

Running Head: CB INTERVENTIONS WITH BEREAVED ANXIOUS YOUTH

CASE STUDY ANALYSES OF COGNITIVE BEHAVIORAL INTERVENTIONS
WITH BEREAVED ANXIOUS YOUTH

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CB INTERVENTIONS WITH BEREAVED ANXIOUS YOUTH

Abstract

The death of a loved one is a major life event that can be stressful and may increase risk for mental health problems in youth (Cerel, Fristad, Verducci, Weller, & Weller, 2006; Kaplow, Saunders, Angold, & Costello, 2010; Kranzler, Shaffer, Wasserman, & Davies, 1990). There is still much to learn regarding effective interventions for youth who are experiencing the adverse effects of loss. Two cases were intensively reviewed to explore how clients expressed, and how therapists accommodated around, bereavement themes in a course of an empirically-supported cognitive behavioral therapy (CBT) for anxious youth. In one case, where the youth met criteria for principal generalized anxiety disorder, bereavement-focused strategies were incorporated secondarily into a standard manual-based protocol for anxiety. For the second youth who was treated primarily for bereavement, general CBT principles and strategies were applied to target bereavement-related themes, but a specific manualized treatment was not used. Intensive review of each case revealed bereavement themes that may contribute to bereavement-related distress, including: (1) depressive dysfunctional thoughts about the self, life, and the world; (2) specific anxious dysfunctional thoughts about the grief reaction; (3) fear of abandonment; (4) depressive avoidant behaviors, such as withdrawal from relationships or activities; (5) avoidance of loss reminders; and (6) problems integrating the loss. These bereavement themes were found to be prominent in the earlier part of treatment and were targeted using cognitive behavioral interventions, including bereavement-related exposures, behavioral activation, and proactive problem solving. This study supports the use of a CBT approach to conceptualizing and treating bereavement issues in anxious youth. The principles and framework of CBT appear to appropriately target the

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dysfunctional thoughts, avoidance behaviors, and poor integration of the loss that work to complicate the grieving process.

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An estimated 3.5% of U.S. children under the age of 18 have experienced the death of a parent (Social Security Administration, 2000). The percentage of bereaved children increases when considering the loss experienced when a close relative, peer, or significant other dies. Most individuals who experience the death of a loved one are able to cope and recover without complications (Bonanno, 2004). However, there are a number of children who find it more difficult to cope with loss. Emotional problems following bereavement can result in bereavement-related depression, bereavement-related anxiety, complicated grief, traumatic grief, or more severe psychopathology (Kranzler et al., 1990).

There are a number of overlapping terms and constructs related to problematic coping with loss, including *bereavement*, *prolonged grief*, *complicated grief*, and *childhood traumatic grief*. *Bereavement* was categorized in the DSM-IV-TR section “Additional Conditions That May Be a Focus of Clinical Attention” and described when the clinical focus was a reaction to the death of a loved one (APA, 2000). The typical clinical presentation may be similar to a major depressive episode; for example, exhibiting depressed mood, anhedonia, fatigue, poor appetite and sleep. It can, however be differentiated by the absence of some specific symptoms of depression. These include guilt about things other than those related to the circumstances of the death, morbid preoccupation with worthlessness, marked psychomotor retardation, and prolonged and marked functional impairment. According to the DSM-IV-TR, a diagnosis of major depressive disorder (MDD) was generally not given unless depressive symptoms, such as feelings of sadness, anhedonia, insomnia, and poor appetite continue to be present two months after the loss. With the recent update in the DSM-5 (APA, 2013), the

bereavement exclusion criterion was eliminated. Therefore, those presenting with depressive symptoms after the loss of a loved one can still be diagnosed with MDD. The DSM-5 (APA, 2013) offers Persistent Complex Bereavement Disorder as a “Condition for Further Study,” rather than as an official diagnosis. The proposed criteria include a persistent yearning or longing for the deceased (in children, behaviors that reflect being separated from and also reuniting with a caregiver or other attachment figure), intense sorrow and emotional pain in response to death, preoccupation with the deceased, or preoccupation with the circumstances of death (in children, the preoccupation may extend to preoccupation with possible death of others close to them). Additionally, at least six of the following symptoms are present: marked difficulty accepting the death, experiencing disbelief or emotional numbness, difficulty with positive reminiscing about the deceased, bitterness or anger about the loss, maladaptive appraisals about oneself in relation the deceased or the death, excessive avoidance of reminders of the loss (in children, it may include avoidance of thoughts and feelings regarding the deceased), a desire to die in order to be with the deceased, difficulty trusting others, feeling alone or detached from others, feeling that life is meaningless or empty, confusion about one’s role in life or diminished sense of one’s identity, or difficulty or reluctance to pursue interests (e.g. friendships, activities). These symptoms must be experienced on more days than not and to a clinically significant degree for at least 12 months after the death for bereaved adults and 6 months for bereaved children (APA, 2013).

Prolonged Grief Disorder, formerly referred to as complicated grief (or traumatic grief) is defined as a syndrome following the loss of a significant other that includes longing and searching for the deceased, preoccupation with thoughts of the deceased,

feelings of purposelessness and futility about the future, detachment from others, numbness, difficulty accepting the death, a sense of a loss of security and control, and anger over the death (Prigerson, Frank, & Kasl, 1995). These symptoms fall into two distinct categories of separation distress and traumatic distress. It has been confirmed to be a form of bereavement-related distress, which is distinct from depression and anxiety in bereaved adults and distinct from depression, anxiety, and PTSD in children and adolescents (Dillen, Fontaine, & Verhofstadt-Deneve, 2009; Melhem, Moritz, Walker, Shear, & Brent, 2007; Prigerson et al., 1995).

The central feature of complicated or traumatic grief is the separation distress and yearning for the deceased person (Prigerson et al., 1995). However, Brown et al. (2008) conceptualized traumatic grief in children differently. Rather than separation distress as the main difficulty, they found that avoidance symptoms were at the forefront of the disorder. The traumatic aspects of the death may impede the natural grieving process as these children avoid all reminders of the event, including talking about the death. Children with traumatic grief are unable to think about any memory, happy or sad, of their deceased loved one without bringing back to mind the traumatic aspects of their death.

Bereavement and Psychological Functioning

Several studies have found that bereaved children may be at an increased risk for psychological problems (Cerel et al., 2006; Kaplow et al., 2010; Kranzler et al., 1990). Children who experienced parental death (N=360) were found to have increased rates of psychiatric problems during the first two years following the death, however, their levels of impairment were less than those of children diagnosed with clinical depression (Cerel

et al., 2006). Their depressive symptoms were found to begin to resolve approximately 6 months after their loss and continued to decline at 13 and 25 months, giving a possible clue as to the trajectory of bereavement-related depressive symptoms. Similar findings by Worden and Silverman (1996) found that depressive symptoms were elevated in bereaved children as compared to non-bereaved children. Furthermore, the risk of future depression was found to be three times higher among bereaved youth (Melhem et al., 2007).

A recent longitudinal, epidemiological study found that children who experienced the loss of a parent (N=172) or another close relative (N=815) were more likely than non-bereaved children (N=235) to show symptoms of separation anxiety soon after the occurrence (Kaplow et al., 2010). Kranzler et al. (1990) also found that parental death in early childhood was associated with an increased risk for developing internalizing disorders, particularly anxiety. Bereaved children expressed more fear than controls when placed in situations of separation and were more anxious and clingy about their surviving parent. These bereaved pre-school aged children showed higher rates of disturbance compared to non-bereaved controls.

