COGNITIVE THERAPY FOR TRANSDIAGNOSTIC COMPLICATED GRIEF

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COGNITIVE THERAPY FOR TRANSDIAGNOSTIC COMPLICATED GRIEF

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Introduction to the CBT-grief individual format

Dear reader,

This manual is intended for individual treatment of Prolonged Grief Disorder and other forms of complicated grief disorders, meaning psychological disorders that arise after a loss and are linked to the loss by the bereaved. Prolonged grief disorder and loss-related depression or PTSD are the most common forms of complicated grief and there is often a high degree of comorbidity between these disorders (Komischke-Konnerup et al., 2021). Cognitive behavioral therapy has been shown to be effective in treating prolonged grief disorder (Boelen et al., 2007) as well as other forms of complicated grief reactions (Komischke-Konnerup et al., 2024). Screening for symptoms of prolonged grief disorder, as well as depression and PTSD, should be done before and ideally also after the CBT-grief treatment program. Treatment should generally only be offered to bereaved individuals with clinically relevant symptoms of one or more of these disorders. A certain amount of time should have passed since the loss – typically at least six months, although starting after three to four months may be an option if deemed clinically relevant. In English and many other languages, The Traumatic Grief Inventory-Self Report Plus (TGI-SR+) can be used (Lenferink et al., 2022). In Danish and several other languages including English, the Aarhus PGD Scale (A-PGDs) is recommended when screening for prolonged grief disorder (O'Connor et al., 2023). A-PGDs is freely available in short or long forms at https://psy.au.dk/en/research/research-centres-and-units/unit-for-bereavement-research/resources-to-professionals/rating-scales-and-interviews

Relevant education, in-depth knowledge of and clinical experience with cognitive behavioral therapy, as well as clinical experience working with grieving individuals, are prerequisites for using this manual. Regardless of experience level, it is strongly recommended to receive ongoing supervision from a supervisor experienced in CBT-grief and to ensure opportunities for collegial consultation in daily practice.

The program outlined in this manual usually consists of 12 sessions of approximately 50 minutes. All potential clients begin with an individual intake interview, during which the presence and severity of symptoms related to the different types of complicated grief reactions (PGD, loss-related depression, PTSD, and possibly anxiety) are assessed, and the treatment plan is introduced (see below).

Issues that may be addressed during the preliminary interview:

- To what extent does the client feel able to confront the reality of the loss and allow the accompanying sadness and pain to be present?
- Does the client have difficulties regaining trust in themselves, in others within their surroundings, in life, or in the future?
- Is the client capable of engaging in helpful and potentially enjoyable activities that could assist them in adapting to the new situation without the person they have lost?

In addition, the content of the treatment is explained and linked to the three central tasks of CBT-grief:

1. To confront the loss and the accompanying pain
2. To regain trust in oneself, others, life, and the future
3. To engage in helpful activities that promote adaption to the new life situation

The term "Tasks" refers to the psychological work undertaken by the bereaved in therapy to manage their grief. These are ongoing tasks that the bereaved must repeatedly address and engage with throughout the treatment process (Boelen et al., 2006; Boelen & Eisma, 2022). These tasks can also be seen as a way of being in the grief that adaptively promote adjustment to the new daily life without the deceased.

Below is a suggestion for how the three tasks can be presented. Throughout the manual there will be suggestions on how the different elements of CBT-grief can be presented, but the therapist is always welcome to use their own words.
"In this treatment we will try to achieve your treatment goals by working with the three tasks I just mentioned. In the first part of the treatment (session 1-5), I will help you work on Task 1: to confront the loss and the associated pain. We will do this by using exposure. Exposure is another term for "being in contact with". We work with the first task by helping you expose yourselves to the reality and consequences of the loss as well as the emotions related to the loss. In session 6 to 10, we will work on Task 2. In this task, we use cognitive therapy. Cognition is another term for thoughts. We work with the second task by using cognitive therapy to help you identify and change negative thoughts about yourselves, others, life, and the future into more positive and realistic thoughts. In the thirds part of the treatment (session 11 and 12), we will work on Task 3. Here, we will explore activities you used to engage in before the loss occurred and examine which activities you could gradually reengage in to help you adjust to the loss and turn more toward the future".

For each of the three main parts of the therapy, there is a general introduction to that part. Following this, a suggested agenda for each individual session is provided. The therapist is encouraged to read the entire manual thoroughly before use and to then re-read the general introductions and often revisit them during the therapy as needed. At the end of the document, there is an appendix with attachments and handouts. These should also be read carefully at the beginning and revisited as necessary.
Print the manual here along with the attachments and use it directly to guide the individual sessions and as a reference during the therapy. It may also be a good idea to add your own notes and ideas throughout the sessions as you work with the manual multiple times.

Enjoy the reading and, most importantly, the work with clients dealing with complicated grief reactions.

Best regards,
Paul A. Boelen and Maja O'Connor

Introduction

If possible, the client has been asked to read Appendix A before the first session. Alternatively, Appendix A is given to the client in the first session. Appendix A contains information about the cognitive model that forms the frame of the treatment. In the beginning of the first session, the focus is on information about this model.
Issues that can be addressed are:

I. To what extent does the client feel that he/she is able to confront the reality of the loss and allow the presence of the accompanying sadness and pain?
II. Does the client have trouble regaining a sense of confidence in himself/herself, other people in the surrounding environment, life, or the future?
III. Is the client able to engage in helpful and potentially pleasurable activities that can help him/her to adjust to the new situation without the person that he/she has lost?

In addition, the content of the treatment is explained and connected with the three tasks:

I. Confronting the loss and the pain that goes with it
II. Regaining confidence in oneself, others, life and the future
III. Engaging in helpful activities that promote adjustment to the new life situation

"In this treatment we will try to achieve your treatment goals by working on the three tasks we just mentioned. In the first part of treatment (sessions 1-5), we help you to achieve Task I. To confront the loss and the pain that goes with it. We will do that by using exposure. Exposure is another word for "being in contact with". We work with the first task by helping you to expose yourself to the reality and the consequences of the loss as well as the emotions associated with the loss. In sessions 6 through 10, we work on Task II. We use cognitive therapy for this. Cognition is another word for thoughts. We will be working on the second task by using cognitive therapy to help you to change negative thoughts about yourself, others, life and the future into more positive thoughts. In the third part of treatment (session 11 and 12), we will work on Task III. Here we will explore what activities you used to engage in before this loss occurred, and what activities you could gradually reengage in, in order to help you to adjust to this loss and orient toward the future."

SESSION 1 TO 5: EXPOSURE THERAPY

Introduction

The underlying principle of exposure therapy is that *avoidance* is important in the development and the maintenance of different forms of complicated grief. In most cases, this avoidance relates to *the reality of the loss* and to *feelings associated with the loss.*
People with complicated grief rationally know that the loss occurred and that the separation is irreversible, but they tend to avoid this fact and what it means to themselves, their lives, and their future. This avoidance behaviour is often strengthened by fear: in many cases, clients are afraid of the emotions they experience when they confront the implications, irreversibility, and pain of their loss. Clients often fear that the experience of these emotions will 'drive them crazy' or that they will 'lose control'.

Avoidance of the loss can manifest itself in different types of behaviours. For example, it may include not visiting the grave, not talking about the deceased, actively suppressing or denying particular thoughts, feelings, and memories, and avoiding particular external or internal stimuli that are reminders of the loss. On the other hand, clients may also be inclined to engage in behaviour with the purpose of maintaining a strong connection with the deceased. This can result in behaviour such as visiting the grave daily, talking about the deceased as if he/she is still alive, refusing to talk about the future, only talk about the past, or stop doing activities that are not associated with the deceased (work, hobby's, social relations). All these types of behaviours can have the same goal, namely to refrain from confronting and elaborating the reality of the fact that the person is dead and gone forever and the pain that accompanies this reality.

During the exposure sessions, different means and assignments are used to reduce the avoidance of the loss, and to help clients to gradually (but certainly) confront the fact that the deceased person truly will never return, and to reflect upon the implications of this reality for themselves, their lives, and their futures. The goal is that the clients learn and experience that they are able to handle their feelings associated with the loss (without going mad or losing control) and that confronting the loss helps them integrate the loss into their life and to orient toward the future without the lost person. In terms of the cognitive model, exposure is primarily concerned with Task I: Confronting the loss and the pain that goes with it.

Steps in the exposure treatment

The exposure treatment comprises four steps:

Step 1: Explore the rationale of exposure
The treatment rationale explains that avoidance is a very common and understandable reaction. However, when the avoidance continues and is driven by fear, the processing of the loss strands. Using a systematic approach, a reduction in the client's avoidance is promoted.

Step 2: Determining what the client is specifically avoiding
After explaining the treatment rationale, the therapist and client formulate hypotheses about the type of stimuli that are specifically avoided. Four categories of avoidance strategies can be distinguished.

1. **Avoidance of the reality the loss:** In many cases, clients have a general tendency to avoid internal and external stimuli that remind them of the fact that the separation from their loved one is irreversible. They suppress feelings and thoughts about the loss. For example because they are afraid of what will happen if they allow them - or

because they simply find it too painful to take time to elaborate on what the loss means to them.

2. **Avoidance of specific stimuli, situations, objects or people:** Some clients fear and avoid very specific stimuli, such as particular photos, film material showing the deceased, music (e.g., played at the funeral), or places (e.g., site of the death). This avoidance is similar to phobic avoidance behaviours (seen in simple and social phobias).

3. **Avoidance of memories:** It happens that people avoid or suppress memories or images of certain events surrounding the loss. For instance, when a loved one died because of a traffic accident, there are usually all kinds of very painful memories, which people would rather not consider. However, other memories can also be very sad or painful and tucked away. For example, some people would rather not think about the funeral because they would become intensely sad.

4. **Compulsive proximity seeking:** It can also happen that people try to maintain the connection to the deceased as if nothing had changed, spend inordinate amounts of time in imaginal company with the deceased person or engage in other activities to keep the memory of the deceased person alive. This behaviour may serve to avoid the reality and pain of the loss.

Step 3: Selecting specific exposure interventions

Different types of interventions may be used to gradually expose clients to thoughts, memories, and feelings connected with the irreversibility of the loss. Below, examples are given.

1. **Avoidance of the reality of the loss.**
   Intervention: General exposure: With general exposure, the therapist uses different tools to encourage the client to realize what it means that the loss is irreversible. Different tools can be used: talking about the deceased (using his/her name and where relevant using the words "… when Peter died" or "….that Peter is dead"), reminisce, looking at photos, listening to music, bringing objects that are linked to the deceased (e.g. clothes), talking to others about the deceased and the loss.

2. **Avoidance of specific stimuli, objects, or people.**
   Intervention: Stimulus exposure: In stimulus exposure, the client is helped to gradually confront feared stimuli (as in behavioural treatment of simple phobias). The purpose of this intervention is to show clients that they are able to confront their fears and that the intense emotions that may be felt when confronting the feared stimulus always diminish automatically because of "habituation" (a form of learning in which an instinctive response to a stimulus decreases after repeated or prolonged presentations of that stimulus).

3. **Avoidance of memories.**
   Intervention: imaginal exposure: In imaginal exposure, the client is asked to repeatedly recall memories (or construct images) of specific situations (e.g., circumstances causing the death). The client has to imagine that he/she relives these moments, and describe what he/she perceives, thinks, feels etc.. The procedure resembles "prolonged imaginal exposure" as applied in the treatment of posttraumatic stress disorder (PTSD).

4. **Compulsive proximity seeking**
   Intervention: reducing the 'compulsive grieving behaviour': In this intervention, clients are encouraged to decrease the time they spend on activities that are engaged in to maintain proximity to the deceased on the one hand, and to increase other activities that are not related to the loss on the other hand.

Step 4: Points of attention when applying the exposure interventions
During the actual exposure, therapists should consider several points:

Explain the rationale of exposure repeatedly: Because exposure may elicit strong emotions and encourages clients to confront stimuli that they prefer to avoid, it is useful to be clear about the rationale and to repeat it through the treatment sessions:

"I can understand that is it not easy to feel the pain and to focus on the painful reality of the loss. But, as I mentioned before, to integrate and process the loss, it is very important to gradually but certainly focus on what this loss means to you, and how it feels that your loved one will not return. Step by step, doing so will help you."

Use principles from cognitive therapy during exposure: Exposure can be framed as a behavioural experiment in which fearful cognitions about the consequences of confronting particular stimuli are tested. It is helpful to make these cognitions explicit before the actual exposure:

"You are afraid of going back to the place where your husband died. Can you tell me what you think might happen exactly when you go there? What do you expect will happen?"

It is also important to return to these cognitions after the exposure:

"In advance you feared that going to the place where your husband died would elicit extremely painful and unbearable thoughts and feelings. Now that you went to the place, what have you learned? Did what you feared happen?"

Give the client control: Explain to clients that they can always give a sign when they feel that the therapist is too confrontational or feel that the distress level is going up too high.

"I know that focusing on the loss may be very painful. But of course I don't want to distress and trouble you too much. And you should never feel tormented. Whenever you think I am too confrontational or you don't feel like continuing to focus on a specific topic anymore, I trust that you will tell me."

TIP! Use a stress thermometer (**FORM 1**, p. 73), to give the client a sense of control. Ask the client to indicate his/her stress level on a 0 to 10 scale, and repeat every few minutes. Take a step back if the client experiences the stress level to be too high (e.g., 7 or 8).

Create an atmosphere of safety: The therapist is there to support the client and to create a safe environment where everything can be felt, said, and shared. To this end, the therapist should have an empathic and sensitive attitude all the time, and constantly monitor the client's responses and engagement in order to ensure that the interventions he/she applies are not too difficult, too exhausting, or too hard. In case the treatment appears to be too heavy, if the client doesn't understand the importance of the treatment anymore, or if the

client thinks about quitting the treatment, the therapist should take a step back (e.g. by addressing a less 'dangerous' topic).

Monitor the therapeutic alliance: In cases where the therapeutic alliance is not fully established, the client may not want to do the things he/she fears. It is thus of great importance for the therapist to monitor the therapeutic alliance. As soon as it becomes clear that the client is not motivated, cancels appointments or refuses to do the assignments, this should be discussed explicitly. Part of the therapist task includes asking the client if there is anything *the therapist* could do differently or better to keep the client engaged and motivated in the therapy.

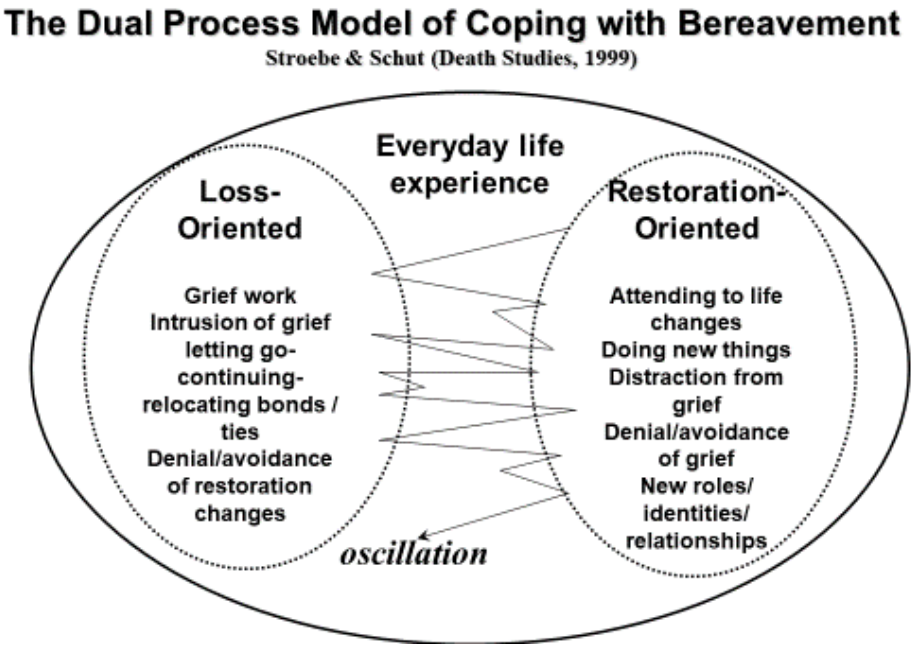
Encourage the client to do their homework assignments: During the exposure sessions (but also the rest of the treatment) it is repeatedly emphasized that exposure treatment requires active participation of the client. A lot of work is done during the session with the therapist, but most work is done by the clients themselves, in-between sessions.

TIP! Always discuss therapy related problems in your team and with your supervisors.

SESSION 1

Psychoeducation on grief reactions
Reflection on the psychoeducation about the cognitive model of prolonged grief disorder
Introduction to exposure
Determine what the client is avoiding
Explanation of the course of treatment

Grief and grief reactions
In providing psychoeducation on grief, "The Dual Process Model of Coping with Loss" is (see Appendix B). The therapist has a copy of the model on the table or draws the model on the whiteboard.



"Grief is a natural human reaction to the loss of a loved one. Grief can be said to contain two main challenges: On one hand, it is about confrontation with the loss and getting used to the fact that the person you have lost is gone forever. On the other hand it is about finding out, how to live your life without the loved one as a living sparring partner."

In the **loss-oriented proces**, you deal with "what happens in me when I think about the loved one I lost?" You find a way to create a bond to the deceased that fits the fact he or she has died and is no longer a living person but a memory. In the loss-oriented process, you are often in close contact with the feelings of grief, and this can be exhausting in the long run.

In the **restoration-oriented proces**, you deal with the changes and challenges in your life that the loss has lead to. It can be taking care of tasks the deceased used to do (e.g. paying bills, cooking, changing the oil in the car etc.) or dealing with changes that are a direct consequence of the loss (e.g. new financial situation, selling the house, living alone). It can also be doing new things you always dreamed of or aquiring new roles in life.
It can be difficult to deal with these challenges, but it can also give a much needed break from the painful feelings of grief.

Adaption to the loss happens through **osccilation** between the two processes. Sometimes you will be overwhelmed by grief, other times fully occupied by coping with the daily life without the deceased. You rarely decide for yourself when you are involved in which of the two processes.

The oscillation is a kind of "dosage mechanism" which facilitates that you little-by-little in suitable doses, can come to terms with the meaning of the loss you have suffered, so the loss gradually becomes a part of your life-story, and the person you are now.

Complicated grief reactions
Sometimes the grieving process becomes stuck or fixed in a way that leads to suffering, and prevents you from living a satifying life. It is this type of grief reactions we are working with here. There are 3 different ways that the grief typically can get stuck. These are described in Appendix A.

Reflection on the psychoeducation about the cognitive model
Before this first session, the client has been ask to read Appendix A (Adjusting to the loss of a loved one: Three tasks) that includes information about the cognitive model that is used as a framework for this treatment. In the beginning of this session, attention is paid to this model.
Issues that can be addressed are:

I. To what extent does the client feel that he/she is able to confront the reality of the loss and allow the presence of the accompanying sadness and pain?
II. Does the client have trouble regaining a sense of confidence in himself/herself, other people in the surrounding environment, life, or the future?
III. Is the client able to engage in helpful and potentially pleasurable activities that can help him/her to adjust to the new situation without the person that he/she has lost?

