PRZEGLĄD PSYCHOLOGICZNY – THE REVIEW OF PSYCHOLOGY
2025, TOM 68, NR 4, 215–230
DOI: 10.31648/przegldpsychologiczny.12961

Cognitive Behavioral Therapy of Prolonged Grief Disorder

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Abstract

Aim: The purpose of this paper is to present the cognitive-behavioral models of the prolonged grief disorder, to compare the mechanisms that, according to individual authors, are the source of the persistence of symptoms, as well as the therapeutic protocols built on their basis, their components and the therapeutic techniques used.

Method: The introduction includes a brief history of understanding the prolonged grief reaction in its specificity as a distinctive nosological category currently included in the DSM-V-TR and ICD-11. The main part of the text contains a description of three cognitive models and corresponding therapeutic protocols intended for individual therapy, the one by Boelen, van den Bout and van den Hout, the second by Shear et al. (Prolonged Grief Disorder Theraphy – PGDT), and third by Pfoh, Rosner and Kotoučová (Complicated Grief – Cognitive Behavioral Treatment CG-CBT) as well as the presentation of research results on their effectiveness.

Conclusion: All three cognitive models derive the source of maladaptive, prolonged grief from the lack of integration of the loss experience with the patient's cognitive-emotional system. However, the authors of the individual models emphasize different aspects of this disintegration: Boelen stresses deficits in the updating of the patient's self-schema, Shear the lack of revision of the attachment model, Rosner the dysfunctional pattern of reaction to the experience of loss itself. The effectiveness of the described protocols was tested in a randomized controlled trial (RCT) procedure and the results of these studies prove their satisfactory effectiveness.

Keywords: psychotherapy, cognitive-behavioral, grief, prolonged grief disorder

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Grief following the death of a loved one is a natural, albeit painful, process. Although grief is inevitable, research shows that people respond to it in very different ways. Some people seem to be very resilient, experiencing only minor psychological distress, while others experience severe but bearable grief for 1–2 years. However, there are also those who experience severe, debilitating, and sometimes even life-threatening grief (due to increased risk of suicide), which is now called prolonged grief disorder (Boelen & Prigerson, 2013). Psychologists and psychotherapists have encountered serious difficulties in trying to define what so-called "normal grief" is. This was due to the fact that people experience and express grief in different ways, and this is further modified by factors such as culture, gender, personality and living conditions (Rosner et al., 2011).

Diagnostic Criteria for Prolonged Grief Disorder (PGD)

For many years, none of the commonly used classification systems for mental disorders (ICD and DSM) included a disease entity related to the experience of grief. Since the mid-1990s, researchers and clinicians have increasingly called for the inclusion of grief syndrome in disorder classification systems, referring to the phenomenon of pathological, complicated, and ultimately prolonged grief. Horowitz and colleagues proposed diagnostic criteria for "pathological grief" in 1993 and a revised version for "complicated grief disorder" in 1997 (Horowitz et al., 1993; Horowitz et al., 1997). Similar to PTSD, these disorders were described as consisting of a cluster of intrusive symptoms, avoidance, and adjustment difficulties. Around the same time, Prigerson and her colleagues published two important studies in this area. In the first study (Prigerson, Frank et al., 1995), they distinguished symptoms of complicated grief from grief-related depression and found that it was associated with mental health impairments other than those associated with depression. In the second article, they proposed the Inventory of Complicated Grief (ICG), a 19-item measure of the symptoms of this disorder, along with data demonstrating the psychometric value of the tool (Prigerson, Maciejewski et al., 1995). It is worth mentioning that the ICG has been adapted in many countries and has also been adapted to Poland (Ludwikowska-Świeboda & Lachowska, 2019).

Since Prigerson's first article in 1995, numerous other studies have replicated her findings (reviews in: Prigerson & Jacobs, 2001; Shear et al., 2011). The ICG scale has provided researchers with a tool for examining the construct's validity and measuring its correlates.

This research resulted in the development of preliminary criteria for complicated grief in 1999 (Prigerson, Shear et al., 1999). According to them, complicated grief includes symptoms of separation stress (e.g. longing) and post-traumatic stress (symptoms representing the feeling of trauma caused by the loss) occurring to such an extent that they interfere with daily functioning for at least 2 months (time criterion). A little later, the time criterion was extended to 6 months, and posttraumatic stress symptoms were no longer distinguished from separation stress symptoms because they were found to load together on one factor.

