

# Cognitive-Behavioral Therapy for Complicated Grief

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## Keywords

Complicated grief · Cognitive-behavioral therapy

## Summary

Acute grief, albeit often a painful experience, is a normal reaction to the loss of a significant other; yet, most bereaved persons recover from grief without professional help. A minority of bereaved persons, however, experiences persistent and disabling grief symptoms, also termed complicated grief. Complicated grief as a distinct diagnostic entity receives increasing attention, partly because of its consideration in the revisions of the established classification systems ('International Statistical Classification of Diseases and Related Health Problems' (ICD-11) and 'Diagnostic and Statistical Manual of Mental Disorders' (DSM-5)). In the diagnostic process, both potential overdiagnosis (pathologizing normal grief) and misdiagnosis of complicated grief need to be considered. Interventions aimed at all bereaved persons (universal prevention) showed only minimal effectiveness. Whether complicated grief can be prevented in high-risk populations or in highly distressed acute mourners is still being critically discussed. Recent randomized controlled trials, however, demonstrated the efficacy of disorder-specific interventions. A broad evidence base supports both exposition to grief- or loss-associated stimuli and cognitive restructuring of grief-specific dysfunctional beliefs as parts of a cognitive-behavioral treatment. Setting new goals for a life without the deceased is also often incorporated in the treatment. Additionally, behavioral activation demonstrated preliminary positive effects for the treatment of complicated grief. Next to face-to-face psychotherapy, internet-based treatment approaches yielded promising results. However, further research is needed concerning, e.g., the differential effectiveness of specific treatment components.

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## Schlüsselwörter

Komplizierte Trauer · Kognitive Verhaltenstherapie

## Zusammenfassung

Akute Trauer als normale Reaktion auf den Verlust einer nahestehenden Person wird in der Regel schmerzhaft erlebt. Dennoch bewältigen die meisten Betroffenen ihre Trauer ohne professionelle Hilfe. Eine Minderheit erlebt anhaltende und schwerwiegende Trauersymptome, die das Bild einer komplizierten Trauerstörung erfüllen können. Die Aufmerksamkeit für komplizierte Trauer als eigenständiges Störungsbild nimmt zu, auch bedingt durch die Berücksichtigung in den Neuauflagen der Klassifikationssysteme «International Statistical Classification of Diseases and Related Health Problems» (ICD-11) und «Diagnostisches und Statistisches Manual Psychischer Störungen» (DSM-5). Die Diagnostik muss allerdings die Gefahr einer Pathologisierung normaler Trauerreaktionen sowie Fehlklassifikationen berücksichtigen. Interventionen, die sich an alle Trauernden richten (universelle Prävention), zeigen nur minimale Effekte. Die Möglichkeit der Prävention komplizierter Trauer in Risikogruppen oder bei hochbelasteten Akuttrauernden wird kritisch diskutiert. Aktuelle randomisiert-kontrollierte Studien belegten aber die Überlegenheit störungsspezifischer gegenüber anderen Behandlungsansätzen (interpersonelle Psychotherapie) bei komplizierter Trauer. Bezüglich kognitiv-verhaltenstherapeutischer Interventionen sind die Exposition gegenüber trauer- oder verlustassoziierten Stimuli sowie die kognitive Umstrukturierung trauerspezifischer dysfunktionaler Gedanken hochgradig evidenzbasiert. Ein weiteres Behandlungselement ist die Etablierung neuer Ziele für ein Leben ohne die verstorbene Person. Auch die Verhaltensaktivierung zeigte erste positive Effekte. Neben der klassischen Face-to-Face-Psychotherapie sind dabei auch Internet-basierte Behandlungsangebote vielversprechend. Dennoch besteht weiterer Forschungsbedarf, beispielsweise hinsichtlich der differenziellen Effektivität einzelner Behandlungskomponenten.