In addition, the content of the treatment is explained and connected with these tasks.
Part of this may have already been reviewed in a preliminary conversation. If so, one can summarize briefly again. If there has not been a preliminary conversation, the following is reviewed with the client and Appendix A is handed out and read for the next session:

"In this treatment we will try to achieve your treatment goals by working on the three tasks we just mentioned. In the first part of treatment (sessions 1-5), we help you to achieve Task I. We will do that by using exposure. Exposure is another word for "being in contact with". We work with Task I by helping you to expose yourself to the reality and the consequences of the loss as well as the emotions associated with the loss. In sessions 6 through 10, we work on Task II. We use cognitive therapy for this. Cognition is another word for thoughts. We will be working on the second task by using cognitive therapy to help you to change negative thoughts about yourself, others, life and the future into more positive thoughts. In the third part of treatment (session 11 and 12), we will work on Task III. Here we will explore what activities you used to engage in before this loss occurred, and what activities you could gradually reengage in, in order to help you to adjust to this loss and orient toward the future."

Introduction to exposure

The exposure can be introduced as follows:

"In the process of coming to terms with loss, confronting the reality of the loss and the pain that goes with that reality is very important. Put in other words: it is important that people mentally and emotionally accept that the loss has occurred. This is central to Task I of the

three tasks in the cognitive model. However, it happens that people have difficulty with that, and that they avoid admitting their feelings and thoughts about the loss.

That is understandable. Feelings about a loss can be so intense that people are afraid of these feelings. The consequences of a loss can also be so painful that people prefer not to think about them. While these avoidance reactions are understandable, the avoidance can become increasingly severe, and people may become increasingly frightened to confront the loss and allow the presence of the feelings connected to the loss. As a result, the processing of the loss can get stuck, and as a consequence, the pain of the loss continues to be very distressing, and interferes with the person's satisfactory functioning in different areas of the person's life.

In the next few sessions, we will examine to what extent you are inclined to avoid thoughts, feelings, and memories associated with the loss of X. Next, we are going to help you confront the reality of the loss, and reflect on what the loss means to you. In addition, we will reflect on the emotions connected to this reality. All this is done to help you to adjust to the loss and, in terms of the cognitive model, to achieve the first task of grief. Does this explanation make sense to you?"

Determine what the client is avoiding

Next, the therapist and the client try to determine the avoidance strategies and behaviours the client engages in:

"People experiencing complicated grief can avoid different things**. First** of all, they can suppress feelings and thoughts about the loss, for example because they are afraid of what will happen if they allow the presence of these thoughts and feelings – or because they simply find it too painful to really think about and reflect on what loss means to them. **Secondly,** some people of avoid specific places, such as the grave of the deceased, or objects, such as photographs of the deceased. **Third**, it happens that people suppress memories or images of certain events. For example, some people would rather not think about the funeral, because they would become intensely sad. After a traumatic loss, meaning a loss caused by an accident, people may avoid memories connected with the traumatic circumstances of the loss**. Fourth**, some people can become very involved with the loss trying to maintain proximity to the deceased. For example, some people go to the grave every day because they don't dare to distance themselves from the deceased."

"In what parts of these examples do you recognize yourself? Which of these examples correspond most with your problems? Do you recognize yourself in any of this? Are there feelings, places, or memories that you avoid? Or do you realize that you have difficulties focusing on anything else but the deceased? Or do you have more trouble expressing your sadness and confronting the reality of the loss?''

Sharing hypotheses about avoidance behaviours

Most of the time, the therapist will have some ideas about what the client avoids, based on the information discussed in previous sessions. She/he can present these to the client.

"I get the impression that you are not avoiding specific situations or thoughts about X, but that you have a particularly hard time confronting the actual reality of the death; the fact that the separation is forever and cannot be made undone. The truth hits you again every time you think about the fact that your son is no longer here. Is it true that you struggle with accepting the reality of the loss in this way?"

“I get the impression that you are very occupied with the loss. You told me that you find it difficult let go of X. You think that you should visit the grave daily. You also explained that you feel like you abandon X, if you are less occupied with him, and continue with your own life. Is this true for you?’’

“I remember that you told me that the funeral was very unpleasant, and that you would rather not think about it. At the same time, you tell me that you feel guilty about the funeral and have nightmares about it. Is it true that you try to avoid these memories?’’

TIP! As a therapist, it is important that you have hypothesis about what the client avoids, but you have to be cautious when you present your ideas to the client (e.g. “Please correct me if I am wrong, but I get the impression that you find it particularly hard to think about what your son experienced in the final moments of his life, after being hit in this accident. You seem to be trying to avoid these thoughts and images. Is that true for you?”)

Based on this exchange, the therapist and the client create a brief overview of what the client tends to avoid. The therapist writes this down on the whiteboard. The avoidance behaviour is categorized into four types of avoidance behaviours:

1. Avoidance of the reality of the loss
2. Avoidance of specific situations, objects and people
3. Avoidance of images and memories of circumstances surrounding the loss
4. Compulsive proximity seeking

Explanation of the course of treatment

‘’We have seen that it is difficult for you to confront different kinds of stimuli that are associated with the loss. As a result, it has been difficult to confront the loss and the pain that goes with it, and to start adjusting your life to this loss. In the following 4 or 5 sessions, we will address and focus on the feelings (thoughts, places, memories) that you preferably wish to avoid. You might think that this is scary, but we will do it step by step. We will always stop if you feel that it becomes too distressing or unpleasant. By doing this, you will be experiencing three things.
First, you will experience that you are capable of handling the feelings (thoughts, places, memories) associated with the loss. Now you are probably thinking that you will not be able to bear the pain when you think back to the accident that took your son’s life (or: the pain connected to the fact that you’ll never see you husband again), but I predict that you will experience that you are in fact capable of handling your feelings.
Secondly, you will experience that very gradually, talking about the most painful aspects of the loss will relieve your pain. It may sound strange, but to some extent, you will actually get used to the pain.
Thirdly, focusing on the details of the loss and what the loss means to you will help you to think about the steps that you can take to integrate the loss into your life, to make new plans for the future, and to reengage in all kinds of work-related and social activities that were meaningful and provided you with joy before the loss.”

Homework

The client is instructed to complete **FORM 2** (Things I prefer to avoid) for the next session. Alternatively, the client can compose a timeline (**FORM 3)** to get an overview of which thoughts, feelings and actions are relevant to work with in therapy.

SESSION 2
Decide which avoidance reactions to be addressed first
Choose exposure-techniques
Start exposure

Finish overview of the client's avoidance behaviour

Based on the client's homework (**FORM 2** or **FORM 3**), the therapist and the client again compose an overview of what the client avoids. The therapist writes this down on the whiteboard. The therapist should try to be as specific as possible in writing down what is avoided. This will make it easier to do the actual exposure later in treatment. It is also important that the avoidance behaviours are categorized in the four avoidance strategies mentioned previously (1. Avoidance of the reality of the loss, 2. Avoidance of specific situations, objects and people, 3. Avoidance of images and memories of circumstances surrounding the loss, 4. Compulsive proximity seeking).

Depending on the problems, this overview can be more or less extensive. For clients where the two most important problems are 'experiencing disbelief' and 'difficulties accepting the loss', the overview could look like this:

> **Things I prefer to avoid**
> Accepting and expressing my sadness
> Realizing that the deceased will never come back again

In clients who avoid many things, the overview could be more extensive:

> **Things I prefer to avoid**
> The grave of the deceased
> Memories of the funeral
> Accepting and expressing my sadness
> Looking at photos of the deceased

Deciding which avoidance reactions to be addressed first

Next, it is determined in what order the avoidance reactions should be addressed, and which one should be addressed first.

"We established that there are several things you avoid (shortly mention the list). We will focus on these things, but first we will determine the order in which we will address them. Do you first want to focus on the avoidance of the grave, or on the avoidance of certain memories?"

If the client is not sure about the order, the therapist tries to find out what stimuli the client feels sufficiently comfortable with to address at this stage, and which stimuli are currently too distressing.

"Let's start with figuring out what is the most difficult for you. What is still too scary for you at the moment? And what aspect of your avoidance would you feel comfortable to work on now?"

The therapist summarizes the order in which the avoidance reactions will be addressed in the next sessions:

''In summary, we will first work on the avoidance of the grave, and after that we will work on the avoidance of the memories of the funeral.''

Select a form of exposure

The therapist can select one of four forms of exposure to target the avoidance of the client.

Dominant avoidance of the client?	**Form of exposure?**	**Submanual**
Avoidance of the reality of the loss	Exposure to the reality of the loss	A (p. 17)
Avoidance of memories	Imaginal exposure	B (p. 22)
Avoidance of specific situations, objects and people	Stimulus exposure	C (p. 24)
Compulsive proximity seeking	Reducing 'compulsive grieving behaviour'	D (p. 26)

Use the stress thermometer (**FORM 1**) regularly throughout each session.
Each of these four forms is explained in a submanual (Submanual A, B, C, and D below). In this second session, the therapist already begins with one of these submanuals.

TIP! If the client has difficulties confronting the loss in general, without avoidance of specific places, object or memories, then Submanual A (General exposure) is used.

TIP! Discuss in supervision and team meetings when you are not sure which exposure treatment to choose.

SESSION 3, 4, and 5

Discuss homework from previous session
Perform an exposure exercise in session
Explain new homework assignment

In session 3, 4, and 5, one or more of the four submanuals (described below) are used. Each of these sessions has roughly the same structure, including the following issues:

Discuss homework from previous session

Each session starts with discussing the homework. The client is praised/recognized for his/her efforts. In case the client did only little, or none of the homework, this is also discussed.

TIP! Make sure the therapy is not too distressing for the client. Take a step back if the client cannot handle the homework, or if it seems that the client's state is worsening. Encourage the client to get support from his social environment.

Perform an exposure exercise in session

Submanual A, B, C, and D below are used for 20 to 30 minutes to perform exposure. This is done in each of the sessions. In these sessions, the therapists should try to ensure a smooth transition between the forms of exposure (described in the submanuals). This can likely easily be done because all four forms of exposure are focused on the same goals:

(i) Helping and encouraging the client to confront the reality of the loss.
(ii) Reducing unhelpful avoidance behaviours.
(iii) Promoting the expression of emotions about the loss.
(iv) Reducing the degree of distress that the client experiences while she/he thinks in detail about the implications of the loss and the fact that the loss is permanently irreversible.

Explain new homework assignment

All exposure interventions include their own homework assignments. As a general guideline, clients are expected to spend 4 hours each week (for a maximum of 30 minutes each time) working on their homework assignments.

TIP! It is important to repeat the three tasks of grief from time to time and to emphasize that these first sessions are focused on the achievement of Task I. Putting exposure in the framework of cognitive model may encourage the client to take the necessary steps to confront, reflect upon, and work through the reality of the loss and the accompanying pain.

SUBMANUAL A: EXPOSURE TO THE REALITY OF THE LOSS

The aim of this exposure is to face the fact that the loss is irreversible, to focus on the implications of this reality and to work through the emotions connected with this realization. What clients fear most of all is that they cannot bear the pain connected with the reality of the loss. Therefore, one further aim of exposure to the reality of the loss is that clients experience that they can bear the pain better than they had expected, and that confronting the reality and pain of the loss actually brings relief.

Explanation

"Considering the painful reality of the loss and the feelings and thoughts associated with it is perhaps the most difficult aspect of a grieving process. It is not strange that you would rather avoid that. In the coming sessions we will gradually bring you into contact with what you would rather avoid, namely reflecting on the irreversibility of this loss, what this means for you and your life and future. We will also work with emotions associated with the loss. At this time, it may seem scary to talk about what the loss really means and to admit to and express the feelings associated with this reality. However, you will experience that it is less scary than you fear. It may not be easy to reflect in detail on what this loss means to your current life and your future, and to face the pain that goes with that. In the end, however, you will find that you get more and more control over your thoughts, feelings and memories. You will also find that you will be able to process your feelings of mourning better if you are working on them, instead of avoiding them."

TIP! This protocol refers to 'the deceased' or X. Instead of using this word, the therapist uses the name of the deceased. Hereby, the therapist confronts the client to the reality of the loss through the words he/she uses.

During the exposure

The therapist uses the following techniques to foster exposure to the reality of the loss:

1. Zooming in on the circumstances of the loss
2. Retelling the last moment with the deceased person
3. Talking about what is missed the most
4. Working with objects and photos
5. Focusing on the future and what will be missed

1. Zooming in on the circumstances of the loss

'Zooming in on the circumstances of the loss' is a powerful tool to confront avoided feelings and thoughts.

"You have already told me several things about when X died. But can you tell me again what happened? What happened the days before his death? How (at what time, on what day) did he die exactly? How did you hear about it? What happened afterwards?"

While listening, the therapist tries to figure out what the most painful elements of the death of X and the circumstances surrounding the death are. That is, the elements that are most meaningful and elicit most intense feelings. The therapist should formulate hypotheses about these painful elements, check these hypotheses with the client, and make sure to confront the client with these elements.

"'You told me that you didn't arrive in time at the hospital when X was lying there, and that you weren't there when he died. This seems to be the most painful element of your story. Am I right? Can you tell more about 'arriving too late at the hospital?' How did you hear that he was death? How did you feel at that moment? How are you feeling about that now?''

Clients are often inclined to avoid specific emotions connected with circumstances of the loss (sadness, anxiety, anger, feelings of guilt, etc.). It is important that the therapist tries to clarify these specific emotions and to encourage the client to reflect upon these:

"It looks to me like you get angry when you think about the days after the death. Is that correctly observed? Tell me something more about that while you try to hold on to that anger."

The therapist focuses on and responds to the client's (non-verbal) emotional reactions:

"I notice that you suddenly became extremely sad. What makes you so sad? Try to hold on to that sadness."

TIP! As a therapist it is important to formulate hypotheses about the most painful elements of the loss, that is, the elements that are most meaningful and elicit the most intense feelings. It is these elements that the therapist should (gradually) confront the client with.

2. Talking about the last moment with the deceased person

Memories of moments surrounding the death can be particularly emotional and confrontational:

"Think back to the moment where you last spoke with (the deceased)… Describe how that was… How do feel when you look back on that moment?''

TIP! Read the protocol for 'Imaginal Exposure' in submanual B (p. 22) for general inspiration for recalling memories.

The therapist also asks about memories that are associated with painful feeling or thoughts:

"You told me that you miss talking to her. Could you describe the last moment that you talked with her? How do you feel about not being able to talk to her again?''

"The fact that you had these conflicts in the days before your husband died is still bothering you. At the same time, it is difficult to think back to these moments. Can you describe one particular example of a conflict you had, in the final days of his life?'

The recall of memories encourages the client to reflect upon the painful aspects of the loss. In doing so, the client will learn and experience that:
(I) She/he doesn't have to be afraid of her/his feelings.
(II) Even though feelings and memories can be painful, the client can handle them.
(III) She/he can control his feelings instead of her/his feelings controlling her/him.

3. Talking about what is missed the most

Talking about what is missed the most now that the one's loved one is dead is something that clients generally find difficult. That is because this most strongly confronts them with the

irreversibility and implications of the loss, but also because this will elicit the most intense yearning and longing. 'Talking about what is missed' is, however, the most important and powerful component of the exposure treatment.

'Talking about what is missed the most' includes two elements:

(A) Retrieving positive thoughts, feelings, and (gentle, tender, fond) memories connected with specific characteristics of the lost person, meaningful everyday moments with him/her, and meaningful life events experienced together.

(B) Confronting the fact that one will never be able to enjoy these characteristics and everyday moments again, and that one will never be able to share what was experienced together now that X is gone.

Examples with focus on characteristics of deceased person:

"Could you give a description of X; what did he look like? What clothes did he used to wear? What did he do? What did he love? What did he hate? What are specific characteristics of him…?"

[The client is given time to zoom in; the therapist prompts for questions that encourage the client to describe details, particularly those that seems meaningful and elicit feelings of grief.]

"When considering all this, can you tell me how it feels to think of all these typical characteristics of your husband."

"And when thinking of all this, how does it make you feel when you are confronted with the fact that you will never be able to enjoy all these characteristics again?"

"In what moments during the day or the week do you particularly miss these characteristics?"

Examples with focus on everyday moments with deceased person:

"Can you give some examples of typical, normal everyday moments that you shared with X? What did you do when you were having a meal together (what did you usually talk about, what did you eat, what did he/she like to eat?). What was it like when you went out for a walk together? You told me that you frequently telephoned. How did a normal telephone conversation usually go?"

[The client is given time to zoom in; the therapist prompts for questions that encourage the client to describe details in a way that provides the therapist with a clear image of typical, normal, yet meaningful everyday moments. The therapist zooms in on details that seem meaningful and elicit feelings of grief.]

"And when thinking of all this, how does it make you feel when you stand still with the fact that you will never be able to enjoy all these tender, loving, typical everyday moments again?"

Examples with focus on unique loving exchanges with deceased person:

"Can you give a description of a typical loving and tender exchange between you and X. What were your ways of expressing affection toward each other? Did you have very specific words that only you two understood, or particular jokes you made between each other? Give an example of something, an exchange, a way of making contact that was specific to your relationship? Please describe that in as many details as possible."

[The client is given time to zoom in; the therapist asks questions that encourage the client to describe details, especially those that seem to be meaningful and increase feelings of yearning.]

"And when thinking of all this, how does it make you feel when you recognize the fact that you will never be able to enjoy these moments again, these moments that were so special to the relationship you had with X?"
"In what moments during the day or the week do you particularly miss these tender exchanges?"

4. Working with objects and photos

Many clients have particular objects that symbolise their relationship with the deceased (e.g. a piece of clothing, a letter, a piece of jewellery, music or photos). The therapist asks whether the client has such symbols or objects that he either avoids or cherishes:

"People who have lost a loved one often have specific objects that have a special sentimental value to them, and which symbolizes their relationship to the deceased. For some people it can be a photo, for others a piece of clothing or a specific piece of music. Do you have examples of objects, music or photos that have special sentimental value to you?"

The therapist then asks the client to bring the object (or piece of music) with them to the next session. They will take a look at the object (or play the piece of music), and in details they will discuss the value it has for the client and the feelings it triggers:

"Why does this photo have such a special meaning to you? What does this photo remind you of? What feelings are triggered?"

If the client has difficulties looking at the object, the therapist encourages the client to do so anyway:

"It's not easy to look at that picture, because you don't know what will happen. Try to take a look and allow the feelings that may emerge."

TIP! If the client has great trouble to confront photos immediately, this can be done in a graded fashion. First, for instance, by covering up the item and letting the client control the speed with which it is uncovered again. For further tips on graded exposure, see submanual C about stimulus exposure (p. 24).