Based on the emerging tools measuring the occurrence of symptoms of prolonged grief and the proposed diagnostic criteria, the first epidemiological studies on the scale of this disorder were conducted. Its prevalence is estimated differently depending on the criterion used and ranges from 2.4% in Japan (Fujisawa et al., 2010), 3.7% in Germany (Kersting et al., 2011) to 4.2% in Switzerland (Maercker et al., 2008). Shear et al. (2011) estimate that approximately 10% of people who have lost a loved one develop pathological grief. As a result, the 5th revision of the DSM, published in 2013, included proposed criteria for "Persistent Complex Grief Disorder". However, in the latest, 11th revision ICD from 2019, full-fledged diagnostic criteria for "Prolonged Grief Disorder" (PGD) were already included, providing them with the code 6B42. The essential (required) features of this disorder include: (1) a history of mourning after the death of a loved one (usually a partner, parent or child); (2) a strong, persistent and overwhelming longing for the deceased or persistent focus on the deceased, accompanied by intense emotional pain manifested by strong emotions: sadness, guilt, anger, but also denial, blame and difficulty in accepting the fact of death; a sense of losing a part of oneself; inability to experience positive emotions; emotional numbness and difficulties in engaging in activities (social and other). The third criterion is temporal in nature, where grief persists for an unusually long period after the loss, significantly exceeding the expected social, cultural or religious norms typical of the individual's culture and context. It is generally accepted that mourning lasting less than 6 months should not be considered as meeting this criterion, although in some socio-cultural contexts the period considered as "normative" mourning may be longer than the 6 months mentioned. The final, fourth, essential feature of this disorder is significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If this functioning is maintained by a person, attention should be paid to whether this is not only due to great effort on his part.

Additional clinical features of this disorder may include persistent preoccupation with the circumstances of the death and preserving all of the deceased person's belongings exactly as they were before death. The patient may oscillate between excessive preoccupation with the deceased and avoidance of all memories and stimuli associated with the loss. Moreover, there may be difficulties in coping with everyday life without a loved one, difficulties in recalling positive memories of the deceased, limited trust in other people, social withdrawal and a feeling that life has lost its meaning. There may be increased use of tobacco, alcohol and other psychoactive substances, and there is a risk of suicidal thoughts and behavior.

Cognitive-behavioral Treatment Protocols for Prolonged Grief Disorder

Work on creating a prolonged grief disorder therapy based on the assumptions of cognitive-behavioral therapy began in the mid-1990s, in parallel by several teams of researchers and practitioners. The inspiration came from Horowitz's first proposals for diagnostic criteria for this disorder, and above all, Prigerson's creation of the first psychometric tools to assess the severity of symptoms in specific patients. Due to the significant need for a therapeutic protocol for prolonged

grief, at least three protocols for individual patients have been independently developed (by Boelen, Shear & Rosner), a protocol intended for group therapy (Bryant et al., 2014) and even an internet protocol in which the patient communicates with the therapist via e-mail (Wagner et al., 2006). The following part of the article will present the three therapeutic protocols mentioned above, intended for working with individual patients in an ambulatory setting.

A Cognitive-Behavioral Treatment Protocol for Prolonged Grief by Boelen, van den Hout, and van den Bout

The starting point for the investigations of Paul A. Boelen, Marcel van den Hout and Jan van den Bout was the observation that people suffering from PGD feel such a strong longing for the deceased person that they have problems in everyday functioning, and at the same time they are accompanied by a sense of unreality of the loss. Even though they remember the funeral of their beloved one and are confronted with the absence of their presence every day, they are often not fully convinced that the loss is irreversible and behave as if the lost loved one could return at any moment. As a result, the disbelief, pain of loss and separation from a loved one, which normally occurs soon after death, intensifies rather than gradually disappears. In an attempt to explain why in some people strong grief reactions persist and sometimes even intensify, researchers have developed a cognitive-behavioral model inspired by the cognitive model of PTSD proposed by Ehlers and Clark (2000). The model of Boelen, van den Hout, and van den Bout (2006, 2013) assumes that three interrelated processes are responsible for the development of a prolonged grief reaction: (1) insufficient elaboration and integration of the loss event in autobiographical memory; (2) negative thinking; (3) anxious and depressive avoidance behaviors.