## Introduction

The loss of a significant other can be regarded as a universal life event. The concept of bereavement describes the reaction to such a loss. Most people recover from their grief without professional help, even though the period of mourning is painful. Some bereaved persons, however, experience persistent psychosocial impairment because of the grief, combined with various emotional, cognitive, physiological, and behavioral symptoms. In what follows, we use the term ‘complicated grief’ to describe this phenomenon. Its prevalence in Germany is about 4%, according to a survey of a representative population sample [Kersting et al., 2011].

## ‘Normal’ Grief

Grief is an adaptive response to loss. In the past, stage models of grief were often accepted, according to which typical emotional reactions occur in a certain sequence. The sparse empirical investigations of these stage models [e.g., Maciejewski et al., 2007] are methodologically objectionable [Bonanno and Boerner, 2007; Silver and Wortman, 2007], so that despite their popularity, they have found no empirical corroboration. Grief is in fact extremely individual, with an important role not only for the characteristics of the grieving person and the nature of the relationship to the deceased, but also the socio-cultural context. There is great variability in the emotions that arise (sadness, anxiety, anger, longing, relief), in the physiological correlates and symptoms (loss of appetite, sleep disorders, increased cortisol levels, changes in the immune system), in thoughts and feelings (guilt, rumination), and in behaviors (deliberately ‘summoning up’ memories, avoidance, crying). This variability pertains to the type and intensity of the above-mentioned reactions, as well as to the temporal course of the grieving process. The absence of a grief reaction should also not necessarily be regarded as pathological.

Acute grief can lead to massive functional impairment; it is associated with increased mortality and morbidity [Stroebe et al., 2007]. Nevertheless, most people manage to integrate the loss. They develop an integrated grief, i.e., the grief decreases in intensity and frequency, and moves into the background, so that a future-oriented continuation of one’s life becomes possible. Sometimes this also creates the prospect of personal development. Such integration is not contradicted if the grief suddenly becomes more intense on certain anniversaries or during a visit to the grave. The dual process model [Stroebe and Schut, 1999] is suitable as a description of a normal grieving process, as it describes an oscillation between loss-oriented (grieving) and recovery-oriented behaviors (e.g., taking up new activities). However, a normative time frame in which acute grief should be expected to pass over into integrated grief is difficult to establish, making it difficult to distinguish pathological grief trajectories.

## Classification of Complicated Grief Disorder

In the absence of a recognized diagnosis, different groups of researchers have long used different terms to describe the phenomenon, such as ‘complicated grief’, ‘prolonged grief’, or ‘traumatic grief’. These terms emphasize different aspects of the phenomenon (e.g., its duration or the circumstances of the death) and were combined with slightly divergent criteria as suggestions for classification. There is widespread consensus, however, that the disorder is characterized by an intense yearning for the deceased, intrusions, avoidance of stimuli associated with the loss, anger or feelings of guilt about the loss, a feeling of emptiness, emotional numbness and/or strong emotional or physiological reactivity when confronted with stimuli that remind one of the loss [Mancini et al., 2012]. The revisions of the established classification systems take into account complicated grief and presents obligatory criteria.

### *New Diagnostic Criteria: DSM-5 and ICD-11*

*Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*: The concept of ‘persistent complex bereavement disorder’ is used to describe ‘a condition for further study’; in other words, complicated grief is not treated as a distinct diagnostic category [APA, 2015]. The loss must have been at least 12 months prior (for children, 6 months). At least one principal symptom – persistent longing, intense anxiety/emotional pain, preoccupation with the deceased, or excessive mental involvement with the circumstances of death – must have existed for most of that time. Furthermore, there must be at least 6 secondary symptoms that are associated with the type of distress caused by the death (e.g., emotional numbness, bitterness, dysfunctional beliefs about oneself), as well as with social or identity problems (e.g., difficulty trusting others since the loss; the belief that one can no longer function without the deceased). Also required are an impairment of psychosocial function or clinically significant suffering, and a grief reaction out of proportion to cultural, religious, or age-related norms. With respect to the circumstances of the death, a specification can be made about the existence of traumatic circumstances of the death (grief after a murder or suicide; ‘with traumatic grief reaction’).