Besides avoiding objects, some people cherish core symbols. If the symbol is cherished, the therapist can ask the client what it would be like to distance I from it.

"You always keep that particular photo of X in your pocket. What would it be like if I asked you to give me that picture for the rest of the week? What would you think of that? […]. What makes it so difficult for you?"
"You always wear that piece of clothing, because it makes you feel like you're still close to. At the same time, you know that X is dead and will never come back, and you want to process that. Try to put that piece of clothing away… Try to take a step back from it. I know that it is very difficult for you, but if you want to move on in your grieving process and thrive again in your lIfe as it is now, you have to accept that X is dead. She will always be with you, but not in the same way as before…"

5. Focusing on the future and what will be missed

For clients who have a particular tendency to hold on to the past, visualizing images of the future can be an effective way to induce emotions. The therapist asks the client to imagine

what his/her life will be like in half a year, and to dwell on the moments she/he will miss the deceased the most.

"You have to move on without your husband. That is not easy… At what times will you miss him the most? At what times will you be confronted with the fact that he is dead and won't ever return again?''
"It appears to me that you feel great anxiety when you think about the future without X. As if a disaster could happen at any time now that you have to live on without X. Do I get this right? Can you tell me what you are afraid of?"

Homework: farewell letter to the deceased

The homework assignment is an ongoing farewell letter to the deceased. The client is instructed to work on this letter for a fixed time of 30 minutes, at least four times per week. **FORM 4** (p. 78) can be used as inspiration for the homework.

"I want to ask you to spend time writing a farewell letter to your deceased partner. More specifically, I request you to spend four times each week, in which you spend a maximum of 30 minutes writing a letter to your partner. It is important that you address the following topics in your letter:

1. How are you doing and feeling now that your partner is gone?
2. What are the most important changes in your daily life from before he/she died, until now?
3. In what moments in the last few months have you missed him/her?
4. In what moments in your everyday life do you miss him/her particularly much?
5. What would you like to say to your loved one? What do you want him/her to never forget?
6. What feelings and thoughts arise when you think about the fact that you will never see, hear, and feel him/her again?

You can choose the order in which you address these issues, as long as you take some time to reflect on each of these issues. Please do not worry about spelling or style. The main purpose of this assignment is to reflect on these issues, for a maximum of 30 minutes each time. It is not supposed to be perfectly written, and I am not going to read what you have written, unless you want me to.''

It is explicitly agreed what time of day is chosen to work on the assignment. The client is also instructed to limit the time to only half an hour. This is done to prevent the assignment from being too distressing and to encourage the clients to gain control over his/her feelings.

Discussing the homework

In each session, the therapist and the client discuss the homework of the previous week: Has the client managed to work on the ongoing farewell letter? If so, how did that go? What emotions were elicited? If not, what were the obstacles to work on the letter? In case the assignment turned out to be too distressing, an alternative assignment is given: talk to a friend or relative a number of times (arranged in advance), about X's death and the accompanying feelings.

TIP! Encourage the client to read the letter out loud. This can be a powerful way to facilitate exposure. To increase the power of this intervention, the presence of the deceased can be symbolised by an empty chair or a picture while the client tries to read the letter aloud.

SUBMANUAL B: IMAGINAL EXPOSURE

The objective of imaginal exposure (IE) is to process memories of specific traumatizing circumstances of the loss, or other very distressing moments associated with the death. This is done by repeatedly recalling and working through memories of that event. This is especially relevant when symptoms of posttraumatic stress are a prominent part of the symptom picture. Here, the timeline from **FORM 3** (p. 76) can possibly be included.

Explanation

The explanation is tailored to the clients' situation and can be as follows:

"You have witnessed the accident in which X died. That moment was so overwhelming that you still have vivid memories of it. Although you prefer not to be reminded of the accident, those memories keep coming back. Although that this may be distressing, it is also very natural. When people experience such a traumatizing, devastating event, all of the feelings, images, and thoughts associated with that event are stored separately in your memory, without forming a coherent whole. As long as there is no coherent narrative of these memories, these images and feelings will keep coming back.

We will use the following sessions to process the traumatic memories about the events surrounding X's death and to turn the distinct fragments into one integrated story. In order to do this, we will zoom in on the details of what happened, and your thoughts and feelings connected with those details. We will do that gradually, first focusing on the general outline of what happened, gradually moving towards the moment and the painful details of this moment. We will monitor you level of distress continuously, and we will take a break if it gets too intense for you.

Why is it important to zoom in on your loss? To begin with, you will experience that the recollection of the event is not as scary as you thought. You'll also notice that you gradually get used to the fear and anxiety associated with these memories. However, the most important thing is that you will experience that retrieving these memories will help you to form a coherent narrative of the circumstances that has a clear beginning and also a clearer ending. This ending was obviously not a positive ending, because it left you with the panful challenge of moving on with life without X. But eventually, you will experience that the bits and pieces of the painful memories no longer intrude into your awareness but that you get some control over these thoughts and memories. Does this make sense to you?''

Global reconstruction of the moment that needs to be processed.

Before the IE starts, the client is asked to give an overall description of the event.

"You told me that you suffer from images of the moment where X died. Before I ask you to recall this moment as vividly as possible, I first want you to give an overall description of the event. Can you give me a global description of the moments right before the accident until the moments after the accident? You don't have to be very detailed, but it is important that I have a general understanding of what happened."

Perform imaginal exposure (IE)

After the explanation has been given and it is clear what specific traumatizing moments the client and therapist will focus on, the IE begins**.**

- Ask the client to close his/her eyes and recall the memories of moments just before the traumatic event.
- Encourage the client to use present tense to describe what she/he sees, feels, and thinks. The client has to 're-experience' the event in a step-by-step manner.
- Ask questions to facilitate the 're-experience' of the event. Ask for a detailed description of the situation and the sensory experiences: "What do you see? What do you feel? What do you hear? What do you smell?"

The following techniques can be used to facilitate the re-experience:

- Freezing the image: The client is asked to focus on a specific moment of the event and to describe this moment in detail: "You see your partner lying in the coffin. Can you describe everything you see and hear?"
- Slow motion technique: The client is asked to relive a moment of the event in slow motion: "I want to ask you to relive that one particular moment when the doctor told you that X died that night. Relive this moment very slowly, as if you were watching a movie in slow motion. Describe every detail of what you see, hear, and do. Describe the feelings and thoughts that are going through your mind in that moment."
- Rewind and replay: The client is asked to recall and describe specific moments of the event a few times in a row, until these particular scenes elicit less distress.

The IE is continued until the event(s) are worked through completely, and the memories of the event invoke fewer emotional responses and are no longer avoided. The stress thermometer (**FORM 1**, p. 73) can be used to monitor distress levels. This part, where the client verbalizes the memories of the traumatizing events that the IE focuses on, has to be recorded (e.g., on a cassette, CD or mobile phone). This is because the client is asked to listen to the recording as homework.

Homework

The homework assignment is to listen to the recording of the session for at least four times during the week. It is explained to the client that this repeated exposure is effective in processing the painful memories associated with the loss and will lead to a decrease in the intensity of the emotions due to "habituation".

As an alternative assignment, a writing assignment can be given. In this assignment, the client is instructed to write a detailed narrative about the traumatizing circumstances of the loss (or other very distressing moments associated with the death) for a fixed time of 30 minutes, at least four times during the week. The level of details is gradually increased. For instance, the client can be asked first to write a global narrative and gradually add more details and reflections on one's own feelings, thoughts and memories connected with the story of the loss. Such a writing assignment can be given if the client does not dare to listen to the tape at home (e.g., because he fears he will be overwhelmed by emotions) or is not able to use a smart phone for recording.

Duration and combination with other exposure interventions

The IE ends when the client feels sufficiently comfortable to talk about the most painful, distressing and meaningful elements of the circumstances leading to the death, without experiencing intense emotions, and when she/he feels more in control over her/his own thoughts, memories and feelings.

TIP! Always switch or go back to "Exposure to the reality of the loss" (Submanual A, p. 17) if this exposure form no longer has a strong effect.

SUBMANUAL C: STIMULUS EXPOSURE

The aim of stimulus exposure is to reduce (phobic) avoidance of specific external stimuli (e.g., objects, places) by encouraging the client to gradually confront these stimuli.

Explanation

"We have determined that you fear visiting X's grave, because you are afraid that you are driven crazy by the sadness you experience if you go there. In the next sessions, we will try to reduce that fear, and gradually work towards you having the courage to visit the grave.''

TIP! Stimulus exposure can be combined with other forms of exposure if it turns out that the client has a phobic fear of a specific stimulus.

Create an exposure hierarchy

Exposure is done gradually. A hierarchy is created using the following instruction:

"The goal is that eventually you feel sufficiently comfortable to visit the grave soon. Right now, that seems like a very scary thing to do. However, fear is an emotion that is subject to what we call habituation. That means that when you visit the grave, you will notice that you might be quite anxious, but this fear reduces naturally after a while. You will somehow get used to the fear. Of course, you do not have to go to the grave on your own immediately, but we will take it step by step. For example, you could first imagine that you visit the grave. A next step could be to visit the grave with a friend. The final step would be to visit the grave alone. It may sound a bit weird, but this is similar to the treatment of spider phobia. To treat people with spider phobia, a spider is first placed in a jar 50 meters away of them, and then the spider is brought closer step by step. But we only do that after people get used to the fear, we never force people to approach the spider immediately. Can you tell me which steps you could take to reach the final step: visiting the grave on your own?''

The therapist writes down all steps and places them in the right order, together with the client. The hierarchy does not have to be extensive.

Below is an example of a brief exposure hierarchy for a client who does not dare to visit the grave of his/her deceased partner:

Step 1: Imagine that you visit the grave (imaginal exposure).
Step 2: Visit the grave together with a friend (exposure in vivo).
Step 3: Visit the grave together with a friend who will wait for you at the cemetery entrance.
Step 4: Visit the grave alone.

Perform the stimulus exposure

A good way to start the exposure is first step is through 'imaginal exposure' to the feared stimulus. The therapist asks the client to close his eyes and to imagine, as vividly as possible, that she/he is exposed to the feared stimulus:

"Close your eyes and imagine that you walk to the cemetery. What do you hear, smell and see? […] Describe the grave; what does it look like […]. What do you feel? What emotions emerge? What memories emerge? Would you like to say something to [the deceased]?"

A good second step is exposure in vivo to the feared stimulus with help from a friend or relative.
During stimulus exposure, the therapist repeatedly explains why it is helpful to confront stimuli that one tends to fear, and how exposure works.

"Two things happen when you confront yourself with things that you are afraid of. First, you will experience that your fearful expectations are not entirely correct. You have told me that you avoid visiting the graveyard, because you feel that you will get to feel so sad, that you will go crazy or lose control. By gradually approaching the graveyard, you will get a chance to experience that this expectation is not correct. That is, going to the grave will elicit emotions, but will most likely not lead to craziness or loss of control. Secondly, you will experience what we call habituation. Habituation is another term for an automatic decrease in the intensity of emotions. When we people experience an emotion such as fear or sadness, this emotion decreases automatically, when we get used to being in touch with the emotion. You can compare it with what happens when you go into a room where there is bad smell; you pay attention to the smell in the beginning, but after a few minutes, the smell seems to decrease."

Homework

The homework consists of the client exposing himself/herself to the feared stimulus outside the treatment sessions. This is of course done gradually. **FORM 5** (Monitoring exposure, p. 79) is used for this assignment. The form is used to formulate the assignment and note the experienced level of distress right before, during and after the assignment (on a scale of 0-10, see **FORM 1**, p. 73, if necessary). The aim of registering the level of distress is to investigate whether the level of distress decreases (as expected) during and after the exposure.

Duration and combination with other exposure interventions

Stimulus exposure can take 1 session but can also last up to 4 sessions. The aim is that th client feels sufficiently confident to expose himself/herself to the feared stimulus and eventually to be able to do this without experiencing intense fear. The stimulus exposure is often followed by another exposure intervention. Once the 'phobia' for a certain stimulus is treated, other grief behaviours may emerge, for which other interventions can be used. The therapist can introduce the transition to general exposure as follows:

''We have worked on your fear of photos of X. Although you don't fear these photos anymore and are able look at them, it seems like you have some difficulties confronting the loss. It is as if you can't believe it actually happened. You also told me that you are regularly overwhelmed by intense sadness. Should we use the next session to work on that?''

TIP! Always switch or go back to 'Exposure to the reality of the loss' (Submanual A, p. 17) if this exposure form no longer has a strong effect.

SUBMANUAL D: REDUCING COMPULSIVE GRIEVING BEHAVIOR

Reducing compulsive grieving behaviour is useful when the client engages in compulsive proximity seeking behaviour with the goal of keeping the deceased person alive and avoid the reality of his/her death.

Explanation

‘’I have noticed that you are intensely absorbed by the thoughts about X’s death. You spend a long time at his grave every day and look at photos of him for several hours. It is understandable that you have an urge to spend a lot of time thinking about X and doing things to continue to feel connected with X. But I think that your strong engagement in activities that make you feel close to X might also be a way to distance yourself from the reality of the loss. As long as you keep yourself engaged with X, you do not have to think about the fact that he is dead. It is as if you have a thought like ‘If I do not spend time thinking of him every day, I will really lose him’’. Is that right, or am I wrong?”

“In the following sessions, we will try to find out if there are other ways you can maintain your bond with X and, at the same time, leave room to orient toward the future. This does not mean that you can no longer visit the grave or look at photos. But in order for you to adjust to the fact that X is gone and will never return, it is also important to acknowledge the fact that he is actually dead, to discuss what that means for you and your life and future, and to work through the grief and the pain associated with this reality. You might think: ‘’I have to visit the grave daily and look at photos of him every day, or else I will forget him, or betray him, or I may be confronted with the pain”. It can be scary to do these things less often than you are used to. We are going to do this step by step and you’ll notice that it is not so scary to skip a day every now and then. You will also notice that you will not forget or abandon him by doing less proximity seeking behaviour, as we call it. In fact, it may actually help you to integrate the loss into your life story, to gradually start making some new plans for the near future or gradually pick up activities that you used to enjoy.”

Preparation

The client is, obviously, not asked to give up on the grieving behaviour completely, but the aim is to reduce the grieving behaviour step by step. The following questions can be used to determine how this can be done:

1. **What is the current grieving behaviour?**

“Can you tell me what you usually do in a week, with regard to the death of X?”
[…]
“Okay, so you visit his grave every day, and spend approximately 2 hours there. And every evening, you look at his photos for an hour. Are there any other things you do?”

2. **What is the grieving behaviour the client wants to engage in eventually?**

“There are different things you do to keep a strong connection to X. How many of these things would you like to do in the long run? For example, how often would you like to visit the grave or look at his photos in six months’ time?”
[…]
“Okay, if I understand correctly, you would like to visit the grave once a week, and no longer look at his photos every evening, but also only once a week.”

3. **What are appropriate steps in reducing the grieving behaviour?**

The therapist and client then go on to discuss what could be the steps in diminishing the behaviour. The therapist can also suggest the following steps:

"My suggestion is that instead of visiting the grave every day next week, you will skip 2 days and that you choose 3 days where you will look at his photos. What do you think of that…?"

TIP! The therapist 'aims high' because it is important that the client 'faces' the reality of the loss as soon as possible.

The actual reduction of the compulsive grieving behaviour

After it has been determined what steps are needed to reduce the grieving behaviour, treatment basically consists of gradually following these steps.

This intervention resembles exposure and response prevention as applied in the treatment of obsessive compulsive disorder (OCD). For instance, people with fear of contamination tend to wash their hands over and over again with the intention that they may reduce the potential risk of becoming infected but also their fear associated with it. In treatment, these people are helped to confront the feared stimulus (e.g., dirty things), without performing their compulsive behaviour (washing hands). This is done so that they expose themselves to their anxiety and thereby experience that their anxiety gradually, but certainly, decreases. People with complicated grief reactions are sometimes 'compulsively' occupied with the deceased in an attempt to keep the grief away. During treatment, clients are encouraged to give up this compulsive grieving behaviour but also to expose themselves to the reality of the loss and the associated emotions. This is done in order to discover that these emotions are tolerable and will become less intense, painful, and distressing.

When the client starts reducing his/her compulsive grieving behaviour he/she will automatically be confronted more with thoughts about the meaning and implications of the loss, and with the pain connected with that reality. To streamline this process, the client can be given the open homework assignment, as described in Submanual A (on p. 17).

Homework

The homework includes two assignments.

1. The first assignment is to reduce grieving behaviour according to the agreed steps: "We agreed that you will not visit the grave every day this week, but that you start by skipping two days. What days shall we choose?" (See **Form 5**, p. 79).
2. The second assignment is a "farewell letter to the deceased", as is described in the Submanual A on general exposure (see **FORM 4**, p. 78).

Duration and combination with other exposure interventions

Reducing compulsive grieving behaviour may take 1 session but can also last more than 4 sessions. The aim is not that clients give up all their activities and behaviours that provide a sense of continued connection with the deceased person. Instead, the aim is that these activities and behaviours take up less space, and that the clients feel sufficiently confident and empowered to think about the reality and implications of the loss and to work through the pain and grief connected with this reality.

TIP! Always switch or go back to 'Exposure to the reality of the loss' (Submanual A) if this exposure form no longer has a strong effect.

SESSION 6 TO 10: COGNITIVE THERAPY

Introduction

A central assumption of the cognitive-therapeutic approach to complicated grief is that negative, unhelpful (or dysfunctional) cognitions play a key role in maintaining the grieving problems. Accordingly, the goals of the cognitive therapy sessions are:

1. Identifying, challenging, and changing negative cognitions that maintain the grieving problems.
2. Teaching the client basic principles of cognitive therapy, so that the client can continue identifying, challenging and changing negative cognitions on his/her own even after the therapy has ended.

The specific negative cognitions underlying grieving problems differ among clients. Mostly, these cognitions are related to one or more of the themes shown in the table below.

Theme	***Examples of negative cognitions***
The self	Since _____ died, I think that I am worthless. I see myself as a weak person since _____ passed away. I can't handle the loss.
The future	My dreams will never be fulfilled. I will never be happy again.
Life	Life has nothing to offer me anymore. My life is over now that _____ is dead. My life is totally meaningless after _____'s death.
Other people	Other people do not really care about me. I have no confidence in other people. No one understands me. I will be abandoned by everyone.
Responsibility for the death	I am to blame for _____'s death. I should have prevented _____'s death.
Blame	Others are responsible for his/her death and should be punished. I cannot rest before the person responsible for _____ 's death is punished.
One's own grief reactions	I don't grieve in a normal way. If I fully understand what _____'s death means, I will go crazy. I will go insane if I think about the circumstances that led to _____'s death

The negative cognitions that are central to the client's problems can also be identified when considering what emotions are most prominent in the client's problems. Examples of particular feelings and associated cognitions are shown in the table below.