In addition to the increased risk for internalizing disorders, distress experienced after loss can lead to disruptive and acting out behaviors. Kaplow et al. (2010) found that bereaved children were at a greater risk than non-bereaved children to develop symptoms of conduct disorder and substance use disorders, and showed greater functional impairment following the loss of a parent or close relative.

Theoretical Conceptualizations of Grief

Several theories of grief and bereavement have been posited over the years. The concept of grief work first gained popularity with Freud's 1917 essay on mourning and melancholia, theorized within a psychoanalytic framework (Granek, 2010). Rather than pathologizing grief as an abnormal reaction, he focused on the normative, active process of detaching libido or mental energy from the deceased and sublimating it into other areas of life. Pathological mourning was defined as the inability to sublimate the lost love object into something more constructive, though Freud argued that this state was rare and only required additional time to mourn (Granek, 2010). Still, other psychoanalysts have proposed "taking in the dead person to oneself" in order to "carry it within and never lose it" (Abraham, 1924) and resolving the activation of past separation from maternal figures during infancy (Klein, 1965).

Arguably the most popular theory in recent history is that of Kubler-Ross (1969), which promotes the five stages of grief as states of denial, anger, bargaining, depression, and acceptance. However, many leading researchers find the static nature of each stage to be misleading. Rather, many clinical researchers are looking to the maintaining mechanisms and psychological processes underlying complicated bereavement.

The cognitive-behavioral model of complicated grief outlines three core processes that contribute to the development and maintenance of bereavement-related distress (Boelen, van den Hout, & van den Bout, 2006a). These include: (1) negative global beliefs and misinterpretations of grief reactions, (2) anxious and depressive avoidance strategies, and (3) poor integration of the separation with existing autobiographical knowledge.

Boelen et al. (2006a) posits that global negative beliefs and misinterpretation of one's grief play a key role in generating symptoms of complicated grief. Global negative beliefs about the world, life, and the self can lead to focusing on the past loss rather than the present and the future, which consequently take on a strong sense of purposelessness. Additionally, the misinterpretation of one's grief reaction can lead to fears of "going crazy" or losing control.

The cognitive component is easily linked to the behavioral component of this model of grief. The global negative beliefs often lead to more depressive avoidance strategies, such as inactivity and withdrawal. These behavioral patterns in turn result in the absence of pleasurable activities and their positive reinforcement, which ultimately strengthen negative beliefs about life and further increase withdrawal behaviors. Anxious avoidance strategies are more situation-specific rather than global. Those with complicated bereavement tend to avoid any situation that will remind them of the loss because they fear losing control or "crazy" grief reactions. The last element of the cognitive-behavioral model is the poor integration of the loss into autobiographical knowledge. In those with complicated grief, information about the loss as an irreversible event is not sufficiently linked with memories, thoughts, and feelings about the person, and may not be experienced as being sufficiently "real." As the information about the death continues to be experienced as a distinct and emotional event, the related distress and intrusive recollections of the event make it more difficult to reduce the intensity over time. This may strengthen negative beliefs that grief reactions are not normal or that any reminder is too difficult to bear, leading to more depressive and anxious avoidance. Boelen et al. (2006a) suggests the use of interventions that allow individuals to review

and elaborate on the meaning and implications of the loss in their life to make it more “real.”

Factors that May Contribute to Bereavement-Related Distress

Stressors. Exposure to stressful life events, such as financial hardship and parental depression, were found to be risk factors for developing a clinical level of depression following parental death (Cerel et al., 2006; Tein, Sandler, Ayers, & Wolchik, 2006). Girls in particular appear to be at increased risk, as they reported more interpersonal stressors, such as loss of support and increased interpersonal conflict (e.g. between family members) than boys reported (Little, Sandler, Wolchik, Tein, & Ayers, 2009). These findings are consistent with an earlier longitudinal study that found that family stressors after parental death partially accounted for increased feelings of hopelessness and low self-esteem in childhood and depression in adulthood (Harris, Brown, & Bifulco, 1986).

Death characteristics. Children who witnessed their loved one suffering from the physical distress of a terminal illness were found to experience greater mental health difficulties than those who did not witness the same level of distress (Salinger, Cain, & Porterfield, 2003). Though unexpected death has commonly been considered to be a factor that can prolong the natural grieving process, Cerel et al. (2006) found no difference in impairment in children who anticipated the death and those for whom the death was sudden or unexpected.

Gender differences. The bereavement literature points to gender differences in internalizing problems after loss, whereby girls experience higher levels of internalizing problems that tend to persist, in comparison to the declining trajectory found in boys

(Little et al., 2009; Schmiede, Khoo, Sandler, Ayers, & Wolchik, 2006; Worden & Silverman, 1996) These higher levels of depression and anxiety symptoms in bereaved girls were found to be mediated by a higher level of interpersonal stressors, greater fears of abandonment, and avoidant coping styles (Lawrence, Jeglic, Matthews, & Pepper, 2005; Little et al., 2009). Given these gender differences in both coping style and levels of bereavement-related depression and anxiety symptoms, it is important to consider the clinical implications that bereaved girls may need more support in both adaptive coping and adjustment to life changes post-death.

Cognitive factors. Several cognitive factors may also impact whether the bereavement process becomes complicated. Dysfunctional cognitions, specifically the fear of abandonment (e.g. fears that their surviving caregiver might abandon them or may be unable to care for them) or thoughts that one is responsible for the death, were associated with increased anxiety, depression, and bereavement complication symptoms (Little et al., 2009; Melhem et al., 2007; Schoenfelder et al., 2011). In addition to the central role of anxious cognitions, global negative cognitions regarding the self, life, and future were also found to be associated with higher levels of complicated grief and depression and predicted prospective symptom levels of both (Boelen, van den Bout, & van den Hout, 2006b).

In addition to content, specific cognitive processes have been linked to increased risk of depression and anxiety in parentally bereaved youth. Rumination over significant stressors and loss has long been linked to more pervasive and stable depression, and even more so for women coping with significant stressors and loss (Nolen-Hoeksema & Girgus, 1994). Appraisals also play a role in girls' higher symptoms of depression and

anxiety. Girls' tendency to make more global, stable, and depressive appraisals of the causes and consequences of the loss and threat appraisals of post-death stressors were related to their higher symptoms of depression and anxiety (Little et al., 2009).

Additionally, the tendency to make threatening interpretations of one's grief reactions was found to be a mediating factor (Boelen, 2006). Threatening misinterpretations of grief-related distress (e.g. deep feelings of sadness or physical pain) can include "losing control" or that it is wrong to still be in such pain.

Treatment Interventions for Bereaved Youth

The majority of bereaved youth are able to grieve naturally without further complication (Bonanno, 2004). Still, a significant amount of grieving children need additional support. There has been a proliferation of psychosocial interventions and resources attempting to address this need. Although some families are utilizing these services, there is a paucity of evidence supporting the efficacy of these programs in improving the functioning of bereaved youth.