*International Statistical Classification of Diseases and Related Health Problems (ICD-11)*: According to the information available up to now, the ICD-11 will include the diagnosis of a persistent grief disorder [Keeley et al., 2015; Maercker et al., 2013]. In contrast to the DSM-5, the time criterion is at least 6 months; the duration of the grief reaction must in any case significantly exceed cultural or social norms. The main symptoms (longing for or persistent preoccupation with the deceased) are similar to those in the DSM-5, and many of the secondary symptoms (intense emotional pain, e.g., sadness, guilt, anger, difficulty in accepting the death, emotional numbness) appear to be similar. There must be an impairment of psychosocial functioning.

The inclusion of complicated grief in the classification systems is an encouraging step, which is sure to stimulate further research; however, the new criteria have been frequently criticized. One

fundamental concern is that ‘normal’ grief runs the risk of being pathologized [Wakefield, 2012]. This concern is not without justification. In one study in which experts conducted a diagnostic assessment of case descriptions based on the ICD-11 criteria, normal grief reactions were classified as a disorder in half of the cases [Keeley et al., 2015]. These results contributed to optimization of the criteria in a formalized feedback process. But individual DSM-5 criteria also appear to be low-threshold and applicable to normal grief reactions, due to their conceptual breadth (e.g., intense worry and emotional pain because of the loss) [Boelen and Prigerson, 2012]. Another problem is that the 2 classification systems use different time criteria. Furthermore, a discontinuity with previous research is feared because of the new criteria (especially in DSM-5), which could limit the validity of existing epidemiological findings and findings about treatment [Boelen and Prigerson, 2012]: For example, estimates of prevalence based on the old criteria are only partly applicable to the newly introduced symptom profiles.

#### *Diagnostics, Differential Diagnostics, and Comorbidity*

There are various clinical interviews available for the diagnosis of complicated grief, such as a German version of Prolonged Grief-13 [Rosner et al., 2015b]. The main self-report questionnaire used in research is the Inventory of Complicated Grief [Prigerson et al., 1995], which is also available in German translation [Lumbeck et al., 2013]. Neither instrument covers, however, all the criteria of the new classification systems. A clarification of suicidality is imperative.

There are many empirical studies dealing with the question of whether complicated grief is a distinct diagnostic entity [for an overview, see Shear et al., 2011; Bryant, 2013]. These have shown that complicated grief is influenced by disorder-specific predictors or risk factors. For example, complicated grief frequently occurs as the result of the loss of a child, but an important role is also played by the circumstances of death (e.g., a violent death) and the relationship to the deceased [for a review, see Burke and Neimeyer, 2013]. Complicated grief differs from normal grief in the occurrence of specific physiological and neuropsychological changes (e.g., changes in the reward system; the recall specificity of the autobiographical memory) [Maccallum and Bryant, 2010; O’Connor, 2012]. The symptoms of complicated grief can also be reliably differentiated from depression, anxiety, and post-traumatic stress symptoms [Boelen and van den Bout, 2005; Simon et al., 2011].

Differential diagnosis is required to distinguish complicated grief from depression and post-traumatic stress disorder (PTSD) [for an overview, see Shear, 2015; Wagner, 2014; Znoj, 2016]. Thus the main distinguishing features compared to PTSD, apart from the duration of symptoms, include the type of intrusions (in the case of complicated grief, both negative and positive intrusions) and the type of stimuli that are avoided. Moreover, in the case of complicated grief, there is no chronic hyperarousal or feeling of threat. Differentiation from depressive disorders is discussed more critically. Relevant features for complicated grief can be intrusions (especially positive ones) and the sudden, intense experience of

both positive and negative emotions. Longing for the deceased, which is very common in complicated grief, appears as a particularly important differentiating characteristic.