Trans-diagnostic complicated grief reactions	
Feelings	***Examples of negative cognitions***
Grief/yeaning	I cannot bear living while she/he is dead. My life is empty/meaningless without him/her. I betray X when I think about him/her less.
Depression	I am of no worth to other people. The future is hopeless. Life is meaningless.
Anxiety	The world is a dangerous place. My loved ones and I are not safe. If I do X (e.g., visit the site of the death), then catastrophe Y (e.g., me going insane) will happen.
Anger	That person (drunken driver, negligent doctor) is responsible for the death of _____, and therefore he/she deserves to be punished. The people around me should be much more supportive in this period.
Guilt	I am guilty of his death I should have prevented _____ 's death.
Shame	Other people think negatively of me, since _____ died

TIP! The Grief Cognitions Questionnaire, included in **Appendix C** (p. 63), is a helpful tool that clients can be asked to complete to obtain information about their negative cognitions.

The four steps in cognitive therapy

Cognitive therapy globally consists of the following four steps:

Step 1: Explaining the treatment rationale

The main principles of cognitive therapy are:

1. Situations or events never directly lead to emotional or behavioural problems. Instead, the cognitions in and about these situations and events cause and maintain these problems.
2. When people have persistent distressing and disabling emotional or behavioural problems, this means that they have negative and unhelpful (also termed maladaptive or dysfunctional) cognitions.
3. Identifying and changing these negative cognitions improves one's mood, lessens the intensity of negative emotions and fosters helpful behaviours and activities.

These principles are repeatedly explained and emphasized in the sessions.

Step 2: Identifying negative, unhelpful cognitions

The second step includes the identification of important negative, unhelpful cognitions that are central to the client's problems. The starting point is specific "emotional episodes"; moments in which the experienced intense, negative, and disabling emotions.

TIP! Note that “emotional episodes” and “hotspots” are not entirely similar. Emotional episodes refer to specific recent moments where the client felt intensely sad, depressed, anxious, or angry (or negative in another sense). These moments form the starting point for the cognitive therapy that is focused on identifying important negative cognitions. Hotspots are specific memories that are distressing.

The identification of cognitions is done using the column schema (**Form 6**, p. 81). That is explained below.

Step 3: Challenging and modifying the negative cognitions

After key negative cognitions have been identified, these are challenged. This means that the therapist and the client together reflect on and discuss the validity (accuracy, rationality, truth, logic) of the negative cognitions. This is done using *Socratic dialogue*, through the identification of cognitive distortions, with behavioural experiments, and by using *additional challenging techniques* (addressed in detail below). The most important aim of challenging the central negative cognitions is raising doubt about the utility and validity of particular cognitions. Next, the negative, unhelpful cognitions are modified. This means that new, alternative cognitions are formulated that lead to less intense negative feelings and encourages and promotes steps toward constructive actions (actions and behaviours that help one to feel better, and that foster adjustment).

Step 4: Identifying and challenging maladaptive basic schemas

Some clients suffer from generalized, deeply rooted maladaptive cognitive schemas. These are personality-related cognitions with strongly exaggerated or extreme judgements about oneself (“I am worthless”, “I am a weak person’’) or other people (“Everyone abandons me”, “Other people can’t be trusted”). When these more basic maladaptive cognitive schemas are involved in the current complicated grief problems, these are addressed in the third or fourth cognitive therapy session. Concrete tools to do so are also discussed below.

SESSION 6
Explanation of the rationale of cognitive therapy
Introduction to the 4-column schema
Explaining the structure of the cognitive therapy sessions

Explanation of the rationale of cognitive therapy

The cognitive-therapeutic treatment can be explained as follows (the explanation is adjusted to the specific situation and problems of the client):

"We have explained that regaining confidence in yourself, other people, life, and the future is an important task in the process of adjustment to bereavement. In cognitive therapy for complicated grief, we mainly work on task II: Regaining confidence in yourself, other people, life, and the future.

In the cognitive therapy sessions, we are going to address this task in-depth. We are going to detect negative, unhelpful thoughts that block the adjustment process and cause depression, anxiety, anger, and other emotions. Then, as the next step, we will discuss these, and we will carefully try to change them into thoughts that are more helpful; thoughts that yield less distress, thoughts that help you to view yourself, others, life and the future with more confidence, and that encourage you to engage in activities that help you to move forward in your grieving process.

Your feelings form the starting point of cognitive therapy. You may have felt very sad and anxious since X died. Although it may seem that these feelings are completely and directly caused by the loss, this is not the case. Actually, not everyone who is confronted with a loss experiences the same feelings. Some people are more sad, depressed, anxious, or angry than others. The feelings after a loss are largely determined by the cognitions that you have connected with the loss. Cognitions is a formal word to refer to thoughts or beliefs. For example, people may have negative thoughts/cognitions about guilt such as, "I should have prevented his/her death." Such a cognition could lead to feelings of guilt. People can also think negatively about the future, for example: "I will never be happy again." Such cognitions cause sadness and block the motivation to engage in activities. Therefore, we refer to such cognitions as negative, unhelpful cognitions.

Although we cannot directly alter feelings, we can in fact try to alter cognitions. We can do so by very carefully reflecting on the degree to which your negative cognitions are really true and help you in coming to terms with the loss. That is why in the next few sessions we will look at the negative cognitions connected with the negative feelings that you are tormented by most often. Once we have identified these cognitions, we will investigate them together. In case we find out that your negative cognitions are not correct, we will try to alter them into different, less negative cognitions, that lead to less intense negative feelings and that help you to do things that help you in adjusting to the loss. Cognitive therapy, which we are going to be working with now, helps you to achieve Task II: Regaining confidence in yourself, other people, life, and the future."

Introduction to the 4-column schema

The column schema is a schema (or analytic framework) that is used in all cognitive therapy sessions. The 4-column schema is seen in **FORM 6** (p. 81) and can be introduced as follows:

"The 4-column schema is a tool for teasing apart and analysing situations or events where you experienced intense feelings of depression, anxiety, anger or other feelings, or where

you tend to engage in behaviours that are not helpful, and where thoughts play a central role. Filling out the 4-column schema involves the following steps:

Step 1) When filling in the 4-column schema you always start with the question: On what occasion (situation, event) during the past couple of days did you feel depressed, anxious, angry, or otherwise miserable? In the column “Situation” you give a short description of this situation/event. It should be a factual description (where were you, with whom, what happened), as if you were describing a photograph of the moment.

Step 2) The next step is to formulate what negative, distressing feelings you had in that situation. Were you mostly sad, scared or angry, or depressed, anxious or furious? Or were you feeling guilty? Or shameful? You write this down in the “Emotions/feelings” column. You should also give a rating of the intensity of the feeling, running on a scale from 1 (the feeling was very weak) to 10 (the feeling was very intense, completely occupied me).

Step 3) In this step you have to describe what cognitions or thoughts you had in the specific situation/event that were associated with the mentioned amotions. What kinds of negative and unhelpful thoughts ran through your head? Was it one of those negative thoughts that we’ve talked about before? (see Appendix). Describe your thoughts as accurately as possible in the column “negative automatic thoughts” – preferably as clear statements. This is the most important part of the column schema, and therefore is has to be clear: “what thoughts made me experience sadness/fear/anger in the specific situation/event?”

Step 4) In step 4, we work together to find alternative thoughts that are more helpful and more realistic. They are written down in column 4. Later, you will come up with suggestions for helpful alternative thoughts on your own at home, but we will start by doing it together.

TIP! Make sure that the clients understand the 4-column schema. The format and terminology of the 4-column schema is used in all cognitive sessions. The goal of these sessions is not to target and change all negative cognitions that the client has but, rather, to **teach clients how to analyse their own emotional episodes and to identify and alter negative cognitions.**

Further explanation of the rationale with examples

The explanation continues with two examples that the therapist uses to show how negative/unhelpful cognitions can cause negative emotions. The first example is a general example.

Example 1

Th: Mr. Jones had lost his wife to cancer two years ago. Every time he thinks of her, this thought occurs: ‘I should have taken better care of her, then she would still be alive today'. How do you think this man feels on these moments?
Cl: I think he feels guilty and maybe angry at himself…
Th: Do you think it helps him in coming to terms with his loss?
Cl: Maybe, but he will probably continue feeling guilty and sad for a very long time.
Th: Because Mr. Jones blames himself for not taking better care of his wife, he feels guilty, and it is likely that this will make it harder for him to cope with the loss. Imagine the following: Mr. Albert is in the same situation as Mr. Jones. Sometimes he thinks that he should have done more for his wife, but at the same time he thinks 'there is no use in blaming myself. At that moment I did the best I could”. How do you think Mr. Albert feels at these moments?
Cl: Maybe sad, but not as guilty as Mr. Jones.

Th: Would he have a harder or easier time dealing with the loss than Mr. Jones?
Cl: Easier, I think.

The second example is based on a situation that the client has experienced himself/herself.

Example 2:

Th: You told me that sometimes you think that you will never be able to process the loss, and then you feel sad.
Cl: Yes, that is true. At times it is all too much for me, and then I think that I will never get over the loss, and that I will never be happy again.
Th: And what do you do then?
Cl: Nothing, actually. Nothing that matter at least. I keep waiting until I feel better.
Th: Could you describe a moment when that gloom was less intense?
Cl: Recently I went into town with a friend. That was quite fun, we even laughed for a while. I did feel a bit sad in the evening, but I was also glad that was able to take my mind of things for a while. For a moment I thought that there were still things to enjoy.
Th: If we look at your thoughts and feelings, we can see two things. One moment you look at the future and have the cognition 'I will never be able to come to terms with the loss and be happy again'. This makes you gloomy and leads you to doing nothing. The other moment, right after you did something nice, you were thinking "There are still things I can enjoy" and that thought seemed to induce a sparkle of hope and positive feelings. Is that right? What does this teach us about the relationship between cognitions and emotions?"

TIP! When working through the two examples, use a whiteboard or a sheet of paper to analyse the examples in the same way as in the 4-column schema. All this is helpful to familiarize the client with the method in the 4-column schema.

Explaining the structure of the cognitive therapy sessions

The subsequent structure of the cognitive therapy sessions can be explained as follows. The explanation is adapted to the clients' emotional problems.

"We have seen that negative emotions do not come out of the blue. Instead, they are the result of particular cognitions that may come to mind in particular situations. Based on our research and experience, we know that people struggling with complicated grief reactions have many negative, unhelpful cognitions. These are cognitions that cause and inflate negative feelings and cause or contribute to unhelpful behaviours and actions.
For example, they think ''I will never get over this loss'' or ''I will never be happy again''. These thoughts can lead to dysphoria or depression. Or they might be afraid of their own emotions because they think ''I will go insane when I really get to know what this loss means to me.'' Over time, it almost becomes a habit to think negatively, and as a result the negative feelings continue to be strong.

What are we going to do in the next few sessions? First, we are going to try to identify the specific negative, unhelpful cognitions that you are tormented by. Secondly, we will try to challenge these cognitions. This means that we are going to determine whether these cognitions are true, or whether there might be other ways to look at things. And, as a third and last step, we will try to formulate other, more positive and more helpful cognitions that are more in line with reality, and that cause you to feel less miserable, and that will help you to engage in behaviours and activities that make you feel better and help you in processing the loss.

Now you may wonder if the goal is to start thinking positively about this loss, or if the goal is not to feel sad anymore. These are of course **not** the goals of the sessions. It is quite understandable - considering what you have been through - that you occasionally feel sad, anxious or irritated. These are very normal feelings that will probably be present for a while. What we are going to try to achieve is that the most extreme negative cognitions that you have will become less extreme, so that you will gradually be able to think a little bit differently about all these things that now seems so negative. Our goal is that your feelings will become less intense and cause less distress, and that you are gradually more capable to function normally in your everyday life in the way you would like to function."

TIP! Ask the client if she/he has understood this explanation. Let him/her repeat the explanation briefly. Make sure that the client does not think that the treatment should lead to a positive view on the loss, and that she/he does not expect that the grief will disappear completely as a result of the treatment. The aim of the treatment is to reduce extreme reactions to grief to 'normal proportions' so that the client can once again function in his/her everyday life.

Homework: complete the 4-column schemas

The client is asked to complete at least one 4-column schema per day during the next week, using **FORM 6** (s. 73).

''I want to ask you to complete at least one 4-column schema per day during the next week. Analyse moments when you felt very bad and miserable. These moments are very important for the treatment. Do not wait too long to complete the schema after you experienced the unpleasant feeling. If you wait too long, it becomes harder to remember exactly which negative cognitions went through your mind and caused the negative feelings.''

TIP! As a therapist, it is important to emphasize that doing the homework assignments is an important component of the therapy. "Because negative cognitions and feelings can be very persistent, it is important that we not only talk about these in our sessions but that you also actively work on identifying and challenging them in-between sessions."

SESSION 7
Discussing questions and comments
Identifying negative cognitions using the 4-column schema
Possible misunderstandings in completing the 4-column schemas (and solutions)
Identifying negative cognitions that are central to the client's problems
Homework

Discussing questions and comments

Does the client have any questions or comments in response to the previous session? Is she/he still motivated? In case the client seems demotivated, check whether that is correct, and why that is. If the client has misconceptions regarding the cognitive therapy, then try to adjust them. Examples of misconceptions are: "Now you want me to start thinking positively! But how is that possible now that my husband has died?", "I think it is normal that I feel terribly miserable, that is something that will never change."
If the client has completed none or only one 4-column schema, try to find out why that is. Explain the treatment rationale once again in case the client does not see the benefits of the cognitive approach. As an example, use the cognition "Cognitive therapy will not work for me" and explain the impact of this cognition on feelings and behaviour. If the client has not completed any 4-column schemas, this is done on the spot based on situations from the past week.

TIP! Clarify that cognitive therapy is not simply about positive thinking. The goal of cognitive therapy is not to formulate extremely positive cognitions ("Life is fantastic") but, instead, to formulate nuanced and functional thoughts ("Life seems less meaningful now, but as time goes by I will be able to retrieve a sense of meaning").

Identifying negative cognitions using the 4-column schema

This session focuses on analysing current emotional episodes. The aim is that the client is trained in identifying his/her negative, unhelpful cognitions. The 4-column schemas that the client has completed are used as a guideline in this session. The cognitive diamond in **Appendix D** (p. 65) can be used in the discussion of recent emotional episodes that has happened since the last session as an alternative to the 4-column schema. Here, the therapist asks the client the following questions:

"Try to recall a moment from the past week where you felt very miserable. Can you think of a moment? […] What was the exact feeling that you experienced? Did you feel sad, depressed, angry, scared?" […] "Can you give a short description of the situation in which you experienced this negative feeling? Describe the situation as objectively as possible, as if a camera would have taken a picture of the situation."

The therapist summarizes: "So last Wednesday night you were cooking, that is the situation-part of the cognitive diamond. And suddenly you started feeling very sad. That is the paprt of the diamond that includes your emotions. Is that correctly understood?" […] "Now try to remember what negative cognitions or thoughts you had in that moment. What happened in your head that – in the middle of cooking something – you got struck by that awful gloom? Take your time."

TIP! Use a copy of a column schema og a cognitive diamond to write down what the client is saying.

The therapist repeatedly emphasizes in a short summary the **connection between the client's cognitions and his/her negative feelings:**

"So, if I understand correctly, in that moment you were struck by an immense fear, because you had the cognition 'I am not able to look after myself, now that X is dead."
Or: "So you felt incredibly guilty and depressed in that moment, because you were thinking 'I could and should have prevented X's death!' Is that correct?"

Possible misunderstandings (and solutions) in completing the 4-column schemas/the cognitive diamond schema

The therapist carefully reflects on what the clients registered on the 4-column schemas and tries to correct possible misunderstandings. Common errors/mistakes in completing the schemas are the following:

a) **The client chose an 'appropriate' feeling as starting point:** Cognitive therapy focuses on exaggerated, 'out of control', very intense emotions. Normal feelings and grieving reactions should not be addressed in the schemas. Therefore, there is no use in trying to adjust 'appropriate' feelings such as missing the lost person, moments of crying and sadness (unless these feelings spiralled into severe distress and/or went on for a very long time).

b) **The description of the situation includes interpretations:** If the client writes down: "I saw a neighbour, and he deliberately ignored me!" as a situation, then that is not necessarily true. That is because "he deliberately ignored me" is an interpretation of what happened. A more objective description of the situation would be: "I saw a neighbour, and he did not clearly respond to me". The notion "he deliberately ignored me" would then be placed in column 3 about negative automatic thoughts/cognitions (**FORM 6**)/the thoughts-box in The cognitive diamond.

TIP! Asking for an objective description of the situation helps the client to discover that they rather automatically tend to mix up interpretations and observations of a particular situations.

c) **The thoughts-column/box contains memories rather than negative thoughts/cognitions:** An example is a client who writes "I was thinking back to the day that X died'' in the thoughts-column and "guilt" in the emotions-column. The negative/unhelpful cognition is missing here. After all, the memory could have led to different feelings. Cognitions are the meanings or interpretations connected with the memory that led to the feeling of guilt. In this example the cognition might have been: "It is so crazy that I left the hospital. I should not have done that. Because I left, I was not with X when he died, and I had promised to be on his side when he died."
When memories are written down instead of cognitions, the therapist can ask: "What were the negative cognitions that went through your mind when you had these memories?"

d) **The client cannot mention any negative cognitions or thoughts:** If the client is able to report a situation and a feeling, but she/he is unsure about which cognitions lead to the feeling, the therapist can do several things:
   - The therapist can ask questions about the implicit meaning of the situation: "What did the situation mean to you? What does the situation tell you about yourself? What did the situation remind you of?"
   - The therapist can give suggestions about possible cognitions: "You say that you were feeling so angry again. You told me before that you feel that some of

the people responsible for X's death seem to be getting away with what they did wrong. Did your negative cognitions in that situation have anything to do with that?"

- The therapist could use visualization. Ask the client to remember the situation in which she/he had the negative feeling as if she/he is reliving it in the here and now. Then ask questions such as: "What is going through your head right now? What are you thinking of? What cognitions make you feel so awful?"

e) The dysfunctional cognition does not match the feeling: If the cognition (e.g. ''I am guilty'') does not match the feeling (e.g. fear) the therapist should try to explore this and possibly nuance and find out other possible thoughts and feelings by asking questions such as: "There seem to be a little discrepancy here; you had the cognition that "I am guilty" but instead of that causing feelings of guilt or dysphoria you felt fear. Where there any other cognitions in the situation that could have caused the fear? Or did you have another feeling besides fear?"

TIP! As a therapist, you can use your own imagination to judge if the key negative and unhelpful cognitions have been identified. You can try to visualize yourself how you would react, if you were in the same situation as the client described (that is: the situation as written down in the 4-column schema), and think whether or not you would have the same emotions and cognitions as the. If not, then all cognitions may not have been identified yet.