Bereavement. Currier, Holland, and Neimeyer (2007) conducted a meta-analysis of controlled studies on grief interventions for bereaved youth. Twelve out of the 13 studies were group interventions, and all interventions addressed the following: "(a) improving coping skills, (b) increasing understanding of death and grief, (c) talking about the deceased loved one, and (d) expressing grief-related feelings via verbal and 'symbolic' modes of communication" (Currier et al., 2007, p. 255). Overall, the combined effect size ($d=0.14$) did not show support for the effectiveness of these interventions, on symptom measures of externalizing disorders, internalizing disorders,

and grief symptoms. They did, however, find that children whose losses were closer to the time of treatment showed better treatment outcomes.

A more recent study conducted two separate meta-analyses of controlled and uncontrolled studies for bereavement interventions for children and adolescents. Rosner, Kruse, and Hagl (2010) found larger effect sizes for both controlled studies and uncontrolled studies of 0.35 and 0.49, respectively, on outcome measures of grief, depression, anxiety, trauma, social adjustment, and somatic symptoms. There was a differential effect in which interventions used with more impaired and symptomatic bereaved youth showed larger effect sizes than interventions for bereaved youth without symptoms. The most successful grief interventions were music therapy and “trauma/grief-focused school based brief psychotherapy.” The music therapy intervention was cognitive-behavioral in nature and consisted of eight sessions focused on affective education, psychoeducation and normalizing the grieving process, behavior modification, and challenging cognitions by using reframing techniques in the context of singing and discussing song lyrics (Hilliard, 2001). Participants showed significant improvements in grief symptoms and behavioral problems at home. The trauma and grief-focused school based psychotherapy groups were also cognitive behavioral in nature, though not explicitly stated. Sessions were semi-structured and followed a manualized treatment protocol with modules focused on psychoeducation regarding trauma/loss and normalizing distress, building coping skills such as cognitive restructuring and problem solving, and processing traumatic experiences through trauma narrative exposure work (Saltzman, Pynoos, Layne, Steinberg, & Aisenberg, 2001). Participation in these groups was associated with significant improvements in PTSD symptoms, complicated grief

symptoms, and grade point average. It appears that cognitive behavioral treatment has considerable support as an approach with bereavement work, though future randomized controlled trials are necessary to establish its efficacy.

A promising preventive intervention showing enduring effects at six-year follow-up is the Family Bereavement Program (Sandler et al., 2010a). This is one of the few programs that has demonstrated efficacy in reducing mental health problems following bereavement in a controlled study. The youth component of the program taught skills to strengthen the relationship with their caregiver, increase adaptive beliefs about why stressors occur, positive coping, and decrease negative thoughts about stressors and the inhibition of emotional expression. The caregiver component focused on strengthening the relationship with the youth, decreasing caregivers' mental health problems, decreasing youths' exposure to negative events, and using effective discipline. Compared to the control group (N=109), youth who participated in the FBP (N=135) showed a greater reduction of problematic grief, lower levels of mental health problems (specifically externalizing problems) and improved self-esteem, and spousally bereaved parents experienced reduced mental health problems (Sandler et al., 2010a; Sandler et al., 2010b).

Childhood traumatic grief. In the treatment of childhood traumatic grief, Cognitive-Behavioral Therapy for Childhood Traumatic Grief (CBT-CTG) was found to be efficacious in both a 16-session protocol and a modified 12-session program for youth ages 6 to 17 years old (Cohen, Mannarino, & Knudsen, 2004; Cohen, Mannarino, & Staron, 2006). Two recent pilot studies (N=22; N=39) found that bereaved children's symptoms of childhood traumatic grief, depression, anxiety, and PTSD improved during

this manual-based treatment program, which utilized trauma-focused interventions followed by grief-focused components. Moreover, PTSD symptoms improved only during the trauma-focused components, while childhood traumatic grief symptoms improved during both the grief- and trauma- focused components. This provides additional support that childhood traumatic grief is distinct from PTSD, and that focusing on both trauma and grief are important in improving symptoms of this form of complicated bereavement.

Additional Cognitive-Behavioral Techniques to Apply in Bereavement Work

There is evidence in the literature that suggests that other cognitive behavioral interventions and strategies can be helpful for those grieving the death of a loved one. Since a specific treatment approach has not been shown as a standard of care, it is important to consider any additional cognitive behavioral strategies that may improve clinical care in this area.

Exposure. Exposure exercises have been an essential tool for increasing approach behaviors and decreasing avoidance in anxiety disorders, such as panic disorder (Barlow, Gorman, Shear, & Woods, 2000; Ost, Thulin, & Ramnero, 2004) and post-traumatic stress disorder (Ehlers, Clark, Hackman, McManus, & Fennell, 2005). Additionally, variations of traditional exposure have been used effectively in behavioral activation treatment for depression (Addis & Martell, 2004) and cognitive behavioral treatment for eating disorders (Fairburn, 2008). Exposure-based exercises have only recently been used as an intervention in bereavement work. Exposures may be beneficial in helping bereaved individuals to decrease avoidance behaviors, approach seemingly painful reminders, and disconfirm fearful cognitions and dysfunctional beliefs about the grieving process.

Behavioral activation. Behavioral activation is an effective treatment for depression, particularly in those with severe episodes (Dimidjian et al., 2006). It aims to improve mood by scheduling activities and using graded task assignments to increase positive reinforcement from the environment, as well as target low motivation and avoidance behaviors (Addis & Martell, 2004). Behavioral activation may be a beneficial intervention for those coping with difficult loss to help them re-engage in normal activities and relationships.

Writing. Constructing a coherent narrative about important events can lead to an integration of thoughts and feelings through cognitive processing and restructuring of the event (Margola, Facchin, Molgora, & Revenson, 2000). To that end, writing interventions have been used effectively in work with various confusing and stressful events, such as trauma (Deblinger, McLeer, & Henry, 1990). Researchers believe that extending its application to bereavement work may also be beneficial (Cohen et al., 2006). Expressive writing can help the writer make meaning and increase understanding of stressful life events, two tasks important in resolving grief and adjusting to loss (Neimeyer, Prigerson, & Davies, 2000). Writing tasks focused on “meaning making,” with specific instructions to disclose about the benefits, positive changes, or growth resulting from the loss, were found to decrease depressive and PTSD symptoms more than undirected bereavement writing tasks (Lichtenthal & Cruess, 2010) These findings may help shape clinical interventions with bereaved individuals who are struggling to find meaning and better understand their loss experiences.

Aims

The current case series aims to explore the relevance of cognitive-behavioral themes and interventions in two cases presenting with bereavement issues. Based on the extant literature, it is expected that youth expressing bereavement concerns will present with dysfunctional cognitive distortions related to their grief (e.g. global depressive beliefs, misinterpretations of their grief reactions, and fear of abandonment), depressive avoidant behaviors (e.g. withdrawal from relationships and activities), anxious avoidant behaviors (e.g. avoidance of loss reminders), and difficulty integrating the loss into their lives as a real event. We expect these types of themes to present themselves even when cases present with a definable psychological disorder (e.g., anxiety disorder). Based on the treatment literature, it is also expected that a range of traditional and bereavement-specific cognitive behavioral interventions will be helpful for bereaved youth. We expect cognitive behavioral interventions to be helpful for both general outcomes (e.g., anxiety symptoms) and bereavement-specific outcomes (e.g., level of distress when reminded of loss). The current study uses single-case design to explore two outpatient cases for presence/relevance of bereavement-specific themes and effectiveness of cognitive behavioral interventions.