Various symptoms can occur as the result of a loss. Losses are considered as a risk factor for, among other things, depressive disorders, substance abuse and dependency, and anxiety disorders [Zisook et al., 2014]. The comorbidity rates of complicated grief with other disorders are high (about 75% of those with complicated grief also receive an Axis I diagnosis according to DSM-IV [Simon et al., 2007]). Comorbid depression occurs in an estimated 50–70% of complicated-grief cases. In a German outpatient patient sample, this rate was 62% [Rosner et al., 2014], and in an in-patient sample, it was even higher, as would be expected [Rosner et al., 2011].

### **When Is Treatment Indicated?**

Reviews have shown only minimal effect sizes of interventions aimed at all bereaved persons [Currier et al., 2008; Wittouck et al., 2011]. Some authors maintain that psychotherapeutic interventions actually negatively affect the course of normal grieving [Jordan and Neimeyer, 2003; Lilienfeld, 2007]. Universal interventions therefore do not appear worthwhile. But the question is to what extent it is possible to prevent complicated grief, e.g., in certain risk groups. Meta-analyses have shown that preventive interventions have no significant effects in the short term [Wittouck et al., 2011], or only minor effects [Currier et al., 2008]. In the long term, no significant effects were achieved [Wittouck et al., 2011]. Recent studies on prevention have shown a mixed picture [Litz et al., 2014; Wittouck et al., 2014]. Preventive interventions seem more promising if they are addressed to highly distressed persons who show symptoms of complicated grief, even if too early to qualify for the diagnosis (3–6 months after the loss) [Litz et al., 2014]. Nevertheless, considering the available empirical data as a whole, psychotherapy seems indicated only when there is a complicated grief disorder.

### **Models of the Disorder**

Several etiological models of complicated grief have so far been developed, based on, e.g., attachment theory or general models of stress adaptation [Maccallum and Bryant, 2013; Shear and Shair, 2005]. The models of Znoj [2016] and Rosner et al. [2015b], among others, have proven their value as clinical models for application in practice. Boelen et al. [2006] proposed a cognitive behavioral therapeutic disorder model, which is still stimulating much empirical research, with definite analogies to the cognitive model of PTSD [Ehlers and Clark, 2000]. According to this model, 3 processes are crucial for the emergence and maintenance of complicated grief after a loss:

- 1) a lack of elaboration or integration of the loss into the autobiographical memory;

- 2) dysfunctional beliefs (e.g., negative evaluation of oneself, the environment, and the future) or catastrophizing evaluations of one's own grief reactions;
- 3) anxious avoidance behavior (e.g., cognitive or behavioral avoidance of stimuli that remind one of the loss) or depressive avoidance behavior (e.g., social withdrawal).

On the basis of the initially acute grief reaction, these processes can lead to complicated grief. It is only through the interplay of these processes, however, that the maintenance of the disorder can be explained. If, for example, intrusions regarding the loss occur due to a lack of integration into the autobiographical memory, these will be maintained by catastrophizing assessments and subsequent avoidance behavior and eventually become pathological. Dysfunctional assessments of one's own grief reactions (e.g., 'I cannot bear this pain') promote mental avoidance or open avoidance behavior and thus prevent the patient from grappling with the loss in a way that would promote memory integration. Individual or loss-related risk factors affect the symptom severity only through these processes. Although this model requires further empirical validation and has been criticized in various ways [Maccallum and Bryant, 2013; Neimeyer, 2006], the essential starting points for psychotherapeutic treatment of complicated grief can still be logically derived from it.

### **Cognitive Behavioral Therapy of Complicated Grief**

Individual therapy and also group psychotherapy can be used for complicated grief. The individual setting (usually outpatient) allows for greater individualization and intensity of treatment, which, for one thing, affords advantages in biographical work and a possible focus on exposures. However, the direct social environment of group therapy offers, among other things, a depathologization of the symptoms, and social support through communication with other bereaved persons. Social avoidance behavior can also be treated well in groups. On the other hand, situational avoidance behavior may be better handled by in vivo exposure (or in sensu exposure) within individual therapy, which is why group programs often incorporate additional individual sessions [Bryant et al., 2014; Rosner et al., 2011].