Insufficient Processing and Integration of the Loss

Typically, in uncomplicated (normative) mourning, the conscious knowledge that separation from a loved one is irreversible is integrated with the subject's existing knowledge about himself and constitutes the basis of this part of the autobiographical memory. This process is supported by active processing of the consequences of the loss in the past, present and future, as well as by confronting the internal changes caused by the loss. Therefore, through the process of active elaboration of memories, explicit knowledge about the loss gradually becomes linked to internal knowledge about the self and the relationship with the deceased person. The result of this process is that the loss becomes part of the individual life story of the grieving person and gradually becomes less destructive and more normalized (although still painful).

According to the authors of the model, in the case of PGD the processing and integration process has been suspended or is incomplete. This has its consequences. The first is that because the memory knowledge about separation is not connected with other memory resources, the death of a loved one remains

a very shocking, unbelievable event. The lack of connection between memories related to the loss and other knowledge stored in memory causes these memories to remain active in the field of consciousness, resulting in intrusion symptoms similar to those found in PTSD and a prolonged sense of shock.

The second consequence is that knowledge about the self is insufficiently updated, which causes the person to have a reduced sense of clarity about his or her own identity. Integrating the reality of loss with knowledge of the self is a necessary condition for the grieving person to be able to redefine who they are without their loved one. This limited clarity about one's self leads to a desire to return to the period before the loss, difficulties in accepting the loss, isolation and a lack of meaning in life – symptoms that are characteristic features of PGD.

Another consequence is that the internal representation of the relationship with the deceased loved one is insufficiently updated, so the suffering associated with separation does not decrease. People create mental representations of relationships with close people as part of their autobiographical memory. When a loved one dies, the normal process is to incorporate the fact of the irreversibility of the loss into the mental representation of the relationship. This is associated with a gradual reduction in separation distress. The extent to which the fact of loss is not integrated with the representation of the relationship determines the extent to which the absence of a close person will continue to generate symptoms of separation distress, which is the core symptom of PGD.

Generalized Negative Beliefs and Maladaptive Interpretations of Grief

The second key process that Boelen and colleagues included in their model, which contributes to the maintenance and exacerbation of PGD symptoms, is rigid, negative, and dysfunctional beliefs and interpretations. Two categories of these beliefs are particularly significant. The first includes negative, generalized beliefs about oneself (e.g., "I am worthless without my husband"), about life (e.g., "Life has no meaning for me anymore"), and about the future (e.g., "I will certainly never find happiness again"). These generalized negative thoughts may develop when the event of loss disrupts previously positive beliefs (e.g., a vision of oneself as a parent), or when the loss reactivates previous, hidden negative assumptions (e.g., that one is worthless).

The second category of dysfunctional beliefs can result in a catastrophic response to loss. People experiencing loss must cope with painful emotions, thoughts and memories. The ability to accept them facilitates emotional processing. The problem arises when people interpret their own reactions to loss in a catastrophic way. Mourners may interpret the intensity of their experience of sadness as evidence of a loss of control, perceive their numbness as a harbinger of depression, and interpret vivid and intense intrusions as a symptom of insanity.

Anxious and Depressive Avoidance

The third, behavioral element of the Boelen et al. model concerns two types of avoidance: anxious and depressive. Anxious avoidance refers to the reluctance

to confront the reality of loss, its consequences, and the pain associated with it, driven by the fear that such a confrontation would be unbearable. Anxious avoidance may manifest itself as situational avoidance of places, images, and people associated in some way with the loss. It can also take the form of cognitive avoidance, including blocking unwanted thoughts and memories by ruminating on events surrounding the death of a loved one ("Why did this happen?"; "How could this have been prevented?") as a way of keeping more painful thoughts and memories out of consciousness.

Anxious avoidance should be distinguished from depressive avoidance, which refers to withdrawal from social, occupational, or recreational activities that could be rewarding and give meaning to life. In grief, depressive avoidance may occur when the loss limits access to activities that support mental health. Additionally, this can occur when mourners lack the skills necessary to achieve worthwhile goals, when their loved one is not with them, or when they believe that engaging in these types of activities without their loved one is a sign of disrespect for them or the fact of their death.

