations, avoidance strategies, and characteristics of his/her memories of the loss. Then, working hypotheses are formulated about which and how processes are working together in maintaining the problems.

In our experience, CG symptoms can often be conceptualized as arising from two of the three processes working together. Examples are that they can be hypothesized to arise from fearful misinterpretations of grief reactions working together with anxious avoidance, depressive avoidance interacting with negative views of life and the self, and poor integration of the loss interacting with compulsive attempts to leave the tie unchanged. The therapist uses these working hypotheses to select interventions. Looking at the examples just mentioned, this could mean that, in a provisional treatment plan, the therapist selects a combination of cognitive restructuring and exposure to external reminders of the loss, behavioral activation and cognitive restructuring, and imaginal

exposure and response prevention. Treatment then continues along the lines of the working hypotheses and the general treatment plan. The current approach uses the pragmatic truth criterion. This means that the working hypotheses and treatment plan are considered to be adequate to the extent that they lead to alleviation of the patient's problems and that they are adjusted when they do not (cf. Jacobson et al., 2001).

Apart from the working hypotheses and treatment plan, there are various considerations that guide the course of treatment. For instance, the degree to which patients can handle intense emotions is taken into account when interventions are planned. With highly vulnerable patients, interventions such as imaginal exposure should be preceded by less-confronting interventions (e.g., writing assignments). Comorbidity is also taken into account when therapy is planned. When severe depression accompanies the CG symptoms, cognitive restructuring and behavioral activation may play a key role in the initial part of treatment. PTSD symptoms may be prominent when the death had a violent cause. In this instance, it is recommended first to address the traumatic events leading up to the death (e.g., with imaginal reliving) before attending to the loss itself. This is in keeping with literature on violent loss (Kaltman & Bonanno, 2003; Raphael & Martinek, 1997) and the current model's notion that PTSD symptoms are disruptive to the processing of the loss itself and should therefore be treated before addressing the separation.

SUMMARY AND PREDICTIONS

The conceptualization proposes three processes in CG: (a) poor integration of the separation with autobiographical knowledge, (b) negative global beliefs and misinterpretations of grief reactions, and (c) anxious and depressive avoidance. These processes in themselves are assumed to account for the *occurrence* of CG symptoms, whereas their interaction is thought to be critical to symptoms becoming *marked* and *persistent*. The model acknowledges the influence of background variables (individual vulnerability factors, characteristics of the loss event, and characteristics of the loss sequelae), but postulates that the three core processes in the model mediate this influence.

In keeping with our aim to offer a tool for research, many of the hypotheses the conceptualization gives rise to await empirical investigation. Future studies could, to

begin with, develop and improve operationalizations of the processes in the model. Some can be assessed relatively easily. For example, interview methods and questionnaires can be used to assess beliefs and emotions, and diary-keeping methods can be used to map out avoidance behaviors. The assessment of the model's first core process (poor integration) is more complex. Various well-known research paradigms are possibly useful in this regard.

As a first example, we could expect poor integration of the loss to manifest itself in information about the lost person being semantically close to thoughts about proximity to him/her and semantically distant from thoughts about his/her death. If indeed so, we could predict that, in a lexical decision task, following priming with a stimulus related to the deceased (his/her name or image) CG patients would be faster than nonpatients in identifying proximity-related words ("closeness," "proximity") but slower in identifying separation-related words ("absence," "dead") (cf. Mikulincer, Gillath, & Shaver, 2002). A second example is that we could expect poor integration of the loss to coincide with automatic behaviors aimed at restoring proximity to the lost person. If so, CG patients could be expected to display an attentional bias toward cues associated with the deceased. As a third example, we could expect poor processing to manifest itself in differences in the content and organization of narratives between CG patients and nonpatients (cf. Foa, Molnar, & Cashman, 1995). For instance, we could expect CG patients to use more present-tense verbs when asked to write about the deceased and to have less coherent narratives when asked to write about their future.