Psychoeducation takes place at the beginning of the treatment, addressing the difference between 'normal' and 'complicated' grief; this is the basis for developing an individual model of the disorder and its maintenance. This model is used to derive the therapeutic rationale and to work out individual therapeutic goals. Sometimes it is recommended that the patients at first conduct a daily monitoring of grief symptoms [Shear, 2015; Wagner, 2014]. This provides a better overview of the individual grief symptoms, their frequency or times of occurrence and/or -variability, as well as the triggers for intense grief reactions. The grief journal is not only a diagnostic tool, but the daily observation of grief symptoms can also lead to their reduction. Cognitive behavioral therapy often uses a combination of the following treatment methods: 1) confrontation with the loss, 2) modification of dysfunctional cognitions, 3) behavioral activation/establishment of new goals.

### *Confrontation with the Loss*

Confrontation with the loss is an integral component of therapy. It can be followed by the use of specific techniques with different objectives. If there is anxious avoidance behavior, that should be reduced by exposure. If there is a lack of integration into the autobiographical memory, the goal is the elaboration of the loss, i.e., to recognize the reality of the loss and all its consequences, as well as to identify dysfunctional beliefs and painful memories that maintain complicated grief [Boelen et al., 2006]. Exposure promotes emotional processing of the loss and is thus an important component in the reduction of grief symptoms [Bryant et al., 2014].

Confrontation in sensu is often guided by the 'prolonged exposure' approach [Foa and Rothbaum, 2001]. Here, the patient is first asked to recount in detail the 'history' of the loss (e.g., the communication of the infaust prognosis, the situation in which the death occurred, the notification of the death, the funeral, etc.). For exposure to the most painful aspects of the loss, the 'hot spots' are ascertained. During the exposure itself, the patient confronts the most difficult memories about the loss (a first-person narrative, present tense, including all sensory perceptions). The objective may also be awareness of the loss in its full personal significance, through exposure. Thus, particularly painful and avoided aspects of grief as well as the reality of the loss are activated and integrated into the autobiographical memory. Exposures can also be used to identify dysfunctional thoughts, which can later be modified by cognitive restructuring. Writing tasks are also used in this context [e.g., Rosner et al., 2015b; Wagner et al., 2006]. A message to the deceased can be composed to further cope with the loss (e.g., in the form of a letter). Since avoiding confrontation with the loss can also be a result of dysfunctional cognitions (e.g., fear of being overwhelmed by grief and unable to act), confrontational interventions could also challenge these dysfunctional beliefs in a behavioral experiment. In vivo exposures to triggers are also possible in the treatment of complicated grief. Observable avoidance behavior is explored, e.g., situations or places connected to the circumstances of death, the corresponding stimuli/situations are ordered hierarchically, and the patient is thus confronted with classical in vivo exposure.

### *Modification of Dysfunctional Cognitions*

The modification of persistent, grief-specific, dysfunctional thoughts as well as feelings of guilt and/or shame is another important component of therapy. Dysfunctional grief-specific beliefs can be divided into 2 principal domains [Boelen et al., 2006]: They can, first of all, relate to the self, the environment, or the future (e.g., 'without the deceased person, my life has no meaning'; 'I will never be able to love anyone again'). Secondly, they can relate to the grief symptoms (e.g., 'I cannot endure this pain'; 'if I allow my grief to be less strong, I will betray the deceased'). Feelings of guilt can represent an additional area which expresses itself, e.g., in contra-factual thinking ('this wouldn't have happened if I had taken better care of the deceased'). Dysfunctional thoughts can be identified by self-observation or in the therapy session. In sensu confrontations

often provide clues to thoughts that make it more difficult to cope with bereavement. The procedure for cognitive restructuring follows the common methods [Beck, 1979]; a focus on grief-specific expectations and their verification [Rief and Glombiewski, 2016] is therefore possible.