Based on the treatment literature, the following are hypothesized:

- 1) Anxiety and bereavement distress will decrease during both the manualized CBT program and CB-informed treatment.
- 2) Bereavement themes outlined in Boelen et al.'s (2006) cognitive behavioral model of complicated grief will be present in both cases. Specifically, the following themes will be related to bereavement distress: (1) global depressive

dysfunctional beliefs about the self, life, and the world; (2) specific anxious dysfunctional cognitions about the grief reaction; (3) fear of abandonment; (4) depressive avoidant behaviors, such as withdrawal from relationships or activities; (5) avoidance of loss reminders; and (6) problems integrating the loss.

Methods

Participants and Setting

The current study will examine two youth psychotherapy clients (ages 11 and 16) who presented to an outpatient clinic for concerns related to bereavement. One youth presented to treatment for primary anxiety and mood problems, and bereavement issues played a significant role in complicating these issues. The second youth's primary treatment goal was to address distress related to her mother's recent death. Both were female adolescents and received a primary diagnosis of generalized anxiety disorder (GAD). The current case study will explore two different approaches to intervening with bereavement within a CBT framework. The first youth (Anna¹) was primarily treated for her anxiety disorder following a 16-week manual-based treatment for anxiety disorders (Kendall & Hedtke, 2006). Bereavement-related interventions were incorporated into her treatment as a secondary focus during exposure sessions. The second youth (Mary²) was primarily treated for bereavement-related distress following the death of her mother and her generalized anxiety was a secondary target of treatment. In this case, the therapist did not employ a single manual-based protocol; rather she employed a "principles-based" CBT approach to make use of cognitive-behavioral strategies while maintaining a focus on bereavement issues. The therapist was the same Masters-level clinical psychologist for

¹ Name has been changed to protect confidentiality

² Name has been changed to protect confidentiality

both cases, and both cases were supervised by the same licensed clinical psychologist who specializes in anxiety and mood disorders. Both cases were seen through an outpatient clinic that specializes in youth anxiety and mood disorders. Symptom measures were completed weekly and comprehensive diagnostic assessment was completed at pre- and post-treatment.

Measures

Diagnostic interview. Interview and questionnaire self-report measures were used to assess emotional and behavioral functioning at multiple time points. A thorough diagnostic interview was performed using the Anxiety Disorders Inventory Schedule-DSM-IV-TR – child and parent (ADIS-C/P), a semi-structured diagnostic interview administered to the adolescent and parent regarding the adolescent's symptoms at intake (Silverman & Albano, 1996). The ADIS has good interviewer reliability ($\kappa=.98$ for parent interview; $\kappa=.93$ for child interview; Silverman & Eisen, 1992). The parent and child interviews were conducted individually allowing the diagnostician to derive parent-reported, child-reported, and composite diagnoses. Clinician severity rating (CSR) scales help to assess for the degree of impairment or interference in the adolescent's functioning. The CSR can range from 0-8, with 0 indicating no impairment and 8 indicating very severe impairment. Diagnosticians were trained to reliability by coding videotaped interviews and matching gold-standard ratings of diagnoses ($\text{Kappa} \geq .80$). Three target problems were identified at the end of this interview and were rated on a Likert scale (0-8) at each time point to track progress on client goals. These were used to track changes on those items important to the clients that may not have been captured in the following symptom measures.

Symptom measures. The following child and parent self-report forms were administered at the beginning of each therapy session. The State-Trait Anxiety Inventory for Children (STAIC) – Trait Scale (Spielberger, 1973) consists of two 20-item scales that measure state and trait anxiety in children. The Trait scale focuses on the more enduring tendency to experience anxiety, with retest reliability between .65 and .71 (Spielberger, 1973) and $\alpha=.91$ (Muriset al., 2002). The 20-item child scale and the 26-item parent scale were used. The Multidimensional Anxiety Scale for Children (MASC) – Revised (March, 1997) is a 39-item measure used to assess anxiety symptoms along four dimensions, including Physical Symptoms, Harm Avoidance, Social Anxiety, and Separation/Panic. Test-retest reliability is $r=.93$. Both child and parent versions of an adapted 10-item scale were used.

Analysis

Qualitative analysis. All available videotapes of therapy sessions were reviewed for the presence of key bereavement-related themes and the interventions employed to address them. Specific themes were drawn from the literature on factors complicating bereavement and Boelen's (2006) model of complicated bereavement: (1) global *depressive dysfunctional thoughts* about the self, life, and the world; (2) specific *anxious dysfunctional thoughts* about the grief reaction; (3) *fear of abandonment*; (4) *depressive avoidant behaviors*, such as withdrawal from relationships or activities; (5) *avoidance of loss reminders*; and (6) *poor integration of the loss*.

Bereavement themes were coded in each session for their frequency count and intensity on a 0-5 scale (see Appendix). A score of 0 indicated no presence of the bereavement theme in the session. A score of 1 indicated that a statement was made,

however the participant easily moved on to another topic. A score of 2 indicated that a few statements were made, however the participant was still able to move on to another topic. A score of 3 indicated that the participant made multiple statements, though able to move on with therapist intervention. A score of 4 indicated that the participant appeared to be ruminating, though eventually able to move on with therapist intervention. A score of 5 indicated severe intensity, where the participant appeared to be ruminating and unable to move on despite therapist intervention. These anchors were used for all bereavement themes, except for *depressive avoidant behaviors* and *avoidance of loss reminders*, which were more marked by behavioral indicators rather than statements in session. For *depressive avoidant behaviors*, a score of 1 indicated minimal passive withdrawal (e.g. does not seek out or initiate social interaction). A score of 2 indicated some active withdrawal, such as canceling a scheduled activity. A score of 3 indicated significant withdrawal, such as cancelling more than one scheduled activity during the week. A score of 4 indicated significant withdrawal in multiple areas, such as with family and friends, and a score of 5 indicated severe withdrawal and isolation from others. For *avoidance of loss reminders*, a score of 1 indicated minimal withdrawal, such as the ability to talk about the deceased and confront reminders of the loss, however with some distress. A score of 2 indicated some avoidance, such as the ability to talk about the deceased, but avoiding more painful loss reminders. A score of 3 indicated significant avoidance with an inability to talk about the deceased without significant encouragement. A score of 4 indicated significant avoidance with an inability to talk about the deceased despite therapist encouragement and use of coping skills, and a score of 5 indicated

severe avoidance, such as a refusal to engage in exposure exercises, freezing, or leaving the room.

A description of each participant is given in terms of their demographics, clinical diagnoses, and their presenting problems upon intake assessment. Specific bereavement-related problems and difficulties in functioning are described in relation to each of the outlined bereavement themes. Additional factors that contribute to bereavement-distress, such as circumstances surrounding the death and post-death stressors, are included in each participant's case conceptualization. A description of the treatment course is provided for each case. Specific cognitive behavioral interventions and exposures addressing each of the bereavement themes and complicating factors are explored in detail. The effectiveness of these exposures was determined by (1) the youth's level of emotional distress and (2) ease of completing the exposure. Specifically, youth's self-rated "subjective units of distress" (SUDS) on a scale of 0 (no distress) to 8 (extreme distress) during exposures were used to examine levels of emotional distress. Treatment outcomes are provided for each case and were assessed for significance through quantitative methods of analysis.

