# Short-Term Group Therapies for Complicated Grief

## *Two Research-Based Models*

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# Short-Term Group Therapies for Complicated Grief

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—*William E. Piper*

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—*John S. Ogrodniczuk*

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—*Anthony S. Joyce*

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—*Rene Weideman*

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# Short-Term Group Therapies for Complicated Grief

# INTRODUCTION

Losing a significant person through death is a painful human experience that unfortunately increases in frequency as people grow older. Typical grief reactions include shock, denial, sadness, irritability, insomnia, preoccupation with the loss, yearning for the lost person, searching for the lost person, and experiencing intrusive images and memories about the lost person. Whether such reactions are regarded as normal or abnormal depends on their intensity and their duration. If they are experienced at mild to moderate intensities for short periods of time (e.g., 1 or 2 months), they tend to be regarded as normal and appropriate. However, if they become intense and enduring, the grief reactions are regarded as unresolved and perhaps in need of treatment. This is particularly the case when there are comorbid complications such as depression; anxiety; health-compromising behaviors such as excessive drinking or smoking; and social, occupational, and familial dysfunction. Currently, there is no standard definition or official diagnostic category for *complicated grief* (CG) in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000). Nevertheless, there is reasonable consensus among experts in the field as to what constitutes CG. The combination of unresolved grief symptoms and continuing dysfunctional complications is generally regarded as CG (M. S. Stroebe et al., 2000).

CG is usually treated through individual therapy, but in today's cost-conscience environment, administrators and practitioners alike view group therapy as an increasingly attractive treatment modality. Given the benefits of group therapy, we developed and extensively tested two evidence-based group therapy treatment models for CG: interpretive and supportive group therapies. The purpose of this book is twofold: to summarize the research that supports these models and to present these models so that clinicians can administer them. In the remainder of this chapter, we (a) discuss the benefits of group therapy, (b) explain how our models differ from common grief support groups, (c) note the limitations of short-term group therapy, and (d) explain how the rest of the book is organized.

## BENEFITS OF GROUP THERAPY

Long known to be cost-effective and time efficient, group therapy has a wide range of applications and established efficacy, as demonstrated by mounting research evidence (Burlingame, MacKenzie, & Strauss, 2004; Johnson, 2008). Based on a comprehensive review of the literature concerning prevalence of use, the surgeon general's report on mental health indicates that group therapy is used by mental health professionals in a variety of inpatient and outpatient settings with clients of all ages and stages of development (U.S. Department of Health and Human Services, 1999). Successive reviews of the outcome literature have found considerable evidence for the efficacy of group therapy (often on par with that of individual therapy) in the treatment of situational difficulties, behavioral problems, psychological disorders, and physical conditions (Fuhriman & Burlingame, 2001; McDermut, Miller, & Brown, 2001; McRoberts, Burlingame, & Hoag, 1998; Smith, Glass, & Miller, 1980).

We have argued that group therapy may be the treatment of choice for CG (Piper, McCallum, & Azin, 1992). Many problems that patients present with have their origins in complex human attachment, interpersonal relationships, and social milieus (I. D. Yalom & Leszcz, 2005). Thus, the social learning opportunities that group therapies provide are particularly well suited for addressing a variety of problems (Phares, 1992) such as CG.

Hughes (1995) provided an exhaustive list of beneficial features of groups for people who have suffered a death loss. Group treatments are capable of mobilizing strong forces for change. The group, which is sometimes referred to as a *cohesive social microcosm*, can exert considerable pressure on patients to participate. It is capable of eliciting the typical maladaptive behaviors of each patient. The other patients can observe, provide feedback, and offer suggestions for change. The patient can subsequently practice adaptive

behavior. This process is commonly referred to as *interpersonal learning*. Other patients may learn through observation and imitation. Simply recognizing that other patients share one's difficulties (universality) and helping other patients with their problems (altruism) can be therapeutic. These various processes (cohesion, interpersonal learning, imitation, universality, and altruism) are regarded as powerful and unique therapeutic factors of group therapy (I. D. Yalom & Leszcz, 2005).