Identifying negative cognitions that are central to the client's problems

From the start of the cognitive therapy sessions, the therapist tries to identify negative, unhelpful cognitions that are central to the client's problems. These are the cognitions that come up in many different emotional episodes and many different column schemas. Sometimes central cognitions become clear quite quickly: it might be that a client often has the cognition "I will never be happy again", and that this pessimistic cognition is central to the problems.

It is important that the therapist formulates hypotheses about cognitions that are possibly central to the problems.

Therapist can also use 'the downward arrow technique' to track down core cognitions. With this technique, the therapist asks questions to identify central cognitions that give rise to the cognitions that the client is plagued by frequently in his/her everyday life. Specific questions to ask include: "You have this negative cognition. What if that cognition was indeed true, what would that mean? What would be bad about that? What would that tell us about the kind of person you are?"

Example 1

Th: I often hear you say, 'I don't want to think about John's death'. Can you tell me what would happen if you did do that?
Cl: ... then I would surely get very, very sad....
Th: ... and if you get very, very sad, what would happen then...?
Cl: Then maybe I would start crying so intensely, that it would literally drive me crazy.
Th: OK, and what would that look like if you indeed would get crazy?
Cl: Then I would not be able to function anymore.
Th: And OK, let us imagine that that were true; what would happen then?
Cl: That is difficult. I would probably stay home in bed all day, and nobody would come to visit me anymore. I would probably end up alone.

Th: I think this is important. You have told me that you do not want to think about what it means to you that John is really gone forever. If we dig a little deeper, it seems that you fear that you would get extremely emotional if you confronted the reality of his death. In fact, you predict that you would respond in such a way that, in the end, it would cause you to be alone at home, with nobody looking after you. It seems as if your cognition is: If I would really confront the consequences and pain of this loss that would undermine my ability to function in a way that would scare my friends and family so that they would eventually leave me."

Example 2

Th: In various 4-column schemas/cognitive diamonds it appears that you often think ''I could have prevented the death''. What does that actually mean to you that – in your experience – you could have prevented the death?
Cl: That means that I am guilty of his death.
Th: And could you give some more words to that statement. What does it mean that you are guilty?
Cl: Well that means that I am least partially responsible for the circumstances that lead to his death. I have not prevented all these things from happening…
Th: OK let us dig a little deeper. Imagine that you really believed: I am partially responsible for his death because I was unable to prevent this death. What does that tell us about you?
Cl: Well, if feel like a bad person. I must have been a terrible spouse given that I was unable to prevent this death…
Th: I think that this is an important issue we are talking about here. If we summarize, another cognition is lying underneath the cognition: ''I am guilty''. And that deeper cognition seems to be: 'Because I was unable to prevent his death, I am a terribly bad spouse.' Is this a correct reflection I am making here?

Homework

The homework again consists of completing 4-column schemas/cognitive diamonds. Advise the client to try to complete at least 3 each week.

SESSION 8
Discussing the homework
Explaining the rationale of challenging negative cognitions
Challenging a dysfunctional cognition
Formulating an alternative cognition
If relevant, the goal work can be introduced from here (see Session 11)
Homework: completing 4-column schemas

Discussing the homework

Check whether the client has completed his/her column schemas/cognitive diamonds. If the client has done very little, ask why. Emphasize the importance of an active involvement in therapy. The treatment can only be effective when the client is independently capable of identifying negative, unhelpful cognitions. Review the schemas the client has completed. Check whether the client has completed the different parts of the schemas correctly. Also, check whether she/he has succeeded in identifying some of his/her more central negative cognitions.

Explaining the rationale of challenging negative cognitions

Challenging negative cognitions is aimed at investigating the validity (accuracy, rationality, truth, logic) and utility (effectiveness, helpfulness, adaptiveness) of negative cognitions. This can be explained as follows:

‘’We have seen that negative feelings can be the result of negative and unhelpful thoughts. This means that you would feel differently if you were able to adjust your negative thoughts. Of course, this is not something that happens automatically. As human beings, we cannot simply switch a button to start thinking differently. However, it is actually possible to challenge those negative thoughts. This means that we are going to treat the negative thoughts that you have as statements that we can review and talk about, rather than as unchangeable truths and certainties.

So, for instance, you may be used to thinking: “I have nothing to offer to anyone anymore, now that my partner died”. Challenging this thought would mean that we would take a step back and consider whether this thought is really true or a statement that is perhaps too negative and too firm and not helping you. That is what we are going to do in the next weeks. We are going to check whether those negative thoughts are actually true and whether or not these thoughts are helpful in your grieving process. What we aim for is that maybe we can adjust them or nuance them into thoughts that lead to other, or less intense feelings, and that help you to do things that help you in coming to terms with the loss.’’

Examples of techniques to challenge negative and unhelpful cognitions

The therapist can use various techniques to challenge cognitions. We make a global distinction between three types of techniques: (I) Socratic questioning; (II) Identifying cognitive distortions, and (III) Additional challenging techniques. These techniques are explained in Appendix E.

Challenging a negative, unhelpful cognition

After having explained the purpose of challenging negative, unhelpful cognitions, an example is discussed. Based on the completed column schemas/cognitive diamonds, one of the

client's cognitions which is supposed to be central to his/her problems is selected. The therapist writes this cognition on the white board and suggests a further examination and review of the cognition. He thereby emphasizes Socratic questions, but also uses – if applicable - the additional challenging techniques.

Example 1

Th: You say 'I can never be happy without X.' It is understandable that you feel depressed if you are convinced that you will absolutely never be happy again. But is that thought actually true?
Cl: Yes. I cannot imagine that I will ever be happy again.
Th: Ok, you currently cannot imagine that you will ever feel happy again. That is not surprising, considering that you feel sad about the death of your husband. But does that mean that you can make the prediction that you will never be happy again? […] What happens if you keep telling yourself 'I will never be happy again'?

Example 2

Th: You said that you felt extremely anxious this week when you thought about X. What were the thoughts that crossed your mind when you were feeling so anxious?
Cl: I still have great difficulties thinking about what it means that I will never, yes never will see X again.
Th: Because, if you really started to reflect in detail about the consequences of this loss for how you view yourself, and what it means for your life and future, then…
Cl: Then I think I would become so intensely sad, that I would not be able to bear or control my feelings.
Th: And then what would happen?
Cl: Then I would definitely go crazy!
Th: If you think, "When I would reflect about the consequences of the death of X, I would get so sad that I would go crazy", I can imagine that you feel anxious, and would rather avoid memories altogether. But let's examine this particular thought a little more. What could happen? Suppose you are really going crazy with sadness, then what…?' [The therapist applies the additional challenging technique "Imagining the worst".]

Formulating an alternative cognition

After the negative, unhelpful cognition of the client is challenged, an alternative, more valid, less negative, and more helpful cognition is formulated that does not lead to such intense, negative feelings, and that encourages rather than discourages helpful actions.

"We have just seen that the thought, 'I will never be happy again' is not valid especially because it is a very absolute prediction that you actually don't have evidence for. You may not feel happy right now, but that does not mean that you will never be happy again at any time in the future. If you keep holding on to that negative thought about the future, there is a fair chance that you will continue to feel depressed. We will now try to formulate an alternative to this very negative thought; a different thought that fits better with reality and also makes you less depressed.''

When formulating alternative thoughts, it is important that clients are encouraged to come up with alternatives themselves.

Example

Th: We have been looking at one of the central thoughts that you have been plagued by. That thought is "I really should have prevented X's death!". That thought has been

making you restless and gives you a strong sense of guilt. We have carefully reviewed the thought and concluded that this is perhaps a bit too extreme. Now what could be an alternative thought?

Cl: Hm… I don't really know.

Th: OK, let me try to help you. Imagine if I were in the same situation as you, but I would not feel guilty. How could I have gotten to that point?

Cl: Perhaps you would not be telling yourself that you should have prevented the death.

Th: Exactly, but what do you think I might be saying to myself? What could be my thought that would not produce all these feelings of guilt?

Cl: Maybe something like 'I did what I could'…

Th: Yes, that could be the thought I could have if I were in the same situation, not feeling as guilty as you do. Now going back to you; your initial thought was, "I really should have prevented X's death!'. What would be a possible alternative to that thought?

Cl: Something like: "I wish I could have prevented the death; but that was impossible. I did what I could and there was no way to prevent it from happening."

Th: That sounds like a good alternative thought!

TIP! The goal of formulating alternative cognitions is not that clients swap their negative cognitions for positive cognitions and then 'everything will be fine'. That is of course nonsense. It is more about taking a different perspective on the situation which is less negative, less absolute, and less rigid. That is why we speak of changing unhelpful cognitions into more helpful cognitions, rather than changing negative into positive cognitions.

As far as time permits, various of the client's different negative cognitions are challenged in this session and alternative cognitions are formulated. This is all done with the aim of helping the client to understand the principle of challenging and changing negative cognitions.

Homework: completing the 4-column schema/the cognitive diamond

The client is requested to continue completing the schema, including the column/box with "Alternative thoughts". The client is encouraged and motivated to complete at least one full schema every day, including the part about challenging thoughts.

SESSION 9
Reviewing the homework with the 4-column schema/the cognitive diamond schema
Continuation of challenging negative cognitions
The problem: ‘’I know it, but it does not feel that way’’
Designing a behavioural experiment
If relevant, the goal work can be introduced from here (see Session 11)
Homework: completing column schemas/cognitive diamond schemas and performing a behavioural experiment

Reviewing the homework with the 4-column schema/the cognitive diamond schema

The therapist examines whether the client has managed to complete the schemas. When necessary, the therapist provides further explanations. If the therapist suspects that the client has identified superficial cognitions, he/she asks the client to identify cognitions that are more central to his/her problem.

Continuation of challenging negative cognitions

In discussing column schemas/cognitive diamond schemas, a lot of attention goes to challenging the cognitions; has the client managed to ask “challenging questions” about his/her cognitions? What was the effect of this? Has the client been able to come up with alternative, more nuanced cognitions?
The therapist and client review schemas about some important emotional episodes from the past week. It is important that the therapist addresses examples of situations that the client was able to analyse very well (and highlights the schemas that have been completed perfectly fine) in order to consolidate what is learned and to reward the client for his/her good work. Additionally, the therapist focuses on situations in which the client had a hard time to identify his/her negative, unhelpful cognitions, in order to help him/her to continue improving his/her cognitive therapy skills.

The following are five key points of consideration when challenging cognitions.

1. Pay attention to negative, unhelpful cognitions that are central to the client’s problems (cognitions that return in different emotional episodes).
2. Focus attention to cognitions that the client himself/herself could not easily challenge (cognitions that are rigid, not easily falsifiable).
3. Use different techniques to challenge cognitions (see the examples in Appendix E: Examples of techniques to challenge negative and unhelpful cognitions).
4. Take time to carefully formulate an alternative, less negative, more helpful cognition. This helps to make alternative perspectives on situations/events more credible.
5. Do not try to challenge and change *all* negative cognitions. It is better to do it fully and properly on one cognition than to challenge all cognitions halfway.

The problem: ‘’I know it, but it does not feel that way’’

Clients sometimes say that they know that their cognitions are unhelpful and even not true, but that they, nonetheless, still feel negative (e.g., “I know that I am not responsible for her death, but I still feel guilty”, or “I know that people will not treat me badly now that I am alone, but I still feel anxiety and tension when going to social events alone.”). This discrepancy between cognitions and feelings is often caused by the fact that the client is not yet convinced of his/her alternative cognitions, and that the negative cognitions are still ‘’winners of the internal dialogue’’. When the client makes such statements, the therapist explains that challenging and changing negative, unhelpful cognitions is an active process that takes time. Negative thinking has become a habit, and often happens so automatically that negative

thoughts have to be challenged again and again. The following explanation often clarifies this:

"I envision that a dialogue takes place in your head: on the one hand you think 'I am guilty for the X's death'. On the other hand, you also think: 'With the knowledge I had at that time, I could not have predicted his death'. Is that true? I always compare it to a dialogue between a shoulder angel, sitting on one shoulder, and a shoulder devil, sitting on the other shoulder. The devil keeps repeating the negative thoughts. The angel is more nuanced and is trying to convince you that your alternative, more helpful and less negative cognitions are true. But the devil is strong and powerful. And this is not so strange, because he has had plenty of room lately to convince you of his negative statements. The other – more positive – angel is quite new, and his voice is rather soft. Because the devil is still so powerful, he often wins the dialogues. But you will notice that this changes as soon as you give more room to the voice of the angel. The more you let the angel speak, the stronger it becomes, and the more often it will win the dialogue. At one point, the voice of the angel will be so trained, so strong, and so convincing, that the devil fades away.''

Designing a behavioural experiment

During this session, the therapist and client design one specific behavioural experiment that the client is going to do in the next days. Behavioural experiments are aimed at investigating whether a negative cognition is true by engaging in a specific activity. A behavioural experiment encompasses the following steps:

Step 1: Identify the cognition that has to be challenged. Note: it must be a specific cognition that can be translated into a specific testable or falsifiable statement. Preferably, this is a negative cognition that is central to the client's problems.
Step 2: Reformulate the cognition into a hypothesis that can be tested with a specific activity or action. Formulate this hypothesis in the form "if I do X, then the negative consequence Y" happens".
Step 3: Formulate an alternative hypothesis that reflects a more positive prediction. For example: 'If I would do X, then the positive or less negative consequence Z will follow."
Step 4: Determine what specific activities the client must do to test both hypotheses. That is, determine the X in the hypotheses.
Step 5: After the client has completed these actions or activities, review his/her experiences and determine to what extent these experiences have supported the negative prediction and the alternative, more positive prediction.

TIP! Explain **FORM 7** to the client; this form is used to design and evaluate behavioural experiments.

Behavioural experiments for depressive symptoms: When clients experience depressive symptoms, they often have negative predictions about the enjoyment of engaging in activities ("I cannot enjoy anything", "Nothing is fun"), about the usefulness of activities ("It no longer makes sense to take care of myself"), or about their own abilities to arrange particular activities ("I don't know how to plan anything"). These cognitions may lead to inactivity and block actions that could help to adjust to the loss. Behavioural experiments are powerful tools to test these predictions and target the inactivity. In short, the client is encouraged to undertake a specific activity (e.g., visiting friends), as a means to investigate whether his expectations for the activity ("If I visit these friends, then I will not experience any joy"') are true.

Behavioural experiments for anxiety symptoms: In case of anxiety symptoms something that is not rationally dangerous is perceived as a threat which can result in avoidance

behaviour. A client with social anxiety avoids social occasions, because he is afraid that he will ‘fail’, or that people will find him ‘weird’. Or: an example of avoidance behaviour in connection with prolonged grief may be that a client avoids going to the grave because he is afraid that he will be driven crazy or lose control. Behavioural experiments can be used to investigate such expectations. The client is encouraged to engage in a specific action (e.g. go to a birthday or visit the grave) to investigate whether his expectation (‘failing’ or ‘going crazy’) is true.

In **Appendix F** examples are given of the following behavioural experiments:

1. Behavioural experiment for someone with negative expectations about contacts with other people.
2. Behavioral experiment for someone who is angry about the way in which other people dealt with the consequences of an accident in which an acquaintance died.
3. Behavioural experiment for someone who states that his/her grief is unbearable.
4. Behavioural experiment for someone with feelings of guilt over the circumstances of the loss.

Homework: completing column schemas/cognitive diamond schemas and performing a behavioural experiment

The client is requested to continue completing column schemas/cognitive diamond schemas. In addition, the therapist and client together decide on one specific behavioural experiment that the client is going to do. **FORM 7** can be used to design and evaluate the behavioural experiment.

SESSION 10
Reviewing the homework
Challenging negative and unhelpful cognitions
Identifying maladaptive basic schemas
Challenging maladaptive basic schemas
Modifying dysfunctional basic schemas
Homework

Reviewing the homework

Briefly review the 4-column schemas/cognitive diamond schemas that the client has completed. The therapist commends the client for continuing with identifying, challenging, and altering his/her negative cognitions. In this phase of the treatment, clients are usually experiencing that they are feeling better, and that their depression, anxiety, and other emotions are less intense. At the same time, normal grief reactions may become a little more prominent. The therapist normalizes this:

"You say that overall, you are feeling better. At the same time, you notice that you often feel more sad about X's death. This is not entirely unexpected. In the past few months, you were intensely occupied with thoughts and questions about what you could have done and should have done to prevent X's death. You had little room to grieve over the loss you have suffered. Now you have learned, and to a greater extent accepted, that there is no way that you could have prevented X's death, and therefore there is more room to feel the grief now. That may feel painful, but it is also a good sign, because it shows you that there is more room to come to terms with the loss and adapt to life after the loss."

Has the client managed to perform a behavioural experiment? If so, what were his/her experiences? What did he/she discover with regards to the negative and positive hypotheses? If the client did not have positive experiences (e.g., visiting friends was not as joyful as hoped) then discuss what happened, and especially what the client has learned from the experience regardless of the result. Reward the client for the effort!

TIP! Remember that a behavioural experiment can never fail. Even if the client did not have positive experiences, lessons can always be learned.

If the client did not conduct the experiment, find out what the reasons for this were. Ask what needs to be changed about the experiment for the client to conduct it. Adjust the experiment and let the client conduct the experiment as homework.

Challenging negative and unhelpful cognitions

Just like in session 3 and 4 of the cognitive therapy session the largest part of the fifth session is spent on challenging negative, unhelpful cognitions. It is important to continue to be aware of the five key points of consideration while challenging cognitions:

1. Pay attention to negative, unhelpful cognitions that are central to the client's problems (cognitions that return in different emotional episodes).
2. Focus attention to cognitions that the client himself/herself could not easily challenge (cognitions that are rigid, not easily falsifiable).
3. Use different techniques to challenge cognitions (see the examples in Appendix E: Examples of techniques to challenge negative and unhelpful cognitions).
4. Take time to carefully formulate an alternative, less negative, more helpful cognition. This helps to make alternative perspectives on situations/events more credible.

5. Do not try to challenge and change *all* negative cognitions. It is better to do it fully and properly on one cognition than to challenge all cognitions halfway.

Identifying maladaptive basic schemas

It is possible that clients are plagued by maladaptive basic schemas. Such schemas are deeply rooted beliefs and assumptions that have the status of highly exaggerated or extremely negative judgements about the person himself/herself ("I am worthless", "I am a weak person") or other people ("Everyone abandons me", "Other people cannot be trusted"). How can we know if such basic schemas are part of the client's problems? A sign that this is the case is that the client reports that she/he has been having severe emotional and/or interpersonal, relational problems earlier in life. A second sign is that the current grief, traumatic stress, or depressive symptoms are very intense and disabling.

TIP! Cognitive therapy focuses on changing cognitions that lead to emotional problems in the here and now. Therefore, adjusting of basic schemas only happens when the client suffers from them. If no maladaptive schemas come to light, the treatment continues to focus on identifying and challenging negative loss-related cognitions as in the previous sessions.