The format for each case study is as follows: (1) Demographics, clinical diagnoses, and presenting problems, (2) Bereavement specific problems and dysfunction, (3) Overview of treatment course, (4) Cognitive behavioral strategies employed to address dysfunctional cognitions, avoidance strategies, and poor integration of the loss, (5) Bereavement-specific exposures (and challenges), (6) Cognitive behavioral strategies employed to address complicating factors that contribute to bereavement-related distress, and (7) Treatment outcomes.

Quantitative analysis. To assess for statistically significant change in self-report and parent-report anxiety symptoms from pre to post assessment, the Reliable Change Index (RCI), or reliable change beyond measurement error, was calculated (Jacobson & Truax, 1991). This statistical method refers to the clinical significance of the treatment, or its impact on a client and ability to make a difference in their functioning. The RCI was calculated according to Jacobson and Truax (1991):

$$RCI = \frac{x^1 - x^2}{Sdiff}, \quad \text{where } x^1 = \text{pretreatment score, } x^2 = \text{posttreatment score, and } Sdiff = \sqrt{2(SE)^2}, \text{ the standard error of difference between the two scores.}$$

SE = $s_1 \sqrt{(1-r_{xx})}$, where s_1 = standard deviation of normal population and r_{xx} = test-retest reliability of the measure.

Normative data used to measure the RCI were as follows: STAIC: $s_1 = 6.68$, $r_{xx} = .71$ (Spielberger, 1973); MASC: $s_1 = 16.05$, $r_{xx} = .93$ (March et al., 1997), and MASC-10: $s_1 = 4.52$, $r_{xx} = .82$ (March et al., 1997).

Case Analysis: Anna

Demographics, Clinical Diagnoses, and Presenting Problems

Anna was an 11-year-old, 6th-grade girl who lived with her parents and two younger siblings. Anna's father worked full time outside the home, while her mother was a homemaker. Both parents brought her for an intake interview at an outpatient clinic specializing in anxiety and depression due to concerns about her increasing worries and difficulty sleeping at night. During the intake interview, Anna presented as an anxious girl, with good insight on her difficulties. As shown in Table 1, at pretreatment assessment, Anna was diagnosed with GAD (CSR=6), Separation Anxiety Disorder (SAD) (CSR=4), and subclinical Social Phobia (CSR=3). Anna experienced excessive worry about the safety and well-being of close family members and worry about her own safety to a lesser degree. She had a recent history of multiple deaths in her family, and

her anxiety worsened after the death of her uncle ten months prior to intake. Specifically, Anna experienced increased difficulty separating from her parents, isolating from her friends, and significant distress when reminded of her uncle. Her physical symptoms included headaches, stomachaches, irritability, and difficulty sleeping. Anna's three treatment goals were: (1) "to decrease worrying so much in general," (2) "to decrease worries about family," and (3) to decrease worrying about her uncle's death and its aftermath. Her parents' treatment goals were: (1) to reduce excessive worries, (2) to improve sleeping troubles, and (3) to reduce Anna's separation anxiety.

Bereavement Specific Problems and Dysfunction

The initial case conceptualization was that Anna was an emotionally sensitive child, whose family-related anxiety and separation anxiety appeared to have been exacerbated by the more recent death of her uncle. In terms of her more generalized anxiety, Anna's fears centered on her family's safety and well-being. Anna's thoughts were constantly on her family, wondering whether they were "doing okay" and if they were "happy." Her constant worries about her family resulted in a strong need for control. Anna often expressed that she wished she could be around everyone in the family in order to ensure that they were all okay and that nothing bad would happen to them. Anna required much reassurance from her immediate family members. She was particularly concerned about her bereaved aunt and cousins and would "check up" on them whenever possible. In terms of her separation anxiety, Anna's anxiety that something bad would happen to her parents drove her to seek reassurance whenever she or her parents were apart. Her father often traveled on business trips, triggering difficult memories of her

uncle, who died while away on business. It became very difficult for Anna to believe that everything would be okay, given that she had experienced so much loss in her life.

In addition to her generalized anxiety and separation anxiety, Anna struggled with fully processing her uncle's death. Since his passing ten months prior to intake, she had been overly preoccupied with thoughts about his death. These intrusive thoughts included thinking about specific details, such as the manner in which he died ("whenever I see his picture I picture the way he died and it's terrible") and the funeral service, to future fears of losing another family member. These thoughts were often easily triggered by anything that reminded her of her uncle. Due to the distress she experienced, she avoided all reminders of him. She was unable to talk about him, look at his photograph, or be among his personal belongings without significant distress. Furthermore, her intrusive thoughts of her uncle's death could also be triggered by peripherally related topics. According to her mother, Anna experienced "a lot of tears in school, in social studies and reading...they read books about people being killed and slavery, and this one was separated from her family and that's all she thinks about, death, separation, that she can't focus and she has to leave the classroom." Any mention of war, since her uncle served in the armed services, friends speaking about their uncles, or scenes of death in movies could trigger her intrusive thoughts about her uncle.

Overview of Treatment Course

Anna attended twenty-two sessions over the course of eight and a half months. Her parents were seen for two additional parent meetings. Anna attended sessions weekly with a seven-week hiatus after the first half of treatment due to her therapist's maternity leave and her family's summer vacation.

Anna was primarily treated for her generalized anxiety and separation anxiety using the Coping Cat, a manual-based treatment for child anxiety disorders (Kendall & Hedtke, 2006). The first half of treatment focused on coping skills acquisition, including affective awareness, relaxation training, cognitive restructuring, problem solving, and self-reward. Anna responded positively to the material and practiced her skills outside of sessions. Both Anna and her mother noted that the sessions and the skills were helpful and that Anna was benefitting from her engagement in therapy.

The second half of treatment focused on practicing the coping skills in real-life anxiety-provoking situations through graded exposure tasks. In-session and take home exposure tasks were designed to address Anna's social concerns, separation anxiety, and bereavement-related worries. Specific in-vivo exposure tasks included practicing assertiveness skills with strangers, reading aloud in front of an audience, a week-long trip to her aunt's house without her parents, looking at her deceased uncle's belongings and photographs, and talking about her uncle. Understandably, Anna was more resistant to attending sessions due to the anxiety-provoking nature of the exposures. Still, she reported that she was motivated and was able to complete the majority of exposure tasks.

At the 16th session, the focus of treatment shifted due to an increase in Anna's depressive symptoms following news of her parents' separation. Behavioral tasks included talking and writing about the separation, problem solving, and behavioral activation.

It was difficult to determine when to terminate Anna's treatment. The therapeutic goals of separating from her parents more easily and processing her uncle's death were generally met, yet the family disruption required some cognitive behavioral intervention.

After addressing her depressive symptoms, therapy terminated with mutual agreement from the clinician and the family, as Anna had acquired some coping skills to manage future difficulties.