Specifically for the treatment of complicated grief, a partial re-evaluation of the loss can also be achieved by focusing on the patient's positive or comforting memories, which replace the painful memories. If there are feelings of guilt about the death or about the deceased, distinctions should first be made among survival guilt, subjective guilt, and objective guilt. In contrast to the first 2 of these, which can be treated by cognitive restructuring, objective guilt (e.g., the patient as the cause of a fatal accident) is difficult to treat. Here, the main point is to develop acceptance, to integrate what happened into the patient's own biography. Using an empty chair technique with the deceased could be an additional grief-specific intervention for the treatment of dysfunctional self-blame, to challenge the patient's cognitions [Hedlund, 2011; Rosner et al., 2015b; Wagner, 2014].

#### *Behavioral Activation / Setting of New Goals*

Depressive avoidance behavior (withdrawal and inactivity) in the face of complicated grief fosters a loss of response-contingent positive reinforcement [Boelen et al., 2006]. Many treatment programs therefore encourage patients to reactivate their social networks and to resume seeking out social situations [Shear, 2015]. This also promotes the experience of social support. Encouraging the patient to rediscover old life goals or to develop new goals for a life without the deceased is also a common intervention [Rosner et al., 2015b]. If there are feared or actual competence deficits in the patient's ability to cope with certain activities, these can be addressed within the framework of general problem-solving training or specific skill training [see Papa et al., 2013] in order to expand the behavioral repertoire. However, it is not sufficient to identify activities or experiences that facilitate positive emotions or even pleasure, despite the grief. First, it must be explored to what extent the experience of positive emotions is consistent with the beliefs of the bereaved person about 'proper mourning', in order to be able to deal with opposing dysfunctional beliefs beforehand.

Therapeutic elements of behavioral activation [Martell et al., 2001] directly attempt to overcome depressive avoidance behavior. In a recent study, an intervention focused almost exclusively on behavioral activation [Papa et al., 2013]. The results show that a non-specific behavioral activation (along with functional assessment and psychoeducation) can suffice to reduce the symptoms of complicated grief. Even though this was a pilot study with methodological limitations in design and sample size, it illustrates the importance, for the treatment outcome, of approach goals in contrast to avoidance goals as well as goal-directed activity, positive reinforcement, and the experience of self-efficacy.

#### *Other Elements*

The above-mentioned areas are the main foci of cognitive behavioral therapy for complicated grief. Depending on the princi-

pal symptoms, further topics can be explored. For example, rumination was addressed as a possible cognitive avoidance behavior in complicated grief [Eisma et al., 2013] and was explicitly treated in some intervention programs [e.g., Bryant et al., 2014; Rosner et al., 2015b]. In order to reduce excessive preoccupation with a loss (e.g., multiple visits to the grave per day), which can also be a way of avoiding the acceptance of loss, some authors used a variant of exposure and response prevention [Boelen et al., 2007]. At the beginning of therapy, patients may express concern about forgetting the deceased (having to let go). This concern can reduce their motivation for therapy and should be treated by specific motivation-promoting interventions [Rosner et al., 2015b]. For example, at the beginning of the therapy, time can be allocated 'to introduce the deceased' [Rosner et al., 2015b], so that the therapist gets to know the person. This results in a personally meaningful narrative that includes the relationship between the patient and the deceased and a characterization of the deceased, but can also look at the circumstances of the loss as well as the meaning of the loss for the patient's life. More broadly, this engagement with the relationship to the deceased already constitutes a confrontation with the loss. Rituals or symbols (e.g., planting a tree, lighting a candle at certain times) can ascribe space and meaning to the continued existence of the relationship to the deceased beyond death (continuing bonds). The patient can also be asked to search for imprints [see Neimeyer, 2002] and to reflect on which characteristics of or advice from the deceased he would like to realize in his own life (e.g., encouraging friendships, being considerate) or which imprints he rejects as the deceased's 'legacy'. Elements of interpersonal therapy in combination with the above-described strategies have also been used very successfully (complicated grief treatment; [Shear et al., 2005; Shear et al., 2016; Shear et al., 2014]). The efficacy of metacognitive approaches in the treatment of complicated grief is currently under investigation [Wenn et al., 2015].