There are other facilitative features of group therapy as well. Intense negative transference toward the therapist is less likely to occur in group therapy than in individual therapy because the situation is less intimate, and strong affects such as rage are diluted because there are multiple targets for expression. Similarly, feedback from the therapist in the individual therapy situation may be dismissed as biased, but this is much less likely to occur in response to feedback from several peers in a therapy group. In addition, because of the variety of affects expressed by different patients, integration of positive and negative affects is facilitated. In the case of short-term group therapy, time limitations may also provide unique opportunities for therapeutic understanding and change. In the case of CG, limited time is an especially relevant issue because it creates an impending loss for the patients and brings to the forefront all of their emotions and behaviors associated with loss.

In addition, common events in groups, such as patients' lateness to sessions, absenteeism, and dropping out, often trigger feelings and conflicts similar to the reactions that patients had experienced toward people whom they were losing and people whom they eventually lost. Although such events are usually regarded as disruptive and problematic in most therapy groups, they can be examined and used productively in loss groups. Termination of the group, as well, provides an opportunity for patients to examine their reactions to an immediate loss, compare them with previous reactions, and attempt adaptive reactions. Similar to the other naturally occurring events, termination can be used productively.

## INTERPRETIVE AND SUPPORTIVE THERAPY GROUPS VERSUS COMMON SUPPORT GROUPS

Our two treatment models—interpretive group therapy and supportive group therapy—have all the benefits of group therapy but differ from common support groups in several critical ways: They are customized to address issues specific to CG; they have formal evidence of effectiveness; and they are always led by professional mental health specialists. The following sections describe each type of treatment in detail.

## Common Support Groups

There are many different types of grief groups, characterized by such features as purpose (e.g., adjustment to a recent loss or alleviation of a chronic maladaptive grief reaction), duration (e.g., time limited or open-ended), status of the group leader (e.g., peer, professional), theoretical orientation of the group (e.g., psychodynamic, cognitive–behavioral), and the group's target population (e.g., a group for older widows or for parentally bereaved children). According to a recent review by Currier, Neimeyer, and Berman (2008), the most extensive of its kind to date, most group interventions have addressed immediate grief reactions among those with recent losses and those who are devoid of any clinically significant symptoms or behaviors associated with their loss. These kinds of group interventions are often referred to as *support groups*. Very few group interventions have focused on people suffering from CG. In fact, Currier et al. did not include a single study of a group intervention for people with CG. This reflects a considerable inconsistency between the abundant clinical literature on the etiology, signs, symptoms, and prognosis of CG and the scarce literature concerning its treatment, especially with regard to using group interventions.

In support groups, people who have experienced the recent loss of a significant other come together and, with the help of a leader, discuss feelings and reactions to their losses, learn new skills, meet new people, and adapt to life without the person who has died. People who attend support groups do not necessarily suffer from any significant impairment associated with their loss. Rather, they recognize the value of a helping hand and seek the support of others who are in a similar situation. Support groups can be led by a trained professional who has had a great deal of experience working with death and loss or by a layperson (i.e., peer) who has experienced the loss of a significant person and successfully adapted to the loss and wants to help others through a similar situation. Support groups typically have an educational or self-help orientation, yet they can also offer a forum for members to discuss their feelings associated with their loss.

Support groups are often geared toward helping people with specific types of losses. For example, there are support groups for widowed persons, suicide survivors, survivors of homicide victims, parents who have experienced the death of a child, survivors of persons killed by drunken drivers, and children who have lost a parent. Such specialized groups have an advantage in that the group members experience relief of finally being around others who, because of the similarity of their loss, seem to really understand (Hughes, 1995). It is more comfortable to be with people who are close enough to the problem that they do not need long explanations to achieve understanding. However, specialized support groups are not always available in every com-

munity. It is not always possible to offer separate groups for each type of loss because smaller communities do not have the population to maintain segregated support groups or cannot find appropriate and willing leaders. Nevertheless, mixed support groups benefit participants because they learn that all loss engenders grief and that grief is a common human experience.