If maladaptive basic schemas are present, these most often come to the surface when discussing emotional episodes and reviewing column schemas/cognitive diamond schemas. If the therapist suspects that these basic schemas play a role, she/he can address this as follows: "If we summarize what we have discussed so far, it seems that X's death has triggered a deep-rooted conviction in you, something like 'I'm not worth anything". Do you recognize that?''

When the client endorses the therapist's hypothesis, the therapist may suggest taking a closer look at that in the current and the following session: "Shall we consider this negative conviction in this session and in the next session?"

If the therapist suppose that there are maladaptive basic schemas, but she/he does not know exactly how to formulate them, she/he can use the downward arrow technique, that was explained earlier. Other helpful tools to identify maladaptive basic schemas are the following:

1. **Identifying general themes in the client's negative cognitions:** Certain themes may emerge in the client's column schemas/cognitive diamond schemas that reflect a negative view of themselves, such as inferiority, fear of rejection, always being strong, and perfectionism. The therapist can check whether these recurring themes point to the presence of maladaptive basic schemas.

2. **Reflecting upon prior life events:** The therapist can explore whether negative life events play a role in how the client currently responds to his/her loss. Important questions in this regard are: "Have you ever felt this way in your life before?", "Does this situation remind you of something from the past?" It is possible that the client has drawn conclusions about himself/herself based on prior negative life events. Addressing these events and conclusions may help to elucidate maladaptive schemas (parental neglect for instance, may have resulted in the schema ''I am worthless'').

3. **Discussing recurring cognitive distortion:** Recurring cognitive distortions may be a sign of maladaptive basic schemas. For example: constantly placing demands on oneself may indicate perfectionism ("I must always do everything right, otherwise I am worthless"). An extreme degree of responsibility in order to please others can also be

an expression of a cognitive distortion (e.g., “I must always do my best to please others”).

Challenging maladaptive basic schemas

When challenging maladaptive basic schemas, the techniques described in Appendix E can be used. Below, several additional techniques are briefly addressed.

1. **Identifying the pros and cons of the basic schema:** In the case of persistent maladaptive basic schemas, it can be helpful to write down the advantages and disadvantages of holding on to this schema. An important question here is whether the schema helps the client achieve important goals now and in the future. It often appears that the schema is predominantly associated with disadvantages, and that there are actually no real benefits.

2. **Keeping a ‘proof-for-and-against-diary’:** Here, the client is asked to write down some evidence every day (for example for a week) that argues in favour of the negative schema and some evidence that argues against the schema: “Your basic belief is ‘I am worthless’. In the coming week, keep a journal where you write down every day the evidence that is in favour and the evidence against this belief. Also pay attention to the things that happen in the coming week that confirm or contradict this belief’’.

3. **Behavioural experiments:** Behavioural experiments are very important means to challenge maladaptive basic schemas.

   Example

   A client has the belief that he must comply with the wishes of others, because otherwise he will be rejected. In a behavioural experiment, the belief “If I say ‘no’ to other people it will lead to rejection”, is tested. The client experiments with rejecting some invitations for family visits. Based on these experiences, the original negative belief is reformulated as follows: “I do not always have to do what other people expect from me, and which I do not want to do myself. People will not immediately reject me if I say ‘no’ to a request. If they do so, that is annoying, but I can tolerate it.”

4. **Discussing core events that underlie the basic schema:** The therapist can discuss with the client which specific experiences have led to the negative schema. This can help to clarify, for instance, that the belief “I am worthless” has arisen because the client experienced emotional deprivation in childhood. It may also happen that the client has the schema: “Eventually everybody will leave me” based on earlier experiences with losses. Talking about the possible connections between schemas about the self and others and earlier life experiences with neglect, abuse, or abandonment may help the client to realize that the schemas are not valid and helpful in the here and now. A schema such as “I cannot show my emotions. If I do I will be punished” may have been functional in the client’s youth, because showing emotions was actually punished by the parents. However, this belief is no longer valid in the here and now.

Modifying maladaptive basic schemas

Just as with the negative and unhelpful cognitions, it is important that attention is paid to formulating alternative basic schemas that are more valid and credible to the client and less

self-undermining. Since schemas are very persistent and generally very credible to the client, it is important that the alternative schema is formulated very explicitly. Once the alternative schema has been formulated the client can write this schema on a flashcard, together with the arguments, evidence and experiences that argue in favour of the validity of the new schema. The client can carry this card with him/her and read it at times when negative emotions and thoughts from the original schema arise.

Homework

The client is requested to continue completing column schemas. If attention has been paid to a maladaptive basic schema, then the therapist gives an assignment aimed at challenging this schema.

SESSION 11
Reviewing the homework
Explanation of the rationale of activation and goal work
Explaining the connection between activity and mood
Explain the "Goals and steps" form
Formulating steps
Preparing the termination of the therapy

Reviewing the homework

The 4-column schemas/the cognitive diamond schemas and behavioural experiments that the client has done are reviewed. The therapist also addresses the assignments that the client has done in working on challenging maladaptive basic schemas.

Explanation of the rationale of activation and goal work

The activation and goal work can be introduced as follows (the explanation is adjusted to the specific situation and problems of the client):

"In this part of treatment, we are going to pay attention to Task III of the cognitive mode (Appendix A): 'Engaging in helpful activities that promote adjustment to the new life situation'. Let me try to explain that a bit. It is understandable that you have become less active since X's death. However, being passive and doing very little does not help you to engage in activities that promote adjustment to and mastery of this new life situation. Why is doing little unwise? First, if you do very little, you do not have many opportunities to experience pleasurable moments. Even if you do not feel like doing anything, you often notice afterwards that it was quite fun. A second reason is that doing little gives you a lot of time to ruminate and thing about all kinds of negative things, whereas engaging in some activity may help you to distract yourself from negative thoughts. A third reason is that you won't be able to adjust your everyday life to the fact that X is gone, as long as this everyday life is standing still and is not moving on.

There may be various reasons why people discontinue particular activities that they used to engage in after the death of a loved one. One reason may be that people feel so bad that they are not motivated to do anything at all. A second reason may be that people think that they can no longer obtain pleasure or satisfaction from activities that were previously meaningful to them. A third reason may be that people think that they are totally unable to undertake certain activities now that their husbands, wives, or children have died. The result is that people are becoming increasingly passive.

It is therefore understandable that you have engaged in fewer activities since X died. However, in order to adjust to the loss and increase the chance of experiencing positive feelings, it is crucial that you gradually increase your engagement in different activities. In the following sessions we are going to explore what activities you enjoyed to engage in before the loss. We will then try to formulate specific goals for the near future, concerning the specific activities you can perhaps gradually reengage in again. As noted, in terms of the cognitive model, this part of the treatment will be focused on Task III: 'Engaging in helpful activities that promote adjustment to the new life situation'."

Check whether the client recognizes himself/herself in this explanation. To what extent has the loss led to a decline in his/her activities? What social, recreational, educational, and work related activities has the client stopped or reduced? For what reasons? Also discuss what social, recreational, educational and work-related goals are relevant for him/her in the near future.

Explaining the connection between activity and mood

In general, if people do something — engage in an activity — they feel better and less bad than when they do nothing but just sit on the couch at home alone. Does the client recognize that there is a connection between what he/she does and what he/she feels? If necessary, complete an Activity Form (**FORM 8**) with the client. Fill in the activities she/he has undertaken in the past week (or the last couple of days) and ask the client to give a score for the general mood for every part of the day on a scale of 0 (very bad, sad, gloomy, lifeless) to 10 (very good, exuberant, cheerful, energetic).

TIP! Clients usually think that they can only become more active again if they are less sad about the loss. However, explain that the relationship between doing and feeling is often the other way around: being active anticipates an improvement in mood.

Explain the "Goals and steps" form

Working on goals is further explained using **FORM 9**, the "Goals and steps" form. This form can be introduced as follows:

"Personal goals are specific situations or circumstances that people want to achieve. I want to invite you to formulate goals that are important to you. Goals can be connected with different categories of activities. We make a distinction between social activities, recreational or leisure activities, and educational and work-related activities.

Social activities include all activities connected with friends, family or other people. Going out for dinner with a friend, taking a walk with a few acquaintances, going to an evening at the book club, drinking coffee with a nice colleague, are all examples of social activities you may want to engage in more.

Recreational activities refer to all leisure activities and hobbies that were previously fun and relaxing. It can be going to the movies, reading a book, exercising, walking, meditating, doing (other) spiritual activities. Note: Recreational activities and social activities can overlap.

Educational and work-related activities include all activities where you are engaged in study or work. It concerns activities related to your current or future work life or studying during the day. We also include housework and volunteer work in this category. Acquiring information about a specific course, spending a few hours at your workplace, registering for a new study program, starting a well-organized job at work; these are all examples of educational or work-related activities. With this in mind, I want you to think about (and write down) at least three very specific goals in the categories listed on the form. "

Together, therapist and client attend to **FORM 9**. Discuss what social, recreational, educational and work-related activities the client used to engage in before the loss occurred. What are the activities that she/he stopped or is now doing less often? The therapist helps the client in formulating more than one goal in each of the three categories, taking into account the following considerations:

1. **Formulating positive goals:** It is important that the client is encouraged to formulate positive rather than negative goals. Positive goals refer to situations that a person wants to achieve, while negative goals refer to situations someone wants to avoid. Accordingly, a positive goal such as "I want to call my friend Albert again" is preferred over a negative goal such as "I no longer want to avoid social contacts".

2. **Formulate goals that are as “SMART” as possible:** SMART goals are goals that

are Specific (simple, sensible, significant), Measurable (meaningful, motivating), Achievable (agreed, attainable), Relevant (reasonable, realistic and resourced, results-based), Time bound (time-based, time limited, time/cost limited, timely, time-sensitive). The client is encouraged to formulate goals that are as SMART as possible. A goal such as: "I want to feel distressed less often" is, for example, not Specific (What exactly is distressed?) and Not Measurable (How often is less often?). It is better to formulate this goal more precisely as: “I want to do something every other day that gives me a positive feeling for example feeling calm or happy”

3. **Prioritize the goals:** It is important that the client tries to formulate several goals in different domains. However, not all goals are equally important. The therapist therefore instructs the client to indicate with numbers (ascending from 1, 2, 3, 4 ... etc.) in what order she/he wants to work on the goals.

TIP! To gain insight into goals for the future, the following question can be asked: "Imagine that it is now a year later, and you have managed to resume your life, in which the loss has been given a place, and that you are now able to undertake enjoyable and satisfying activities. What would your life look like then? How would you feel? What would you do then? What social, recreational, work-related and educational activities would you undertake?"

Formulating steps

Next, for each goal, the therapist and client try to formulate the different steps that should be taken to achieve the goal. Steps are concrete actions that bring you closer to the goal. Note that it is helpful if these steps, like the goals, are formulated in a SMART way.

Example 1

Goal (social activity): Organize a dinner party for my best friends, a, b, and c, within a month.
Steps on the way:
Step 1: Consider which dates would be eligible.
Step 2: Find out exactly who I want to invite
Step 3: Prepare the invitation: What do I say with the invitation? What do I mention as the reason for the dinner?
Step 4: Make practical preparations for the meal.
Step 5: Prepare what I want to say about the X’s death.

Example 2

Goal (recreational activity): Participate in the 10 km run of the Utrecht marathon in 8 months.
Steps on the way:
Step 1: Look up and study information about training schedules.
Step 2: Purchase the required shoes and clothing.
Step 3: Check whether friends a, b, and/or c want to participate.
Step 4: Plan training schedule up to the day of the run and do the first training session.
Step 5: Ask if friends and family come to encourage me on the day of the 10 km run.

Use one form/page per goal.

Homework

If the client has difficulties to comprehend or believe the linkage between activity and mood, she/he can be asked to complete **FORM 8** (Activity form).

The client is also invited to further complete **FORM 9** (Goals and steps).

A final assignment for the client in session 11 is to start working on the first steps of the first 2 or 3 goals that the client has prioritized.
"After all the preparations, it is the intention that you now get to work with the first steps of goal 1, goal 2 and possibly goal 3. Take the following points into consideration:

- Work on multiple goals. It is good to divide your attention between various meaningful activities.
- Take multiple (small) steps in a short time: Try to take multiple steps in a week.
- Do not consider the goals and steps as a straitjacket: The goals and steps formulated are not intended as a mandatory scenario; they are intended to set a flexible course for your everyday life in the coming months and to give you a better view of valuable activities."

Preparing termination of the therapy

"This is the second to last session, and our time together is coming to an end. Saying goodbye and leaving therapy and using what you learned here on your own can lead to many thoughts and worries. Maybe especially for someone who lost a loved one the way you did. It can therefore be experienced as very final and painful to say goodbye. What are your thoughts on having to end the therapy?
For our last meeting please think about the most important thing you have learned here and we will talk about it next time."

SESSION 12
Reviewing the homework
Obstacles for achieving goals
Plan of action to continue working on the goals
Terminating the therapy and saying goodbye

Reflect on the homework

Has the client further completed **FORM 9** (Goals and steps)? Did she/he manage to accomplish some of the steps for two or three goals? What went well? What went less well?

Obstacles for achieving goals

Different obstacles may stand in the way of achieving one's goals. Two examples include "sabotaging cognitions" and "lack of resources".

Sabotaging cognitions: Sabotaging cognitions are negative, unhelpful cognitions that may undermine one's engagement in steps towards the achievement of valued goals. Three categories of cognitions are particularly important. The first is negative expectations (or pessimistic cognitions) about the effects and usefulness of becoming more active: "If I will engage in sports again as I used to do, that will not bring me any joy". The second category is cognitions blocking constructive action toward goal pursuit and encompasses negative cognitions about one's own abilities and skills: "Although I would like to meet with friends, I don't know how to arrange it". The third category concerns the viewpoint that one would betray the deceased, if one would move on and engage in particular activities: "I can't have fun in life, now that Peter is dead," "I betray him, by continuing my life."

As a therapist it is important to show empathy for these cognitions. It is entirely understandable that one is pessimistic about one's own skills or the joyfulness of doing things, especially in the first months after the loss. On the other hand, it can promote the adjustment process if one is active and focuses on activities that can give a sense of meaning and joy in life. The therapist can use column schemas/cognitive diamond schemas (**FORM 6, Appendix D**) to address the negative cognitions that sabotage Task III in the cognitive model in Appendix A.

TIP! If the client has the idea that she/he betrays the deceased person if she/he is no longer stuck in her/his grieving process and starts to feel better and engage in potentially enjoyable activities again, then ask the following question: "Imagine that we were able to ask about X's opinion. Do you think X would advise you to stay home all day feeling sad? Or do you think X would give you permission to go out of the house and meet with people again? What do you think X would say?"

Lack of resources: For some activities, help from a friend or other people from one's environment is useful. If a client's goal is to return to the reading club she/he was a member of, it can be helpful to get support from a person from the reading club that she/he had a good connection with. Support from other people is an important resource for increasing one's activity level. Information is also an important resource. If one has a goal to follow a painting course, or to start a new education, it helps to know which painting courses are available, and to know which courses are available that match the client's knowledge and time. Support and information are therefore important resources, and the lack of sufficient resources can be a major obstacle in the work towards achieving one's goals.

TIP! People with complicated grief reactions are often bitter about the limited spontaneous support they receive from their environment, or that they are not supported at all. Show understanding of such feelings. Next, discuss what the client himself/herself could do to obtain the desired support.

Plan of action to continue working on the goals

In this final session, the therapist and client address what the next goals that the client will be working on are, taking into account what the client has filled out on **FORM 9**. They also address the question about which people from the social environment may help in achieving particular goals.

Troubleshooting

The therapist and client also address the issue of what can be done if the grief or other emotional responses get worse somewhere in the near future or later on.

"Processing a loss is a process in which the grief sometimes suddenly becomes very intense and at other times is more in the background just as we saw in the dual process model I presented to you when we first met. Although some people think that adjustment to a loss is a linear process in which the pain gradually gets less and less, and eventually is gone, this is not always how it goes. Sometimes the mourning can reappear years after the loss like a sudden wave of grief.

So, although you are fortunately feeling much better now, you may feel sadder again at some point in the future. For instance, suddenly, you may get aware of a particular consequence of the loss that you had not thought of before. Or you may suddenly for unknown reasons get to miss X very intensely again. It is important that you allow yourself to be sad and grieve at that time. It is perfectly natural to feel that way when you have lost someone you love, as you have. It is also important that you do not get scared. If you hide the grief or interpret it in a very negative way, you will probably notice it getting worse. If you allow it to be present, then you will also experience that at some point it disappears into the background again."

Briefly address what the client can do if she/he experiences intense grief again. General advice is:

- Allow and express the emotions that are there instead of avoiding them or suppressing them.
- Seek support from friends and acquaintances and talk about the loss.
- Fill in a column schema/cognitive diamond schema to analyse the negative unhelpful cognitions that may be present.
- Make sure to plan some activities that may distract from the pain.

Homework

As a final homework assignment, the client is asked to write a letter to an imaginary friend, who suffered a similar loss and has been struggling with the same difficulties.

"You have learned a lot about mourning and dealing with loss in this treatment. In this letter we ask you to express that in a letter to an imaginary friend. Imagine that you have a friend named A. A has experienced a similar loss as you have experienced, under the same circumstances as your loved one X died. A has trouble handling the loss and is now at the

point where you were when you started treatment. In terms of the cognitive model in Appendix A, A has the same difficulties as you had with Task I (Confronting the loss and the pain that goes with it), Task II (Regaining confidence in yourself, other people, life, and the future) and Task III (Engaging in helpful activities that promote adjustment to the new life situation).

Write a letter in which you help and advice A to complete these tasks. Use your own experiences during this therapy in writing to A. So, focus on how you have managed to face the reality of the loss and what helped you to work through your pain. Additionally, also try to explain how you managed to regain some degree of confidence in yourself, others, life and the future. Finally, reflect on the goals that you have for the future, and how you have managed to accomplish the initial steps towards achieving these goals. Advise X on how she/he can gradually build up activities that are meaningful and possibly enjoyable."

Saying goodbye

Leaving therapy and having to get by on your own and saying goodbye can be especially challenging for bereaved people. This was briefly brought up in the last session as a preparation for this more formal goodbye.

"Saying goodbye and leaving therapy can lead to many thoughts and worries.
What are your thoughts on having to end the therapy?
What is the most important thing you have learned here?
What can you do to remember what you have learned?"

One option is to do a little exercise where the client is given a small object (a smooth stone, a marble, a bead) to hold in the hand during the exercise and bring home and keep in a strategic place as a reminder of what he/she has learned in therapy.