Both forms of avoidance are dysfunctional. For example, anxious avoidance is harmful because it causes distress and prevents us from processing and integrating the irreversibility of the loss and its consequences. Depressive avoidance is harmful because it interferes with the experience of positive emotions and maintains a negative perception of oneself, life, and the future.

The three processes described by Boelen not only directly contribute to the symptoms of PGD but also influence each other. For example, processing the event of loss and the subsequent integration of this fact with the knowledge about the self and the relationship with a loved one will most likely be blocked when realizing the consequences of the loss evokes negative thoughts about the self, life and the future. Similarly, the tendency towards anxious avoidance will also block this integration. Negative thinking and avoidance behavior also interact. Dysfunctional thoughts about self and life maintain a depressive cycle of withdrawal and passivity. Catastrophic interpretations of grief reactions contribute to anxiety-avoidance behaviors, which ultimately prevent the correction of these interpretations.

The therapeutic protocol proposed by Boelen and colleagues is aimed at alleviating persistent acute symptoms of grief and helping the patient achieve important goals (Boelen et al., 2013). The authors concluded that to achieve this, it was necessary to conduct interventions targeting the three processes described earlier. Therefore, they considered it crucial to: (1) integrate the loss event into the subject's existing knowledge system, (2) identify and change maladaptive thinking patterns, and (3) replace maladaptive avoidance strategies with more adaptive ones.

Verification of the Effectiveness of the Boelen, van den Hout and van den Bout Therapeutic Protocol

The authors of the protocol conducted a randomized controlled trial to verify its effectiveness in the treatment of prolonged grief (Boelen et al., 2007). The

study was conducted on individuals who had experienced the loss of a loved one at least two months before the start of the study, had a score of at least 25 points on the ICG scale, and met the diagnostic criteria for the proposed complicated grief (CG) construct. Exclusion criteria were substance abuse, psychotic symptoms, severe depression with suicidal risk, and participation in a parallel therapeutic process. Fifty-four people diagnosed with PGD were randomly assigned to one of three conditions: two groups using CBT procedures (n = 23 and n = 20) and one group using non-directive psychological support (n = 11). The two CBT conditions consisted of a total of twelve 45-minute treatment sessions. Six of them included cognitive restructuring (CR) and six others included exposure therapy (ET) applied in two time orders (CR+ET vs ET+CR). CR sessions were focused on explaining the importance of cognitive restructuring and learning how to identify, analyze and change negative beliefs. ET sessions included recounting the loss experience in detail, identifying internal and external reminders of the loss that the patient had been avoiding, and gradually confronting these reminders. Various forms of exposure were used (in vivo exposure when patients avoided specific memories, response inhibition when patients engaged in compulsive closeness-seeking behaviors).

The completion rate was 70% and 80% in the CBT groups and 64% in the psychological support group. The results showed that PGD symptoms and other psychopathological symptoms decreased significantly in people who received CBT therapy compared to those who received psychological support. The effect size for the difference between pre- and post-test in the ICG was d = 0.87 for the CR+ET condition and d = 1.29 for the ET+CR condition compared to d = 0.42 for psychological support. In the final analyses, it turned out that the decrease in PGD symptoms was strongly associated with a decrease in negative beliefs and avoidance. A less optimistic result of the study was the fact that only 32.6% of patients from the experimental groups achieved a clinically significant reduction in the severity of PGD symptoms.

Katherine Shear's Prolonged Grief Disorder Therapy (PGDT)

Katherine Shear and her colleagues based their prolonged grief therapy protocol on a biobehavioral model they developed (Shear & Shair, 2005). Considering that the syndrome appears in response to the death of someone very close, they turned their attention to attachment theory to understand its roots. They concluded that pathological symptoms of grief can be understood as an overactivation of the attachment system in response to separation from a loved one. They referred to the work of Bowlby (1980), who argued that the stress associated with such a loss typically triggers a protective reaction involving typical defensive coping strategies. Such strategies are often helpful in the short term, but become problematic when they become an persistent, standard response. Bowlby described the process of effectively coping with grief as requiring acceptance of its finality and a revision of the attachment model, redefinition of life goals and plans. Therefore, according to Shear, the key to PGD therapy is adaptation to

loss, understood by the authors as a learning process that, if completed, reduces the frequency, intensity and duration of grief symptoms. This makes it easier to understand and integrate the consequences of loss and its finality into a new pattern of mental functioning. Although this process is unique to each person and each loss, the adaptation process generally involves accepting the reality of the loss and rebuilding psychological well-being. When adaptation becomes distorted, grief symptoms remain strong and persistent.