Table 1 provides examples of various grief support groups, including those of the mixed variety and those oriented toward people with particular types of losses. Support groups are located in a variety of settings, including local hospices, senior centers, churches, Red Cross centers, local hospitals, and religious-affiliated social service organizations. The Internet is also a very useful tool for locating support groups. For example, the website of the BC Bereavement Helpline (http://www.bcbereavementhelpline.com/index.php?mode=links) posts a list of 40 local, provincial, national, and international agencies that offer support services to the bereaved.

Although many participants of support groups attest to the usefulness of these groups for helping them adjust to life without the person who died, formal evidence of the effectiveness of such groups is often lacking. For example, in their review of bereavement interventions, Currier et al. (2008) found that interventions directed toward people with recent losses but with no indication of a CG reaction fail to benefit them. Although such findings may reflect the reality of the limited efficacy of support groups, they may also reflect the possibility that studies of such interventions have failed to assess aspects of the lives of support group participants that are affected by such interventions (e.g., improvement in instrumental and emotional support). Nevertheless, in the event of a death loss and absence of significant impairment by the survivor, support groups may serve a useful purpose for those who would like assistance in adjusting to their loss.

TABLE 1
Examples of Grief Support Groups

| Organization | Focus of support group |
|---|---|
| THEOS (They Help Each Other Out Spiritually) | Young and middle aged widows |
| Parents of Murdered Children and Other Survivors of Homicide Victims | Survivors of murder victims |
| MADD (Mothers Against Drunk Driving) | Friends and family of people killed by drunk drivers |
| Compassionate Friends | Anyone who has experienced the death of a child |
| Rainbows | Children in grief |
| GriefShare | Anyone who has suffered a significant death loss |

## Overview of Interpretive Group Therapy and Supportive Group Therapy

In contrast to common support groups, our two models of therapy for CG—interpretive group therapy and supportive group therapy—are professionally led groups for adults with CG. The work of our clinical and research group likely reflects one of very few, if not the only, programs dedicated to developing and testing group therapy models for people suffering from CG. Our models each contain 12-session groups that are led by a single therapist.

For ease of communication, many people refer to interpretive therapy and supportive therapy as if they were distinct entities. Others argue that it is preferable to think in terms of a continuum with interpretive therapy at one end and supportive therapy at the other. Although the concept of a continuum is more complex than a dichotomy, it too is an oversimplification. This is evident if one tries to specify the nature of the dimension that defines the single continuum. It quickly becomes clear that the therapies on the continuum differ on many features. Thus, there are actually many continua, one for each feature. This multidimensional perspective is conceptually more cumbersome than a dichotomous perspective or a unidimensional perspective, but it is much more accurate in representing the complexity of the therapies. Consistent with the multidimensional perspective, we have defined features as including overall therapy objectives, session objectives, and therapist techniques or behaviors (Piper, Joyce, McCallum, Azim, & Ogrodniczuk, 2002). In an attempt to reduce conceptual difficulties, we suggest the following definitions and formulations. *Overall objectives* refer to the general or ultimate aims of therapy. Although helping patients solve their presenting problems is an overall objective of both interpretive and supportive forms of psychotherapy, the pathways differ. In supportive psychotherapy, presenting problems are addressed directly. In interpretive psychotherapy, they are addressed indirectly. Sometimes the terms *primary objectives* versus *secondary objectives* are used to make this distinction.

From our viewpoint, the primary (or direct) objective of supportive psychotherapy is to improve the patient's immediate adaptation to his or her life situation. To restore the patient's equilibrium, symptoms must be reduced, self-esteem boosted, and stressors reduced. There is a focus on the immediate needs of the patients. In many cases, there is a crisis-intervention orientation, even if the "crisis" is relatively minor and repetitive. Thus, there is an attempt to initiate restorative procedures as soon as possible and strengthen them as therapy proceeds. The secondary (or indirect) objective of supportive psychotherapy is to teach the patient problem-solving skills that can be used in the future. This includes such skills as learning how to define problems, consider alternative solutions, consider the advantages and disadvantages of solutions, try out solutions, and evaluate the outcomes of