The exercise could go as follows: "Adjust your seat so you sit an erect but comfortable way. Close your eyes, if that feels comfortable for you. Spend a moment feeling your body in this room – your weight going down – the floor stable underneath you. Now, put your hand out as I place a small object in your palm. Fold your hand around this object and bring to mind the most important thing for your own well-being that you have learned in therapy. The one thing that is the main personal motivation for you to continue using what you learned. Find one word or one sentence that describes this motivation or thing you have learned.
Now open your eyes and look at the object in your hand. Maybe this object can be a reminder of what you learned and wish to take home from our time together. If you wish, you can put this object in a place in your home where you see it quite often. Now, would you like to tell me what word or sentence you thought of?"

This exercise is optional and should only be applied if the therapist likes the idea of it and finds it relevant for the client.

"Our time together is coming to an end, and I would like to say thank you for now and for sharing your story with me. It has been a moving and special journey. Thank you for that."

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Appendix A

Adjusting to the loss of a loved one: Three tasks

Adapting to life after a loss is a difficult process. In this treatment, we assume that processing a loss encompasses three important tasks:

I. Confronting the loss and the pain that goes with it.
II. Regaining confidence in yourself, other people, life, and the future.
III. Engaging in helpful activities that promote adjustment to the new life situation.

These three tasks help us to understand what good, adaptive loss processing involves, but also what types of feelings, thoughts, and behaviours that may block the process of coming to terms with a loss and, as such, contribute to the development and maintenance of complicated grief reactions.

Task I: Confronting the loss and the pain that goes with it

Task I is perhaps the most important task. Confronting the loss and the pain that goes with it is a necessary condition (or prerequisite) for adjustment to a loss. By "confronting the loss" we mean that it is important to reflect on the fact that the loss really happened, that the loss is irreversible, and that the deceased will never come back. Confronting the loss is also about being aware of the consequences of the loss; the consequences for yourself (your self-image and the roles you fulfil), the consequences for your future (plans and expectations for the coming months and years) and the consequences for the relationship with your loved one (which will never be supplemented with new events and forever consists of memories). By "confronting the pain" we mean that it is important to become aware of the feelings you may have about the loss, but also to allow those feelings to be there and work with them. The aim is not to forget the person you have lost, but to understand and accept the fact, that he or she is dead, and to find new ways to live a full life without the one, you have lost, by your side.

Some bereaved people find it very difficult to understand and process the reality of the loss, the fact that their loved one truly never comes back. People indicate this with words like “I cannot believe he/she is dead”, “I cannot accept this loss”, or "It feels totally unreal that he/she will never come back."

Some bereaved people tend to avoid the reality of their loved one’s death. That can be done in different ways. Some people reminisce all the time about moments with the deceased and at the same time avoid thinking about the future and the fact that those moments will never come back. Other people completely refrain from thinking that their loved one really never comes back because they fear that they will not be able to cope with the pain this will bring about, and they might even think that they will go “crazy” or “lose control” if they face the loss and the pain. There are still other people who avoid photos of their deceased or other objects or places associated with him/her, because it is strongly associated with pain and sorrow.

We can refer to this behaviour (avoiding internal and external stimuli connected with the reality and pain of the loss) as “anxious avoidance behaviour”. In the short term, turning attention away from the loss can bring some relief and help to focus attention on other issues. But when avoidance behaviour persists, and when it is driven by fear about the consequences of confronting and elaborating the reality of the loss, then the adjustment process may get blocked. For proper processing, it is important to face the loss. Only then

can you properly consider and process the consequences of the loss. And only then can you think of ways to deal with those consequences as good as possible.

Task I is also about working through one's emotions. Every person experiences different emotions after loss. Some people are particularly sad, others are struck by gloom, fear, or guilt and again there are others who are especially angry. There are no rules that prescribe which emotions are good, and which are not. It is useful to give space to the emotions you experience; to feel these emotions, express them, and reflect upon them. It is only when you allow these feelings and give them space that they can gradually decrease. Confronting the pain associated with the loss is therefore essential in processing the loss. Anxious avoidance behaviour can stand in the way of confronting and working through the pain. In this treatment, we will help you to face the loss and the emotions associated with it.

Task II: Regaining confidence in yourself, others, life, and the future

It is entirely normal that the death of a loved one shatters views of yourself and the future and causes your self-image, worldview, and view on the future to be negative for some time. But to move forward in adjusting to the loss, it is important that you have and maintain a sense of confidence and trust in yourself, other people, life, and the future. That is what Task II is about. What do we mean by that? It is only when you have self-confidence that you can continue your usual roles and activities. Likewise, it is only when you have confidence in other people, that you can ask them for help when you need it and you will be able to relate to them in a positive manner. And it is only when you can still believe that life is meaningful that you will be able to orient toward social, recreational, and work and education activities that were fulfilling before the loss occurred.

For some people, trust in themselves, others, life, the future has been seriously damaged following the loss of a loved one, and it can remain so for a long time after the loss. Sometimes people think very negatively about themselves; for example, they think they cannot do anything for others, or they are convinced that they are unable to handle the loss and deal with all the consequences of the loss. It can also happen that all trust in other people is gone. It is not strange that you think very negatively about medical doctors if you hold them responsible for the death, or think negatively of family members and friends who suddenly seem much less supportive of you than you would have expected. People can also get stuck in the conviction that life is totally meaningless after losing their loved one. Likewise, the future may seem bleak when plans that were connected with the loved one's presence can no longer continue.

It is understandable if you do not have that much faith and confidence in yourself, others, life, and the future in the first months after the loss. There has just been a major event in your life that has disrupted everything. That makes it difficult, if not impossible, to see yourself in a more or less positive view. When others can be blamed for the death, it is difficult to maintain a positive view of these people. When the person, who was the most important source of meaning and maybe also support during difficult periods is no longer there, it may seem impossible to believe that life has meaning. When the person who was part of all possible plans for the future suddenly dies, it can be difficult, if not impossible, to have faith that positive plans for the future will come true.

But for proper processing of the loss, it is important that confidence in yourself, others, life and the future returns. That confidence is essential for the integration of the loss you're your life. In the treatment, we will look for ways to regain and maintain this confidence.

Task III: Engaging in helpful activities that promote adjustment to the new situation

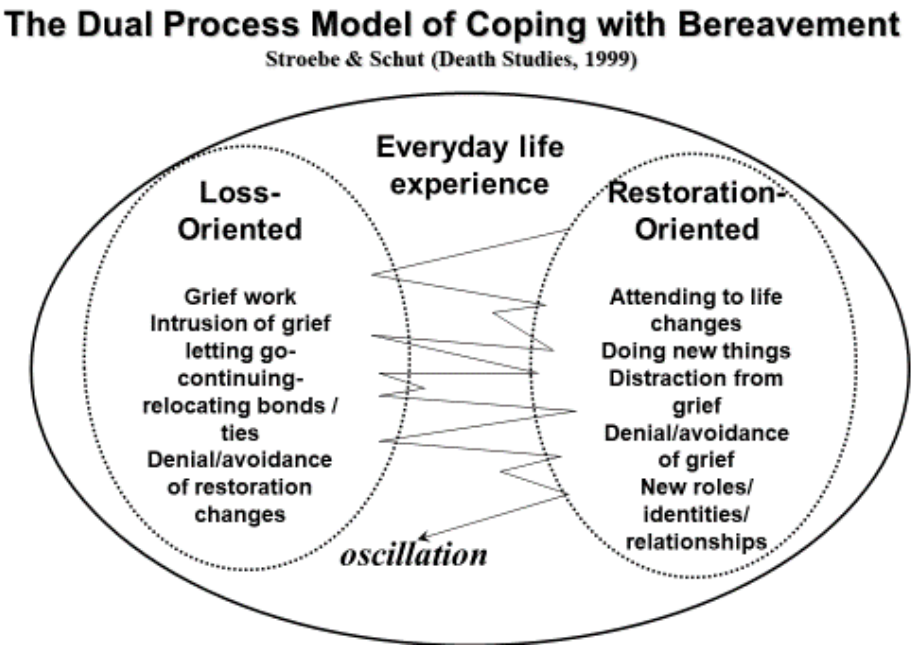
Task III is about the activities that you undertake in everyday life. The principle of this task is simple: adjustment to a loss goes more easily when you are better able to undertake activities that distract you from the grief for a shorter period, and the longer term help you to adjust your life to the reality that you have to move one without the deceased.

Which activities do we refer to specifically? Firstly, they include social activities such as contact with people you feel comfortable with (friends, family). Secondly, they include activities such as (voluntary) work and education. Finally, it is also about recreational or relaxing activities such as your usual sporting activities, contacts at clubs or associations, or reading, listening to music and other activities that previously helped you to relax. The more you undertake such activities, the more you will be distracted from the grief, and you will be helped to deal with the loss.

There can be all sorts of reasons and obstacles that stand in the way of engaging in helpful activities. You may lack the resources needed for this; if something has changed in your financial situation, you may have fewer opportunities to undertake relaxing activities. If your deceased partner usually arranged appointments with friends, it can be difficult to engage in social activities. Perhaps you lack the confidence to undertake activities, or you have a pessimistic belief about the usefulness of doing so. In order to progress further in the process of adapting to your new life situation after the loss, you will have to get rid of these obstacles in one way or another. You will have to search for resources; people who can help you to gain opportunities and resources to do things again. In addition, it is important to try to increase your self-confidence (who says that you are not able to find friends and gradually get back to work?) and try to have a “solution focused” attitude. What exactly do you want to do? What do you need to do to make this possible? Finally, it is important to turn pessimism into optimism. You must avoid thinking: First, I must feel good, and then I will be able to do something again. No, it is often the other way around: when you are sad and listless and yet start doing something (no matter how small), you notice that you subsequently feel better.

So just as “confronting the loss and pain that goes with it” (Task I) and “regaining confidence in yourself, others, life and the future” (Task II), “engaging in helpful activities” (Task III) is important in the process towards learning to live with a loss. It takes a great deal of effort to focus on other things after a major loss — things that sometimes seem so futile and useless in the light of the loss. Yet if you do it gradually, you will find that it helps: it distracts you from the sadness and helps to integrate the loss into your life. In the treatment, we will explore and find ways to gradually resume and increase activities that were previously meaningful to you.

Appendix B


The Dual Process Model of Coping with Bereavement
Stroebe & Schut (Death Studies, 1999)
Everyday life experience
Loss-Oriented
Grief work
Intrusion of grief
letting go-continuing-relocating bonds / ties
Denial/avoidance of restoration changes
Restoration-Oriented
Attending to life changes
Doing new things
Distraction from grief
Denial/avoidance of grief
New roles/ identities/ relationships
oscillation

Appendix C

Grief Cognitions Questionnaire

Below you find different negative beliefs. Please indicate the degree to which you agree with each belief?

		Strongly disagree					Strongly agree
1.	Since _____ is dead, I think I am worthless.	0	1	2	3	4	5
2.	I am partially responsible for _____'s death.	0	1	2	3	4	5
3.	Since _____ died, I have realized that the world is a bad place.	0	1	2	3	4	5
4.	The people around me should give me more support.	0	1	2	3	4	5
5.	I don't expect that I will feel better in the future.	0	1	2	3	4	5
6.	I have to mourn, otherwise I will forget _____.	0	1	2	3	4	5
7.	I see myself as a weak person since _____ passed away.	0	1	2	3	4	5
8.	If I let go of my emotions, I will go crazy.	0	1	2	3	4	5
9.	I am ashamed of myself, since _____ died.	0	1	2	3	4	5
10.	The death of _____ has made me realise that we live in an awful world.	0	1	2	3	4	5
11.	My grief reactions are abnormal.	0	1	2	3	4	5
12.	Life has got nothing to offer me anymore.	0	1	2	3	4	5
13.	I have no confidence in the future.	0	1	2	3	4	5
14.	As long as I mourn, I maintain the bond with _____.	0	1	2	3	4	5
15.	My life is useless since _____ died.	0	1	2	3	4	5
16.	I don't mourn the way I should do.	0	1	2	3	4	5
17.	I should have prevented the death of _____.	0	1	2	3	4	5
18.	Many people have let me down after _____ 's death. ?	0	1	2	3	4	5
19.	The death of _____ has taught me that the world is unjust.	0	1	2	3	4	5
20.	My life is meaningless since _____ died.	0	1	2	3	4	5
21.	My wishes for the future will never be fulfilled.	0	1	2	3	4	5
22.	Since _____ is dead, I feel less worthy.	0	1	2	3	4	5
23.	If I would fully realise what the death of _____ means, I would go crazy.	0	1	2	3	4	5
24.	If I would have done things differently, _____ would still be alive.	0	1	2	3	4	5
25.	Ever since _____ died, I think negatively about myself.	0	1	2	3	4	5
26.	I do not react normally to this loss.	0	1	2	3	4	5
27.	In the future I will never become really happy again.	0	1	2	3	4	5

28.	As long as I mourn I do not really have to let _____ go.	0	1	2	3	4	5
29.	People around me should show much more interest in me.	0	1	2	3	4	5
30.	I will never be able to forgive myself for the things I did wrong in my relationship with _____.	0	1	2	3	4	5
31.	There is something wrong with my feelings.	0	1	2	3	4	5
32.	My life has no purpose anymore, since _____ died.	0	1	2	3	4	5
33.	I blame myself for not having cared better for _____.	0	1	2	3	4	5
34.	The death of _____ has taught me that the world is a worthless place.	0	1	2	3	4	5
35.	Since _____ is no longer here, I have a negative view on the future.	0	1	2	3	4	5
36.	If I allow my feelings to be there, I will lose control.	0	1	2	3	4	5
37.	Since _____ is dead, I am of no importance to anybody anymore.	0	1	2	3	4	5
38.	If I start crying, I will lose control.	0	1	2	3	4	5

Grief Cognitions Questionnaire Subscales

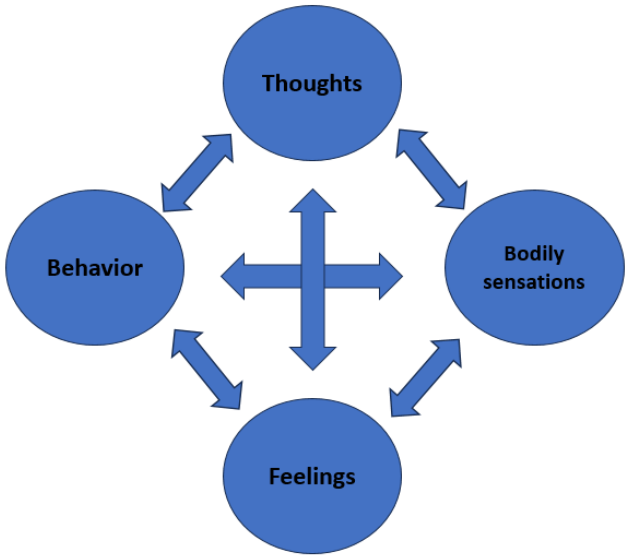
1. Self: items 1, 7, 9, 22, 25, 37
2. World: items 3, 10, 19, 34
3. Life: items 12, 15, 20, 32
4. Future: items 5, 13, 21, 27, 35
5. Self-Blame: items 2, 17, 24, 30, 33
6. Others: items 4, 18, 29
7. Appropriateness: items 11, 16, 26, 31
8. Cherish grief: items 6, 14, 28
9. Threatening interpretation of grief: items 8, 23, 36, 38

Appendix D

The cognitive diamond

Situation

_____
_____
_____



Negative automatic thought: _____
_____
_____

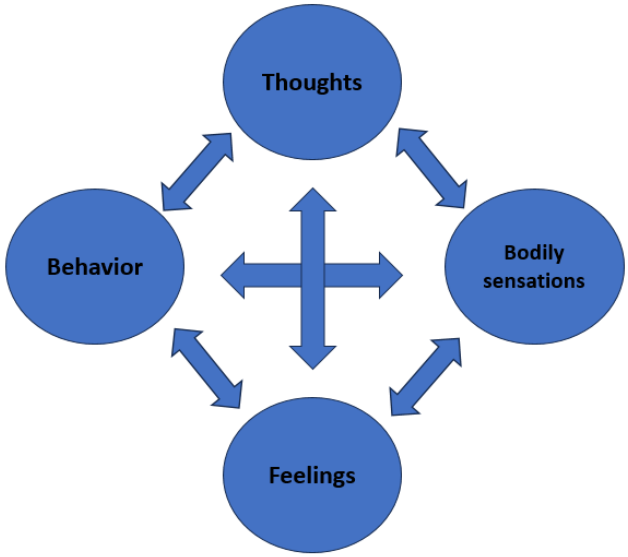
Helpful alternative thought: _____
_____
_____

The cognitive diamond

Situation

I come home to the empty house after spending time with a couple of friends. It's evening, it's dark, it's quiet, and there's no one to share it with

I'll never be happy again



Gets stuck, becomes passive,

stays in the sofa.

Cancels all plans the next day

Body feels heavy

Lump in the throat

Resigned, sad

Powerlessness, Loneliness

Helplessness

Negative automatic thought: I'll never be happy again

Helpful alternative thought: I'm sad right now, but I believe that tomorrow will be better

Appendix E

Examples of techniques to challenge negative and unhelpful cognitions/thoughts

The therapist can use various challenging techniques. We make a global distinction between three types of challenging techniques: (I) Socratic questioning; (II) Identifying cognitive distortions, and (III) Additional challenging techniques. These challenging techniques are explained below.

(I) Socratic questioning

Asking questions about the negative and unhelpful cognitions in a Socratic way is a powerful means to encourage clients to start reflecting on the degree to which these cognitions are true and helpful. The therapist applies genuine curiosity and guides the client in finding out whether his/her cognitions are logical and consistent with reality.

Examples of questions in the Socratic dialogue:

a. Asking for evidence supporting the negative and unhelpful cognition:
"What exactly makes you believe that you will never be happy again?"
"You seem convinced that your life is no longer useful, but is that cognition really true and correct?"

b. Asking for evidence against the negative, unhelpful cognition:
"You seem so convinced that the doctors in the hospital did not do everything they could to save X's life, but can you also mention what evidence there is pleading against this assumption?"

c. Questions about the logic of the reasoning:
"Is it logical to think that no one wants to socialize with you anymore now that your husband has died?''
"You husband died of cancer, but still you think that you are partly responsible for his death. This is not entirely logical to me. Can you explain it a bit?"

d. Questions about the consequences, the adaptiveness, the helpfulness of the negative cognitions:
"What are the consequences if you keep telling yourself that you could have prevented the death in any way?'', "Does this negative cognition help you?"

TIP! Make sure always to address both the validity of negative and unhelpful cognitions (is the cognition really true?), as well as the utility of these cognitions (does the cognition help me in coming to terms with the loss?)

(II) Identifying cognitive distortions

Cognitive distortions are recurring ways of thinking that seem correct and logical, but are not in fact correct and logical. The therapist can point out the misunderstandings/mistakes in the clients' reasoning and then challenge these misunderstandings/mistakes (in a Socratic dialogue). Examples of cognitive distortions are listed below.