Based on this understanding of PGD, the authors designed Prolonged Grief Disorder Therapy (PGDT) as focused on adaptation and coping with factors that distort it. They built it on the basis of elements of Edna Foa's prolonged exposure protocol used in the treatment of PTSD (Foa et al., 2020), including daily symptom monitoring (grief monitoring), imaginal exposures (reliving the story of loss and an imagined dialogue with the deceased), and in vivo exposures (confrontation with situations reminiscent of loss). They operationalized the adaptation process into seven key steps and designed a treatment protocol to address them, resulting in seven main treatment procedures and areas. These steps in adapting to loss are: (1) Understanding grief, (2) Managing strong emotions, (3) Seeing a promising future, (4) Strengthening relationships, (5) Narrating a coherent story of death, (6) Learning to live with reminders of the loss, (7) Building new memory connections. They structured them into 16 sessions of integrative interventions with a planned sequence and a series of specific procedures (Skritskaya et al., 2023).

Verification of the Effectiveness of the PGDT Therapeutic Protocol

Shear verified the effectiveness of her treatment protocol for prolonged grief even before the formal diagnostic criteria for this disorder were included in the DSM and ICD classifications. The first (pilot) study included 21 participants (Shear et al., 2001). People whose relatives had died at least 3 months before the start of the research project and who had ICG scores higher than or equal to 25 points were recruited. The results showed a significant decrease in symptoms measured by the ICG scale, by at least half compared to the pre-test results. However, the pilot study did not include a control group, so the next one was conducted as a randomized controlled trial. Ninety-five patients were randomly assigned to PGDT and interpersonal psychotherapy (IPT) conditions, each consisting of 16 therapeutic sessions (Shear et al., 2005). Patients receiving pharmacotherapy were also included. The results showed a statistically significant difference in favor of PGDT, with almost twice as many patients responding positively to PGDT as to IPT therapy. Patients treated pharmacologically with antidepressants showed a marginally better response to treatment in both CGT and IPT conditions.

The second large randomized controlled trial (Shear et al., 2014) was conducted in older patients (mean age 66 years). It was conducted at a different center, with different therapists and on a sample that was on average 10 years older than the first study. Patients who scored 30 or more points on the ICG and admitted in the clinical interview that grief was their main problem were

qualified. Individuals with a history of psychotic disorders, substance abuse, current bipolar disorder, suicidal ideation requiring hospitalization, Mini-Mental State Examination scores lower than 24, court proceedings related to the death of a loved one, and participating in another form of psychotherapy were excluded. Ultimately, 151 older patients were randomly assigned to receive 16-session PGDT or IPT. The percentage of treatment completion was high in both groups (82% and 81%, respectively). The results showed very clear differences in favor of PGDT (70.5% with clinically significant improvement) versus IPT (32% with clinically significant improvement). The study included patients using pharmacotherapy, but it turned out that this did not affect the effectiveness of the therapy.

The third study involved 395 adults from four different cities in the USA (previous studies were conducted within one metropolitan area), the primary aim of which was to determine the effectiveness of PGDT therapy with or without antidepressant pharmacotherapy (Shear et al., 2016). As before, people who obtained a score of 30 or more in the first ICG measurement were qualified. The results regarding effective response to therapy were as follows: PGDT + placebo group: 83%; no therapy + placebo group: 55%; PGDT + citalopram group: 84%; no therapy + citalopram group: 70%.