#### *Internet-Based Treatment Options*

Internet-based intervention programs offer an interesting approach. For example, Wagner et al. [2006] developed an effective online treatment program for complicated grief. It is based on techniques of cognitive behavioral therapy and contains 3 elements: a) self-confrontation with loss-associated stimuli (including writing about the circumstances of the loss), b) cognitive restructuring (including a supportive letter to a fictional grieving friend), and c) social sharing (including a letter bidding the final farewell to the loved one and/or distancing oneself from the traumatic experience). Patient and therapist communicate with each other only in writing / by e-mail. However, not all of the above-mentioned treatment elements seem to be equally feasible over the Internet. The initial data from a recent study that offered behavioral activation as an Internet-based intervention advise against the online applicability of this intervention because of its drop-out rate [Eisma et al., 2015]. Exposure-focused procedures, however, can be effectively implemented over the Internet [Eisma et al., 2015; Wagner et al., 2006].

## Efficacy of the Treatment

In systematic reviews and meta-analyses, interventions aimed at those suffering from complicated grief have shown at least moderate effect sizes after the intervention [Currier et al., 2008; Wittouck et al., 2011]. The more the patients were suffering, the more successful were the treatments. In the meta-analysis, there was also stability of treatment outcome in what at that time were the relatively few studies that reported a follow-up [Wittouck et al., 2011]. Since the appearance of that review article, some methodologically strong randomized controlled trials have been published [e.g., Bryant et al., 2014; Rosner et al., 2015a; Rosner et al., 2014; Shear et al., 2016; Shear et al., 2014]. Large effect sizes were shown in intent-to-treat and completer analyses, which also argue for the efficacy of cognitive behavioral therapy for complicated grief. The stability of the treatment outcome was also established in the respective follow-up assessments [e.g., Boelen et al., 2007; Rosner et al., 2015a]. The evidence of efficacy pertains to both individual and group therapy. Studies so far have shown that an additional use of exposure is more effective than cognitive-behavioral therapy without exposure [Bryant et al., 2014] or cognitive restructuring alone [Boelen et al., 2007]. In a combination of the interventions, exposure followed by cognitive restructuring proved to be more effective than cognitive restructuring followed by exposure [Boelen et al., 2007]. Pharmacotherapy alone, on the other hand, cannot be recommended for complicated grief [Bui et al., 2012; Lacasse and Cacciatore, 2014]. A recent randomized controlled trial confirmed this [Shear et al., 2016]. That study showed, however, that addi-

tional administration of citalopram (a selective serotonin re-uptake inhibitor) in combination with psychotherapy can optimize treatment by improving the accompanying depressive symptoms.

## Conclusion

Complicated grief as a distinct diagnostic entity is gaining more and more attention, also in the new editions of the established classification systems. Recent high-quality randomized controlled trials demonstrate the efficacy of cognitive behavioral therapy for complicated grief. Exposure and cognitive restructuring are important treatment elements, and combining them is particularly effective. However, further research is needed [see also Doering and Eisma, 2016]. The differential efficacy of individual treatment components seems to be a key issue here. Similarly, the question arises of whether the treatment components should be systematically adapted to subgroups of bereaved persons. Further research to optimize the treatment will be able to contribute to providing an answer.

## Disclosure Statement

The authors hereby declare that they have no conflicts of interest with regard to the present manuscript.

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