Cognitive Behavioral Strategies Employed to Address Dysfunctional Cognitions, Avoidance Strategies, and Poor Integration of the Loss

Bereavement themes present in Anna's therapy sessions are shown in Figure 1 and examples of bereavement themes are shown in Table 2. The first few sessions Anna presented with *fear of abandonment* (1 out of 5 in intensity in the first session and 2 out of 5 in the second session) and *avoidance of loss reminders* (5 of 5 in the third session). This is consistent with Anna's presentation and primary diagnoses of separation anxiety and generalized anxiety. As treatment progressed and the treatment focus moved to her bereavement-related distress, around session 8, several bereavement themes increased in frequency and intensity. *Depressive dysfunctional thoughts* (an intensity of 3 at session 8), *anxious dysfunctional thoughts* (an intensity of 2 at session 8 and intensity of 4 at session 11), *fear of abandonment* (an intensity of 2 at session 6 and an intensity of 4 at both sessions 7 and 8), *depressive avoidant behavior* (2 in intensity at session 8), and *avoidance of loss reminders* (5 in intensity at both sessions 8 and 11) became more present. Approximately halfway through treatment (Session 13) bereavement themes were no longer present.

Dysfunctional cognitions. Anna presented at intake and throughout treatment with depressive and anxious dysfunctional thoughts. In terms of *depressive dysfunctional thoughts*, Anna believed that she had been "scarred" because she had experienced "so many deaths" in her family. As seen in Figure 1, Anna's depressive thoughts increased at

Session 8. Notably, they came at the one-year anniversary of her uncle's death.

Psychoeducation about anniversary grief reactions was provided. Specifically, the therapist provided education that grief reactions were a common and normal experience for those who have lost loved ones. Additionally, it was important for Anna to know that there were external events and circumstances that could trigger a grief reaction and to increase her awareness of her specific triggers so she could prepare for them.

Anna's ruminative thought process replayed her *anxious dysfunctional thoughts* about her uncle's death and possible future deaths in the family ("whenever I see the pictures, I picture the way he died and it's terrible to think about all the bad things about it"). She often noted that she "can't stop thinking about bad things happening" to her family. Anna's anxious thoughts typically increased during sessions when bereavement exposures were conducted or when the related problem of separating from her parents was discussed.

While dysfunctional cognitions are typically questioned regarding their accuracy and utility, it appeared to be more difficult in Anna's case to challenge the accuracy of her dysfunctional thoughts. Her worries that her family members would die or become hurt were difficult to disconfirm since she had experienced many unlikely deaths in her life. Rather than focus on the accuracy of her dysfunctional thoughts, it was important to discuss the utility of her thoughts and the effect it had on her anxiety. Anna had the insight that when she ruminated on her anxious thoughts she felt worse. She also was able to say that it helped to "plug in a good thought to go over and over in [her] head," repeat her coping thoughts to herself, or write in her journal.

Avoidance strategies. Anna utilized many *depressive and anxious avoidance* strategies, which were helpful for decreasing her distress in the moment, but only served to maintain her long-standing anxiety surrounding her uncle's death. If a topic came up at school that was vaguely connected to her memories of her uncle, Anna's general response was to run out of the room crying. She avoided conversations about her uncle and could not look at photographs for fear of her intrusive thoughts about the way he died.

During the second half of treatment, graded exposure tasks were utilized to help Anna approach painful loss reminders so that she could more fully process her uncle's death. As seen in Figure 1, Anna's avoidance of loss reminders and anxious dysfunctional thoughts increased during the bereavement exposures (Sessions 8-13). Earlier tasks focused on maintaining conversations about her uncle, which ranged from telling positive stories about him to talking about his funeral, as well as the things she wished she could tell him if he were still alive. Later tasks included looking at photographs of her uncle and making a memorial to honor him. The culminating exposure was a weeklong trip to her bereaved aunt's house. Her aunt's house was filled with reminders of her uncle; therefore, it was the most challenging task that Anna completed. Anna was motivated to complete these exposures because she understood that her avoidance of loss reminders was maintaining her discomfort. Still, her anxiety and sadness when discussing her uncle led to some initial resistance and avoidance of the tasks. As she succeeded with easier tasks, her confidence grew and she was able to complete more difficult exposures while experiencing lower levels of anxiety and distress.

Poor integration of the loss. While it was apparent that Anna had not fully accepted her uncle's death, it was unclear whether there was *poor integration of the loss* into her autobiographical knowledge. Throughout the course of treatment, Anna never made explicit statements to indicate that the death was not "real" to her. At times, she expressed the wish for her uncle to be back and for things to go back to normal, but never to the extent that she believed that his death was reversible. Therefore, this was not directly targeted with cognitive behavioral strategies. However, the exposure tasks of talking about his death and completing a memorial for her uncle only served to make his death more "real" and permanent.

Bereavement-Specific Exposures (and Challenges)

As noted above, graded exposure tasks were conducted to help Anna approach painful loss reminders. Similar to traditional exposure work, it began with development of a fear hierarchy with her least distressing situations at the bottom and most distressing situations at the top. Rather than focus on things or situations that were feared, Anna's hierarchy focused on her discomfort and distress in situations that reminded her of her uncle's death. As noted above, her hierarchy included telling a positive story about her uncle (SUDS of 5), telling an upsetting story about her uncle (SUDS of 7), looking at photographs of her uncle (SUDS of 8), and visiting his home (SUDS of 8).

Anna was very insightful and understood how her anxiety was exacerbated by the loss of her uncle and its related distress. Therefore, she was very motivated to engage in the exposure tasks, though she knew it would be "uncomfortable." The initial exposure task at Session 8 focused on simply maintaining a conversation about her uncle. Coincidentally, the first exposure session happened to occur at the one-year anniversary

of his death. Anna came into the session “feeling sad and not wanting to do anything.” When asked to simply talk about her uncle, Anna had a difficult time making and maintaining eye contact and displayed many gratuitous body movements, such as playing with her nails and hair band. Five of the six bereavement themes were present during this exposure and varied in intensity. Anna’s *avoidance of loss reminders* during this task was at a 5 in intensity, as demonstrated in her inability to maintain a conversation, make eye contact, or respond to prompting. It helped Anna to discuss the reasons for conducting the exposures and to remind her to use the FEAR plan to cope with the distress. The intensity of Anna’s *anxious dysfunctional thoughts* (2) and *depressive dysfunctional thoughts* (3) increased during this exposure. These were helped by the use of cognitive restructuring and coping thoughts. Anna was able to reflect on how she had been unable to talk about her grandfather after he passed, but with time she became more comfortable. She noted that she had to “adjust and make [herself] more comfortable” with talking about him and that she had to do the same with her uncle. She was urged to think about these exposure sessions as a way to do so. This helped to increase her motivation for completing exposures. Furthermore, her ability to reflect on her success in dealing with a previous loss experience helped to normalize her current grief reaction and realize that it was possible to succeed with this as well.