Cognitive-Behavioral Therapy for Complicated Grief (CG-CBT) by Rosner, Pfoh, and Kotoučová

The last of the cognitive-behavioral therapy protocols developed for patients suffering from prolonged grief presented in this review is the protocol by Rita Rosner, Gabriele Pfoh, and Michaela Kotoučová (Rosner et al., 2011), which they call Cognitive-Behavioral Therapy for Complicated Grief (CG-CBT). The cognitive-behavioral model developed by the authors covers the main symptoms of prolonged grief, i.e. intense longing and loneliness, inability to accept the death of a loved one, overwhelming and all-encompassing physical and emotional pain, as well as loss of identity. The grieving person reacts to these symptoms either by avoiding thinking about the deceased (cognitive avoidance) or any situations associated with them (behavioral avoidance), or by becoming excessively preoccupied with the deceased. In the short term, this leads to a reduction in symptoms (less longing and loneliness, less pain, greater acceptance of the new situation). However, in the long term, it leads to emotional, cognitive and functional impairment, which in turn acts as a reminder of the loss (internal stimulus) and results in a sense of hopelessness and helplessness, which secondarily strengthens the symptoms. This feeling of hopelessness and helplessness is also triggered by external stimuli, i.e. everything that reminds the patient of the loss of a loved one.

The proposed protocol contains typical elements of cognitive therapy: psychoeducation, building motivation for change, exposure, cognitive restructuring, and integration of the developed cognitive content into a new whole. The authors aimed to provide an effective therapy for complicated grief for patients with co-occurring DSM-IV Axis I disorders, who, according to their preliminary analysis, have a high rate of therapy dropout (Rosner et al., 2011). The authors

borrowed some techniques from other therapeutic models: Gestalt therapy, solution-focused therapy, multigenerational systemic therapy, defining the nature of their protocol as integrative. For example, to acknowledge loss and enhance the therapeutic alliance, the protocol involves the use of genograms. Genograms were added to the protocol after the pilot phase when the authors realized that some patients needed a representation of how their family passed on the tradition of mourning to the next generation. According to the authors, knowledge about family communication in this area not only serves to build trust in treatment, but also enriches psychoeducation.

The therapeutic protocol was planned for 20 sessions, which are divided into three parts: (1) therapeutic alliance, stabilization, exploration and motivation; (2) exposure and cognitive restructuring; (3) integration and transformation. With the exception of the first session, each subsequent session begins with the question: "What has changed?". The therapeutic contract is focused on the expectation of change in the patient. At the same time, this recurring question structures subsequent sessions.

Verification of the Effectiveness of the CG-CBT Therapeutic Protocol

Shortly after the publication of the therapeutic protocol itself, the authors verified its effectiveness in a randomized controlled trial (Rosner et al., 2014). When recruiting patients for the study, a stratified random sampling method was used, taking into account two important variables: the type of relationship with the deceased person (child or other form of kinship) and the type of death: natural vs. unexpected (unnatural). People who were over 18 years of age and met the diagnostic criteria for PGD were qualified for the project. Exclusion criteria were acute psychosis, substance abuse, suicidal risk, unstable pattern of pharmacotherapy use, and concurrent participation in other psychotherapy. The control condition was a waiting list for therapy, with a waiting time of four months or more. Finally, 51 people were qualified for the study, 24 were randomly assigned to the treatment condition and 27 to the control condition (waiting list). The vast majority of patients (86%) also met the criterion for at least one disorder in addition to PGD (in the last 12 months). These disorders were: depression, PTSD, GAD, panic disorder, and somatoform disorders. Prolonged grief symptoms were measured using the results of the PG-13 structured interview, which measures eleven PGD symptoms. The overall improvement in various psychopathological symptoms was also measured using the SCL-90-R, Global Severity Index (GSI), and symptoms of co-occurring disorders using the Computerized Structured Interview for DSM-IV.

Five patients in the CG-CBT group dropped out during therapy – however, no variable was identified that would differentiate those who completed therapy from those who dropped out. Analysis of covariance (pretest value as covariate) which taking into account those patients who dropped out of therapy (intent to treat analysis – ITT) showed a strong effect of CG-CBT compared to the control group (group of people waiting for treatment) based on the main measure of PGD symptoms, i.e. the PG-13 interview (effect size d = 1.32). For those who

remained in therapy, the effect size was *d* = 1.61. Strong effects were also revealed when comparing pretests with posttests (*d* = 1.26) in the CG-CBT group, whereas in the control group the differences were not statistically significant. Measures of general psychopathological symptoms did not produce such strong effects. For SCL-90-R, the overall level of well-being increased significantly (*d* = 0.64), while a similar increase was not observed in the control group. Analysis of covariance, however, revealed no significant differences between groups. The observed improvement was primarily related to symptoms of depression and somatization.