Overgeneralization: Forming a general conclusion based on a single situation or event (''I will never be able to overcome this grief and be happy again'', ''Life has nothing left to offer me'').

Jumping to conclusions: Forming conclusions without evidence (‘’That I don’t cry much, means that I am not normal", “I could have done more for the deceased, and therefore I am guilty of his death’’).

Personalization: Attributing events to personal shortcomings or failure (‘’It is my fault that he is dead’’, ‘’My kids are unhappy because I cannot handle the loss properly’’).

Mind reading thoughts: Thinking that you know what other people are thinking ("Others think that I am guilty of the death", "People find me uninteresting now that I’m alone").

Predicting disasters: Predicting an extremely negative outcome of an event or situation (‘’If I really let the loss sink in, it would drive me crazy’’, “Now that I am alone I will languish and never be happy again’’).

Catastrophizing: An extremely negative evaluation of unpleasant situations ("It is terrible that I am still not over the loss", "That I am alone now is terrible, and I cannot bear it").

Demandingness: Translating wishes and desires into demands ("I should be able to handle the loss well", “People must understand how I feel", "The world should be fair and just").

(III) Additional challenging techniques

The therapist can also use several additional techniques to challenge negative unhelpful cognitions. Here, we will discuss a few examples.

The two-column technique:

1. Identify the negative and unhelpful cognition and write it down on a white board with two columns underneath.
2. Use one column to write down evidence for the cognition, and the other column to write down evidence against the cognition.
3. Ask the client to list all possible evidence, arguments and indications that he can think of, for and against the negative and unhelpful cognition.
4. Only write down the evidence that actually pleads for or against the truth of the cognition. The statement ‘’I just feel that it is true’’, is no evidence.
5. If the client cannot think of anything, ask questions such as ‘’Have you perhaps read somewhere that this is true?’’, ‘’If not you but someone else would have this thought, what kind of arguments would you give to show that the thought is not true?’’. Give some suggestions of possible evidence.
6. Discuss whether the evidence actually argues for or against the cognition, and if the evidence is actually real, true, valid evidence.
7. Reconsider the negative, unhelpful cognition in view of the gathered evidence, and let the client think of an alternative cognition.

The pie-chart technique

This technique is especially useful when the client attributes the responsibility for a certain event fully to himself.

1. Identify the dysfunctional thought (e.g.: "It is my fault that he died ")

2. Ask the client to list all possible causes that may underlie the event (‘’List all possible factors that contributed to his death.’’)
3. Ask the client to assign percentages to all of these causes that represent the share of the total cause. In this example, the client can come up with the following ‘causes’: ‘’his illness’’ (60%), ‘’negligence of the doctors’’ (10%), ‘’poor self-care during his life’’ (20%), ‘’I took him to the hospital too late’’ (10%).
4. Display the percentages in a pie-chart diagram.
5. Reconsider the original thought, and formulate an alternative thought.

Gathering information

This technique is especially useful if a client has particular negative and unhelpful cognitions that can be challenged with specific information. If the client has rigid ideas about the course of a normal grieving process (‘’A normal grieving process lasts for one year, and the fact that I am still very sad means that I am not normal’’), then the therapist can refer to accessible literature about the duration and the content of a ‘normal’ grieving process. If the client fears that he suffers from a serious disease (e.g. the same disease that the loved one died of), the therapist can ask the client to find out more about this disease to find out if it is hereditary, or about the risk factors for the disease.

Imagining the worst

This technique is useful when clients fear that a particular situation may have a catastrophic outcome. This technique gives the client insight into the probability that the catastrophe will happen, insight into how bad the catastrophe would actually be if it, and insight into his/her abilities to deal with possible catastrophes.

1) Make the catastrophe explicit, for example:
"Other people blame me for his death, and that is terrible"
"If I really let the loss sink in, it will drive me crazy"
"If I don’t let go of the deceased quickly, I will be alone forever".

2) Assume that the catastrophic idea is true, and ask what that means.
"What if other people indeed think that you are to blame for his death, what would happen then?"
"What if you indeed will be alone forever, what is so bad about that for you?"
"What is the worst thing that can happen, if you really let the loss sink in?"

3) Discuss solution- and coping skills, asking questions such as:
"How could you deal with it, if what you fear actually happened?",
"How could you solve that?",
"What would you still have to learn to be able to properly handle what you fear?’’

Appendix F

Examples of behavioural experiments

Behavioral experiment for someone with negative expectations about contacts with other people.	
Step 1	*Peter's wife has died. Together they had various social contacts. His wife usually arranged that. Peter does not think that anything good will come of it if he arranged his own contacts. He thinks: "People are no longer waiting for me, now that I am alone."*
Step 2	"If I contact that particular befriended couple, they will respond negatively to a proposal to meet."
Step 3	"If I contact them, they will respond positively, agreeing to a proposal to meet."
Step 4	It was agreed that Peter should contact the befriended couple by telephone and make a proposal to have lunch together at the place they had previously visited together.
Step 5	The befriended couple wanted to join for lunch. The positive prediction had come true. Peter experienced that he managed to organize social activities that were previously arranged by his wife.

Behavioral experiment for someone who is angry about the way in which the police have dealt with the consequences of an accident in which an acquaintance died.	
Step 1	*Bram was cycling with an acquaintance when they became involved in an accident. The acquaintance was seriously injured, and died shortly afterwards. None of the police officers had contacted Bram after the accident. He remarks: "The police completely ignored my feelings after the accident." This still makes him angry.*
Step 2	"If I check with the police again, I will only get confirmation that they are not concerned with my view of what happened and my feelings about it."
Step 3	"If I check with the police again, they will be able to answer the specific questions I have, and I will be have to give my perspective on what happened and my feelings about it."
Step 4	Bram and a good friend talked to someone from the police. Bram indicated in advance in an email what he wanted to talk to the police about, and what he hoped for the conversation.
Step 5	The police officer was able to answer his questions and showed understanding for his situation. The positive prediction had come true. Bram found that the police understood him when he spoke to them.

Behavioral experiment for someone who states that the grief is unbearable.	
Step 1	*Sylvia's partner was the only one to die in a train collision in which several people were injured. That was over a year ago. She calls the grief "overwhelming and unacceptable."*
Step 2	"If I really comprehend what my partner's death means to me, I will feel intense sadness that lasts for days, and it will be completely unbearable."
Step 3	"If I really think about what my partner's death means to me, then I will be very sad, but that sadness will become less intense after some time, and it will be manageable."
Step 4	It was agreed that Sylvia and a friend would visit her husband's grave. After that, in a quiet environment, with sufficient time, she would tell that friend what it means for her to live on without a partner.
Step 5	Sylvia experienced that the visit to the grave made her very sad. At the same time, she noticed that the grief, although intense, was also tolerable. She noticed that the grief in the hours after the visit gradually became less overwhelming.

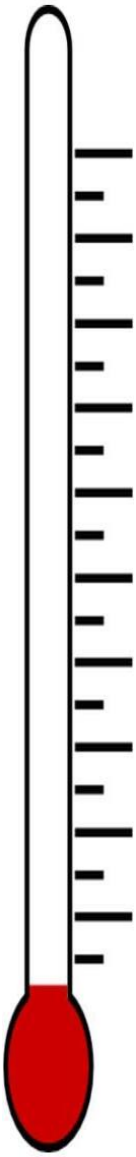
Behavioral experiment for someone with feelings of guilt about the circumstances of the loss.	
Step 1	*Frank's wife Maria died 2 years ago. One year before that, Maria had had increasing health issues. She was coughing a lot and often felt extremely tired. Frank was not very*

	concerned about these issues and tended to reassure his wife that there was nothing wrong. Eventually, she went to the doctor where she was told that she had esophageal cancer. Frank feels very guilty. He thinks that if he would have taken his wife's complaints more seriously, they might have gone to the doctor earlier and might have saved her life. He thinks all this despite the fact that he has been told that esophageal cancer is a form of cancer that is typically discovered, when it is too late.
Step 2	"If I tell other people exactly what happened, what I did, and why I did that, then people will blame me for what happened."
Step 3	"If I tell other people exactly what happened, what I did, and why I did it, people will understand it. I did what I could."
Step 4	Frank agrees with his therapist that he will consecutively talk to his mother, sister and close friend about what happened. Frank will inquire into how these people view the way he acted.
Step 5	Frank only meets understanding for his actions. They do not blame him at all, and they show that they would like to do with him.

Appendix – Schemas and Exercises

FORM 1

STRESS THERMOMETER



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FORM 2

THINGS I PREFER TO AVOID

Fill out the empty lines below with examples of different things related to your loss that you prefer to avoid.

[1] Avoidance of the reality of the loss

Example: Babette lost her husband to cancer 1 ½ years ago. She finds it literally unbearable to dwell on the fact that her husband is really dead and is not coming back. She dwells with sadness on the small and big moments she has shared with her husband, and then becomes overwhelmed by intense disbelief and bewilderment when she realizes that those moments will never be there again. Then she becomes overwhelmed by grief and immediately tries to distract herself.

Are there any thoughts or feelings that you would rather avoid?

_____
_____
_____

[2] Stimulus avoidance of specific situations, objects, people

Example: Albert's son died in a unilateral accident on a provincial road near a nearby village. Since the accident, now 2 years ago, Albert has avoided that road. His avoidance has gradually expanded; he would also rather not come to the village in question. Every route in the direction of the accident causes too much pain, he says.

Are there places or objects that you would rather avoid?

_____
_____
_____

[3] Avoidance of images and memories of circumstances surrounding the loss

Example: Peter witnessed his wife having a brain haemorrhage of which she died a few hours later. He still clearly sees the images of it. His wife wobbling and then falling down. The thump when she hit the floor. The image of his wife, motionless on the floor, regularly comes to his mind. Peter doesn't want to think about it. He tries to suppress the memories, because they hurt too much.

Are there memories, images, or parts of the loss story that you would rather avoid?

_____
_____
_____

[4] Compulsive proximity seeking

Example: Stefanie goes to her husband's grave every day. Her husband died of cancer three years earlier. Stefanie spends many hours at the grave, talking to her deceased husband and caring for the grave. "Then I feel close to him," she says. The idea of skipping a day cannot be discussed.

Are there certain activities that you constantly undertake to feel close to your loved one?

_____
_____
_____

FORM 3

TIMELINE

A timeline can be used in the therapeutic work for several different purposes. It is a therapeutic tool that in the therapeutic work can promote:

- Structure and overview of a given period
- Creating a coherent story/narrative
- Connecting situations with thoughts, feelings, bodily sensations and behaviors
- Separation of thoughts, feelings and events in order to create an overview and a new understanding
- Processing of traumas and particularly difficult events (“hotspots”)
- Separation of person and problem (externalization)
- Visibility, focus and understanding

Timeline:

Situations/events/incidents: (What happened to me?)

_____
_____
_____

Beginning End

Thoughts/feelings/body/action: (How was it for me in that situation?)

_____
_____
_____

Above the timeline, you write briefly and pointwise (we call it points of impact) about the events that have had a great impact on you, and that you remember particularly clearly. It can be both important positive or negative memories.
Below the timeline, you describe how you remember it was to be you in the specific situation that you have described above the timeline. Maybe

you can remember your thoughts, feelings, bodily sensations or your actions/behaviors.
You begin the timeline with the events that are the furthest back in time, and then move forward in time to the present day.
Your therapist will guide you further in the execution of the timeline, and you can work with it together in therapy.
It is your timeline, and there are no special requirements for how it should be made. It can’t be right or wrong.

FORM 4

FAREWELL LETTER

As part of your grief work, write on a consecutive farewell letter to your deceased loved one. You must address the letter to your deceased partner and can, for example, begin it with: "Dear...", or whatever you see fit.

Good themes to get into in a farewell letter can be:

1. How is it going, and how are you feeling now that X is dead?
2. What does your life look like, and what are you doing now that X is dead?
3. What are the most important changes in your everyday life, from before X died until now?
4. What was it like to be you, what did you think and feel in connection with X's illness and death? Feel free to describe specific episodes that were particularly difficult.
5. In what moments in the last couple of months have you missed X particularly much?
6. In what moments of your everyday life do you miss X particularly much? What exactly is it that you miss?
7. What did the deceased mean to you? What have you learned from the deceased?
8. What would you like to say to X? What do you want that person to never forget?
9. Which feelings and thoughts enter your mind when you think about the fact that you will never see, hear or feel X again?
10. What wishes and plans do you have about the future?

You can choose for yourself in what order you address these questions. You don't have to worry about spelling or format. The main purpose of this task is to reflect on these themes, feel your emotions connected to them and make room for them. If you're not comfortable writing, you can talk to X about the various questions and maybe record memos on a phone.

FORM 5

MONITORING EXPOSURE

Describe the exposure assignment you and your therapist have agreed that you are going to do. What exactly are you going to exposure yourself to? Write this in the box below.

Are you going to do so step-by-step? If so, briefly write down these steps.

Step 1:
_____
_____

Step 2:
_____
_____

Step 3:
_____
_____

Step 4:
_____
_____

Step 5:
_____
_____

Register the following points in the table below:

- Date of the exposure assignment
- Level of distress before doing the assignment (on a scale of 0 to 10; see the stress thermometer in **FORM 1**, if necessary)
- Highest level of distress during the assignment (on a scale of 0 to 10)
- Level of distress after the assignment (on a scale of 0 to 10)
- Tools you used during the assignment (e.g. support from others, relaxation).

Date	Level of distress before (1-10)	Highest level of distress during (1-10)	Level of distress after (1-10)	Tools I used to help me to do the exposure (if any)

Write down all positive and negative aspects of the assignment: What went well, and what did not go so well, what did you find difficult etc.

_____

_____

_____

_____

_____

_____

_____

FORM 6

4-column schema for identifying negative automatic thoughts.

Situation What? Where? Who? When?	**Emotions/feelings** What did you feel? How strong was that feeling? (1-10)	**Negative (automatic) thought** What thoughts went through your head just before/when you felt like that? Which of these thoughts is most closely related to the feeling? How much do you believe that this thought is true? (0-100%)	**Alternative more helpful thought** What could be an alternative and more helpful and realistic thought? How much do you believe that this thought is true? (0-100%)

FORM 7
BEHAVIOURAL EXPERIMENT

Step 1: What is the negative cognition that you are going to test?
Step 2: Reformulate the cognition into a negative prediction.
If……, then …..
Step 3: Reformulate the cognition into an alternative (more helpful) prediction.
If……, then……
Step 4: Decide what action you can undertake to test the prediction.
Step 5: After the action: What happened? What did you learn? Which prediction turned out to apply: the negative one or the alternative (more positive) one?

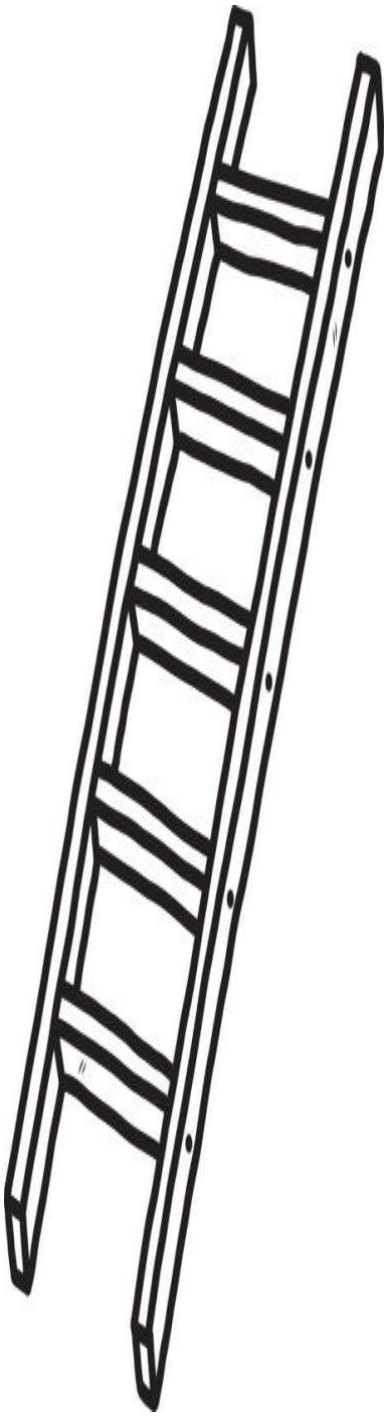
FORM 8
ACTIVITY FORM

Date	**Part of the day**	**What did I do?**	Write an **N** by activities that are nurturing, and write a **D** by activities that are depleting/draining
	Morning		
	Afternoon		
	Evening		
	Morning		
	Afternoon		
	Evening		
	Morning		
	Afternoon		
	Evening		

FORM 9
GOALS AND STEPS

Use one form for each goal

Goal: _____



Step 5:

Step 4:

Step 3:

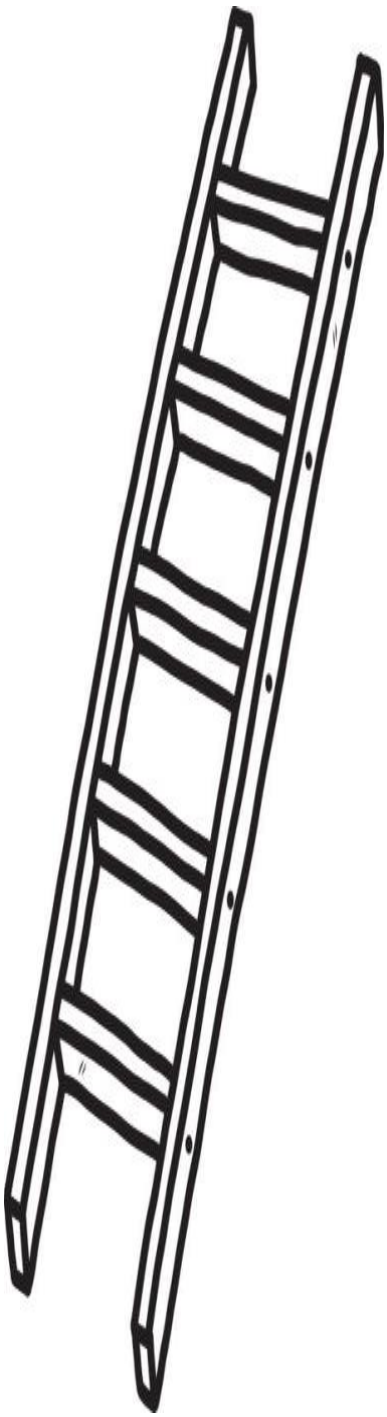
Step 2:

Step 1:

GOALS AND STEPS

Use one form for each goal

Goal: organize a meal for your best friends within a month



Step 5:
Prepare what I want to say about X's death

Step 4:
Make practical preparations for the meal

Step 3:
Prepare the invitation: What should I write in the invitation? What should I mention as the reason for the gathering?

Step 2:
Identify exactly who I want to invite.

Step 1:
Consider which dates might work