The next difficult exposure, which focused on thinking and talking about the “sad stuff,” occurred at Session 11. This exposure task was discussed in the session prior, and was included in her overall exposure hierarchy. At the first mention of the task, Anna felt prepared to do so and even listed several “sad moments” that she could talk about, including “the day [she] found out, the day [she] had to go to school, the funeral, [and]

being down there at the little gatherings.” However, during the following session, when it was time to begin the exposure, Anna immediately shut down, avoided eye contact, and did not appear to respond to any therapist intervention. She was unable to respond verbally, but she was able to write down her thoughts. Anna wrote down that she was thinking about the funeral and “never seeing him again.” She was not pressed to talk about it aloud, but asked to sit with the feeling and try to use her coping skills to manage her distress. Rather than use the FEAR plan for anxiety, she was urged to use the FEAR plan, adapting it to feeling uncomfortable and sad. Using relaxation, breathing, and positive imagery proved to be effective in helping her calm herself enough to begin talking. Anna was asked to replace the sad memory with a happy one to help combat her ruminative thinking about how she would “never see him again.” As she spoke about the “secret island” they used to visit while on vacation, Anna’s SUDS decreased. The goal was for her to use her coping skills to approach and accept the sad and uncomfortable feelings and be able to move on without getting stuck in their intensity. This exposure session appeared to be a critical session, in which Anna was able to sit with the intensely negative feelings and realize her distress would slowly decrease with time and use of coping skills. At the end of the session, the therapist showed Anna how her distress decreased slowly throughout the exposure by drawing a graph of her SUDS. The following exposure sessions showed a decrease in distress, *avoidance of loss reminders*, and *anxious dysfunctional thoughts*.

The most challenging tasks on Anna’s bereavement hierarchy with SUDS of 8 included looking at photographs of her uncle and visiting his home where she would be surrounded by his belongings. Similar to an exposure for the phobia of a specific object,

the photograph exposure was planned so that Anna would have to sit with the photograph for increasing lengths of time. However, after her success with earlier exposures, Anna was able to look at photographs of her uncle and talk about him without any signs of distress on the first trial.

Cognitive Behavioral Strategies Employed to Address Complicating Factors that Contribute to Bereavement-Related Distress

There are several additional factors that may have contributed to Anna's bereavement-related distress. As discussed earlier, the bereavement literature suggests that girls experience higher levels of internalizing problems and that those problems tend to persist (Little et al., 2009; Schmiege et al., 2006; Worden & Silverman, 1996). Interpersonal stressors and fear of abandonment were found to be mediators. It was evident from Anna's worries about losing her parents that she had a strong fear of abandonment. As treatment progressed, it became apparent that Anna also experienced significant stressors at home due to her parents' impending separation. Anna's ruminative thought process also may have contributed to her bereavement-related distress becoming a longstanding difficulty.

While the bereavement literature did not find significant differences when looking at anticipated versus unexpected deaths, the nature of her uncle's death was not only sudden, but also a very unlikely, bizarre accident. Therefore, the circumstances surrounding his death were unusual and may have changed her perception of the world as a more dangerous place than she had previously believed.

Though the amount of interpersonal stress Anna experienced could not be controlled, cognitive behavioral strategies were used to try to help Anna manage and

cope with the stress more effectively. The coping skills learned in the first half of the program were adapted for use with the stressors of her parents' separation. Anna found problem solving and using her coping thoughts to be particularly helpful when her father moved out of their home. Anna's increased awareness of her anxious thoughts and use of coping thoughts also worked to slow down her ruminative thought process, which possibly contributed to her longstanding distress.

Treatment Outcomes

By the end of treatment, Anna demonstrated marked behavioral improvements. She was able to separate from her parents for the longest period to date when she spent the week with her bereaved aunt. Additionally, she went away to a weekend-long retreat with her youth group. She no longer became upset when her father left on business trips and also was able to use proactive coping skills when her father moved out of the home during her parents' trial separation.

In terms of the bereavement-related distress, Anna made vast improvements. At the end of treatment, she was able to talk about her uncle, look at photographs of her uncle (an "8" on her exposure hierarchy), and stay at her uncle's house without distress. She reported that she no longer had intrusive thoughts about his death.

As shown in Table 1, at the time of the post-treatment interview, Anna no longer met diagnostic criteria for GAD or SAD by child or parent report. However, she did meet criteria for minor depression, related to her family disruption. Anna demonstrated statistically reliable change in self-rated anxiety symptoms on the STAIC ($RCI=2.36$, $p < .05$), though did not show reliable change on the MASC. She did not show any statistically reliable change in parent-rated anxiety symptoms on the STAIC or MASC.

However, on parent-chosen therapy targets related to Anna's bereavement distress, Anna's mother did report a slight improvement. In particular, Anna's mother rated her "separation anxiety related to uncle's death" as a "5" at the pre-treatment assessment and rated it as a "3" at the post-assessment, "worries about family" decreased from a "6" to a "4," and "sleep trouble" decreased from a "5" to a "3."

Case Analysis: Mary

Demographics, Clinical Diagnoses, and Presenting Problems

Mary was a 16 year-old, 12th grade girl who lived with her father and younger sibling. Mary's mother passed away six months prior to intake from a chronic and debilitating disease, and Mary was seeking additional support in coping with her loss. She had been previously treated at the same clinic two years prior for GAD, MDD, and social phobia. She was motivated to return for treatment for bereavement-related depressive symptoms, including irritability, depressed mood, anhedonia, and decreased motivation. Additionally, Mary was experiencing some anxiety regarding the safety and well-being of her family members. As shown in Table 1, at pretreatment assessment, Mary was diagnosed with GAD (CSR=6) and Bereavement. Mary's three treatment goals were: (1) "to deal with mother's passing," (2) to increase skills to cope with anxiety, and (3) to better learn ways to handle stress. Her father's goals were (1) to improve Mary's mood and (2) to increase her interest in previously loved activities.

Bereavement Specific Problems and Dysfunction

The initial conceptualization was that Mary was an emotionally sensitive child, whose mood had become increasingly depressed following the death of her mother. She had not yet fully processed her mother's death and believed she required additional

support from someone outside of her family. Mary found it difficult to communicate her struggles with her friends and began isolating herself. Her interest in going out with her friends decreased, and she lost interest in previously loved activities. Mary's father noted that she was "unhappy most of the time" and "cries very easily." Mary believed she was more "sensitive" after her mother's passing, and agreed that she becomes upset and cries whenever anything reminded her of her mother. She was afraid of "breaking down" in public and afraid others would believe she was "weak" if she could not control her emotions.

In addition to her bereavement-related depressive symptoms, Mary also experienced increased anxiety. She reported excessive concerns about her father's health and coped by engaging in checking behavior each night to make sure he was breathing. Though she felt immediate relief after checking, these behaviors were not effective long-term and only served to maintain her anxiety and fear of losing him.

Overview of Treatment Course

Mary attended fourteen sessions over the course of four months. Sessions were completed once weekly. The first half of treatment focused on processing her mother's death and grieving her personal loss. The second half of treatment focused on managing her generalized anxiety and depressed mood by reengaging in activities and relationships.

The initial sessions focused on psychoeducation on death and bereavement to validate and normalize Mary's experience. The different components of grief, including cognitive, behavioral, physical, and emotional, were discussed. In-session graded exposures were used to help Mary process her mother's death more fully and encourage her to approach painful loss reminders. These included talking about the day her mother

died, looking at photos of her mother, writing a letter to her mother about the things she missed and reading it aloud, writing a letter back from her mother, writing an advice pamphlet to help others, and talk about upcoming dates and events that will be difficult. Mary found the letter writing to be the most comforting exercise, as it was a way to stay connected to her mother and to find reassurance in it. Writing the advice pamphlet was also successful in helping Mary communicate better with her friends and engage in her friendships again. At-home exposure and response prevention was used to reduce the frequency with which she checked that her father was breathing at night.