Taking into account the measure of treatment effectiveness, which is clinical improvement, 42% of the CG-CBT group could be considered cured of PGD symptoms (they no longer met the diagnostic criteria), and if the criterion of clinically significant change was taken into account, 53% of the participants experienced a significant reduction in the occurrence of symptoms.

After completing the first study, the control group (waiting list) underwent therapy using the CG-CBT protocol, and then, 1.5 years after the start of the first study, patients from both groups (the original experimental group and the original control group, which then underwent deferred therapy using the same protocol) were examined for symptoms of prolonged grief reaction. This procedure allowed us to determine the stability of the effects of the CG-CBT protocol therapy over time (Rosner et al., 2015). The "delayed" group also showed a significant decrease in PGD symptoms between pre- and post-test, but the effect size was slightly weaker (*d* = 0.80 for the ITT analysis, *d* = 1.30 for those who completed the therapy) than for the original experimental group. After 1.5 years from the start of the project (for the original experimental group this meant that more than a year had passed since the end of therapy, for the "delayed" group that at least 8 months had passed), 76% of participants maintained the results of the therapy measured immediately after its completion. Two people experienced a recurrence of symptoms, but six others showed a significant decrease in symptoms compared to post-test (immediately after the end of therapy).

Discussion

All three discussed therapeutic protocols were based on the cognitive-behavioral model of prolonged grief developed by their authors. Despite the different conceptual apparatus and the more or less extensiveness of the models in terms of their components, all three are conceptually similar. Two of them stem directly from the lack of integration of the experience of losing a loved one with the patient's cognitive-emotional system. Boelen highlights the problem of the lack of updating of the patient's self-schema and the cognitive representation of the patient's relationship with his loved one regarding the fact of his irreversible death. Shear, despite referring to less cognitive sources of his model (Bowlby's attachment theory), understands this lack of adaptation to the death of a loved one as a lack of revision of the patient's attachment model and a lack of redefinition

of life goals and plans, which results in dysfunctional overactivation of the attachment system. Rosner, in turn, sees the source of the prolonged grief reaction in the pattern of the patient's reaction to the experience of loss itself. In her opinion, it is precisely avoidance behavior on the one hand, or excessive preoccupation with the deceased on the other, that leads to impaired cognitive, emotional and social functioning. At the same time, they prevent mourners from accepting the death of a loved one and from making the effort to rebuild their life in the new reality. In all three protocols, the authors identified dysfunctional beliefs and interpretations as well as cognitive and behavioral avoidance as key factors in maintaining the symptoms of prolonged grief.

In this context, it will not be surprising that in each of the protocols discussed, the primary therapeutic interventions are exposures. These are primarily imaginative expositions concerning the circumstances of the death of a loved one and the patient's experience of loss, especially in the first hours and days after being confronted with the news of the death. They are also accompanied by in vivo exposures concerning current situations, people and places associated with the deceased (Boelen's & Shear's protocols). A very characteristic form of exposure found in the Shear's and Rosner's protocols is an imagined conversation with the deceased in the presence of the therapist, which they consider to be the final and most important intervention of the entire protocol. A form of this exposure in Boelen's protocol is writing a letter to a deceased loved one. It is an element of the patient's homework, and the authors of the protocol do not treat it as a key element of therapy. All three protocols also include an element of psychoeducation about grief and the PGD model, elements of behavioral activation, and cognitive restructuring. However, they differ in how much importance the authors attach to cognitive restructuring and what type of cognitive content it is primarily focused on. The most extensive cognitive restructuring procedures are included in the Boelen's protocol and concern generalized negative beliefs about the self, the future, the meaning of life and catastrophic interpretations of grief reactions. A large part of Boelen's protocol also consists of behavioral experiments based on the developed alternative interpretations and also include response prevention (e.g., limiting visits to the cemetery). In the Rosner's protocol, cognitive restructuring is mainly aimed at eliminating the patient's overinterpretation of the circumstances of the death of a loved one.