When valid operationalizations are available for all processes, different lines of research could test more specific predictions. Cross-sectional research could focus on the model's minimal prediction that all processes in the model are significantly related to CG. More specifically, we could expect CG severity to be associated with the loss being poorly linked with extant knowledge (as evidenced by the aforementioned information-processing deficits) and the presence of negative cognitions and avoidance behaviors. Encouragingly, there are recent findings that CG is associated with global negative beliefs (Boelen et al., 2003a; Boelen & Lensvelt-Mulders, 2005), as well as misinterpretations of grief reactions and anxious avoidance (Boelen et al., 2003a,

2004). Furthermore, from the model, we would predict the interaction among processes to be more strongly associated with CG severity than the processes in themselves. Finally, mediated by the three processes, background variables would be expected to influence clinical outcomes of bereavement.

A second line of research could be prospective and focus on the value of the background variables and the three core processes in predicting severity of CG over time. Third, experimental studies could test the postulated causal relations in the model. Treatment studies could be useful in which, for instance, we could expect therapies that succeed in altering misinterpretations of grief reactions to be more effective at reducing CG than therapies that fail to do so. Another approach would be to independently manipulate one of the three core processes and to examine the effects of this manipulation on other processes and the intensity of CG symptoms. For example, we could predict that enhancing the integration of the loss with extant knowledge (e.g., by means of encouraging mourners to elaborate on various aspects of the loss in a laboratory setting) would cause changes in unhelpful thinking and avoidance patterns and, in interaction with these changes, would lead to an alleviation of CG symptoms.

It is hoped that future research will enhance further our understanding of the mechanisms that are involved in the development and maintenance of CG. Eventually, all this will hopefully enable us to better help those who fail to recover from loss.

NOTES

1. This construct was briefly termed *traumatic grief*, but was renamed because of confusion with terms traumatic bereavement (loss due to violent causes) and posttraumatic stress disorder.

2. Little is known about the prevalence of CG. This is likely due to the relatively recent appearance of the concept in the literature. CG has been estimated to occur in 10% to 20% of all mourners (Jacobs, 1999). However, lower rates were found in a recent study by Maercker, Forstmeier, Enzler, and Ehlert (2005). They found that only 7.4% of widowed persons in an elderly sample suffered from CG. To compare: major depression has been found to occur in 16% to 24% of widowed persons across the first year of bereavement (Shuchter & Zisook, 1993) and to occur at subsyndromal levels in at least one-third of widowed persons in the first two years of spousal bereavement (Zisook et al., 1994). With respect to PTSD, Schut et al. (1991) found 20% to 31% of a sample of spousally bereaved persons to

meet criteria for PTSD over the first two years of bereavement, with 9% meeting criteria at all four points of data collection. Comparable rates of PTSD were found by Murphy et al. (1999) in a study of parents bereaved by the violent loss of their children. Little is known about comorbidity rates. Insightful yet is that, in a community-based sample of 67 widowed persons, Silverman et al. (2000) found that 25% met criteria for CG, depression, and PTSD. This indicates that these syndromes can co-occur but are not overlapping constructs.

3. Notice that these manifestations of “continuing bonds” may thus reflect strategic attempts to keep the loved one alive as a means to avoid the reality of his/her death. Yet, similar types of behaviors may also be more habitual in nature in case they reflect automatic attempts to restore proximity to the lost person, as a result of the loss being insufficiently integrated into the autobiographical database (i.e., the “searching behaviors” described in the section The Role of Poor Integration of the Loss in Persistent Attachment Reactions).

4. The term *interaction* is not only used in a narrow statistical sense, but more broadly to illustrate that the co-occurrence of these processes has a nonadditive effect on CG symptoms. How exactly the processes work together needs to be investigated in future research. The first process (poor connectivity) is assumed to be crucial in causing some of the key symptoms of CG. Yet, this is not to say that this process is central in the model with the second and third processes playing a moderating or mediating role. Mediation would require that process 1 would temporally precede processes 2 and 3, with these last processes explaining *how* poor integration causes problems. Moderation would require that processes 2 and 3 temporally precede process 1, with processes 2 and 3 explaining *the conditions under which* poor integration operates to produce CG without having a direct correlation with this first process (cf. Baron & Kenny, 1986). Pending future studies that elucidate how the three processes work together, in terms of the taxonomy offered by Kraemer, Stice, Kazdin, Offord, and Kupfer (2001), the three processes are best described as partially overlapping risk factors.

5. If we would hypothesize that the background variables determine the conditions under which the three processes lead to CG without these variables being related with the three processes, or, conversely, would say that the three processes determine when the background variables lead to CG, then we would speak of moderation. However, this is not what we assume.

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