In general, the Boelen's protocol consists of standard cognitive-behavioral interventions (cognitive restructuring, exposures, behavioral experiments, behavioral activation) adapted to the specificity of the prolonged grief reaction. It also has most common elements with the prolonged exposure protocol for PTSD therapy (Foa et al., 2020). These include primarily exposure techniques: imaginary exposure and in-vivo exposure. Both types of exposure also appear in the Shear's and Rosner's protocols (e.g., in the Rosner's protocol, imaginal exposure is focused on the most difficult memories related to the deceased person – the so-called hot spots). At the same time, the Shear's and Rosner's protocols are more integrative in nature than the Boelen's protocol, using elements of motivational interviewing, solution-focused brief therapy, systemic therapy, and Gestalt therapy. They are also more filled with a variety of interventions, such as the

Table 1

Comparison of the Basic Components of Cognitive-Behavioral Therapy Protocols for Prolonged Grief Disorder in Outpatients

Therapeutic protocol	Number of sessions	Main elements of therapy	Therapeutic techniques used
Cognitive behavioral protocol by Boelen, van den Hout, and van den Bout (2013)	12	(1) Cognitive and emotional processing of the loss event and its integration into the patient's cognitive system. (2) Identifying and changing maladaptive thinking patterns. (3) Reducing anxious and depressive avoidance.	– imaginal exposure; – in vivo exposure; – exposure with response prevention; – cognitive restructuring; – behavioral experiments; – behavioral activation; – homework: written tasks (letter writing, automatic thought table);
Prolonged Grief Disorder Therapy (PGDT) by Shear and colleagues (Skritskaya et al., 2023)	16	(1) Understanding grief. (2) Managing strong emotions. (3) Seeing a promising future. (4) Strengthening relationships. (5) Narrating a coherent story of death. (6) Learning to live with reminders of the loss. (7) Building new memory connections.	– psychoeducation; – imaginal exposure; – in vivo exposure; – behavioral activation; – experiential techniques (session with the patient's loved one, working with photographs, imaginary conversation with the deceased); – homework: monitoring symptoms of grief, questionnaire of memories of the deceased loved one;
Cognitive-behavioral therapy for complicated grief (CG-CBT) by Rosner, Pfoh, and Kotoučová (2011)	20	(1) Therapeutic alliance, stabilization, exploration, and motivation. (2) Exposure and cognitive restructuring – cognitive restructuring and confrontation with dysfunctional thoughts; – experiencing the situation: exposure; – reconciliation: obtaining forgiveness. (3) Integration and transformation.	– psychoeducation; – safety procedure; – problem-solving training; – imaginal exposure; – cognitive restructuring; – relaxation techniques; – experiential techniques (imaginative forgiveness); – genogram; – homework: forms, letter writing, relaxation.

participation of a loved one in the session, working on personal goals, or working with memories and photos (Shear's protocol), and creating a safety procedure, problem-solving training, genograms, and psychodrama (Rosner's protocol). The result is that the Boelen's protocol is more theoretically coherent and internally integrated, while the Shear's and Rosner's protocols are less internally coherent, even eclectic (especially the Rosner's). On the other hand, their advantage is a more experiential nature and greater adaptation to the specific problems of patients suffering from prolonged grief (e.g. redefinition of life roles in the Rosner's protocol). A summary of the main components of the discussed protocols and the therapeutic techniques used is provided in Table 1 (p. 228).

All three described therapeutic protocols were subjected to empirical verification of effectiveness. The effectiveness of each of them was tested in experimental studies using the randomized controlled trial (RCT) procedure, obtaining satisfactory measures of effect size (differences between clinical and control groups), rates of clinically significant symptom reduction and rates of therapy completion. However, the procedures for verifying effectiveness are not comparable between individual studies. For example, the control groups for each study were not the same. In Boelen's study, the control group used non-directive psychological support (Boelen et al., 2007), in Shear's study interpersonal therapy was used (Shear et al., 2005), while the control group in Rosner's study was devoid of psychological influence and was on a waiting list for treatment (Rosner et al., 2014). The differences also concerned the statistical procedures used to estimate effectiveness (test-retest procedure vs. intergroup comparisons; analyses based on interval data, e.g., analysis of covariance vs. analyses based on nominal data, e.g., survival analysis). In summary, the authors of all three protocols can boast of research results proving their effectiveness, however, at the moment without conducting a systematic meta-analysis it is not possible to reliably compare them in this respect.

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