As Mary's distress decreased with the processing of her mother's death, the next treatment target was to help her re-engage in her activities and relationships to further combat depressive symptoms. Mood tracking and behavioral activation were both utilized to increase positive reinforcement from scheduled activities. Mary's generalized anxiety and stressors of her college applications were targeted using review and practice of the Coping Cat (Kendall & Hedtke, 2006) FEAR plan.

Relapse prevention consisted of reviewing dates on the calendar and upcoming and future events that would be difficult for Mary. Proactive problem solving was used to prepare Mary for difficult moments and to plan how to incorporate and honor her mother despite her absence. Termination was mutually agreed upon when Mary had met all of her treatment goals.

Cognitive Behavioral Strategies Employed to Address Dysfunctional Cognitions, Avoidance Strategies, and Poor Integration of the Loss

Mary was seeking treatment for her bereavement, and therefore was forthcoming from the very first session about her bereavement-related distress. Therefore, all six

bereavement themes were present early on in treatment. In the first session, Mary presented with *fear of abandonment* (5 out of 5 in intensity) and *anxious dysfunctional thoughts* (4 out of 5 in intensity). In the second session, Mary continued to present with *fear of abandonment* (5 in intensity) and additional bereavement themes of *poor integration of the loss* (4 in intensity), *depressive dysfunctional thoughts* (2 in intensity), *depressive avoidant behaviors* (2 in intensity), and *avoidance of loss reminders* (2 in intensity). Only *avoidance of loss reminders* (2 in intensity) was present in the third session, and no bereavement themes were present in the fourth session. The following session showed an increase in *depressive dysfunctional thoughts* (an intensity of 2) and *poor integration of the loss* (an intensity of 3). Data is missing from sessions 6 through 8 because of recording and disc errors. Apart from *fear of abandonment* (1 in intensity) during session 9 and *depressive avoidant behavior* (1 in intensity) at session 14, bereavement themes were not significant from session 9 through the end of treatment. Figure 2 depicts the intensity of bereavement themes present in Mary's treatment by session and examples of bereavement themes are shown in Table 2.

Dysfunctional cognitions. Mary presented at intake and the initial sessions with depressive and anxious dysfunctional thoughts. In terms of *depressive dysfunctional thoughts*, Mary believed that she “wasn't a part of anything anymore,” “disconnected,” and “really alone.” She was “scared it's never going to be the same.” It was important to normalize and validate her fear that things would not ever be the same because that was an accurate statement. This thought was dysfunctional for Mary because it kept her focused in the past and prevented her from engaging fully in her present life. It was therefore important to challenge this thought, however, difficult to disconfirm since it

was an accurate statement. Mary was able to come up with a coping thought to help her: “You can never go back to normal, but a new normal.” Instead of thinking “[but] it’s never going to be the same” she was able to replace it with, “I’m going to miss her *and* still be able to do things.” Mary was able to accept that she could develop a “new normal” in which she could still function despite her mother’s absence and enjoy the things she used to enjoy. Processing her mother’s death and engaging in activities naturally helped Mary to slowly build up to a “new normal.” Proactive problem solving was utilized to help Mary prepare for future events that would be difficult and figuring out a way to still make it special and meaningful despite her mother’s absence. With each passing “first” holiday, birthday, or special occasion, Mary found it easier to incorporate new traditions and realized that they were not as sad as she had imagined they would be. These experiences helped reinforce her new coping thought of “I’m going to miss her *and* still be able to do things.” Following her mother’s death, Mary reported that she was 25% back to her “new normal.” Upon entering treatment, she reported that she was 75% back, and at the final session, 98% back to her “new normal,” which to her was living her life, enjoying her activities and friendships, doing well in school, and “feeling good about doing everything.”

Mary’s *anxious dysfunctional thoughts* centered on fears of “breaking down” and crying in front of others. She believed that others would think she was “weak” and “pity” her. It was important to disconfirm these beliefs through use of exposure tasks. These beliefs were easily disconfirmed when she successfully read her essay and letters about her mother aloud during a few behavioral experiments to see if she would actually freeze or “breakdown.”

Fear of abandonment was a prominent theme for Mary. As discussed above, Mary was concerned about her father's health and was understandably afraid of losing him. She began to check that he was breathing while he was asleep, and it had quickly become a daily safety behavior. Her anxiety would immediately decrease after she checked, but it only reinforced her need to check and maintained her fear of losing him in the long term. Mary was motivated to change, as she did not "want to be in college and have to call him to make sure he's living." Therefore, she was agreeable to exposure and response prevention strategies to target these unwanted checking behaviors. Mary was at first asked to extend the amount of time she waited before she checked on him. Eventually, she was able to remove her checking behaviors all together. As her need to check decreased, her fears of losing him decreased as well.

Avoidance strategies. Mary utilized many avoidance strategies, which served to decrease her bereavement-related distress in the moment, but maintained it in the long-term. Mostly due to her fears of "breaking down," Mary generally avoided talking about her mother to anyone outside of her immediate family. School in particular was difficult for Mary because she felt the material in her English class was usually about death or family, topics that reminded her of her mother. She would often try to distract herself or read the material quickly so that she could move on to the next assignment. Her avoidance of death-related material was targeted using exposure tasks that required her to read her letters and essays about her mother aloud.

Rather than talk to her friends about her mother, Mary tended to keep her feelings to herself and grew more isolated, and as a result, more disconnected. It was important to target Mary's *depressive avoidant behaviors* and help her re-engage in her friendships.

Role-play exercises were used for Mary to practice initiating conversations with her friends. There was also a strong focus on proactive problem solving to help her prepare for difficult situations with her friends. The most useful activity according to Mary was writing a pamphlet aimed at helping teenagers support their grieving friends. In devising this pamphlet, she was able to reflect on the things that have been helpful and unhelpful during her own personal grieving process. She was then able to share this with her close friends so they could better understand her experience.

Poor integration of the loss. Mary showed only a few examples of poor integration of the loss into her autobiographical knowledge. Most were expressed as wishes for her mother to be “back.” There was no clear indication or explicit statements that her death did not seem “real.” Therefore, this was not directly targeted with cognitive behavioral strategies. Still, the exposure tasks of talking about her mother’s death and what is missed only served to make it more “real” and integrated into her life story.

Bereavement-Specific Exposures (and Challenges)

As noted above, graded exposure tasks were conducted to help Mary approach painful loss reminders. Mary’s bereavement hierarchy included talking about her mother, looking at pictures of her mother, and reading an essay about her mother aloud. Mary had good insight that talking about her mother would help her process the death more fully, so she was very motivated to complete these tasks. She did not exhibit any hesitation or avoidance behaviors during exposure sessions.

As discussed, there is currently no first-line treatment approach for bereavement or its related distress. Therefore, conducting the bereavement-specific exposures were challenging, as there were no clear guidelines available on how to do so most effectively.

Bereavement exposures were conducted in the same manner as an exposure targeting an anxiety-provoking situation with special attention to any cues of distress, including tensing, poor eye contact, trembling voice, crying, and any gratuitous verbalizations or movements.

Mary seemed to benefit most from exposures that required her to write about her mother (SUDS of 3) and then read her essays or letters aloud (SUDS of 7). The first task was to write a letter to her mother, making sure to include the things she missed about her, the things she did not miss, and anything she would have liked to tell her. These topics were discussed broadly in the session prior to the assignment of letter writing so that all areas could be explored. Mary was then asked to compose the letter to her mother over the week and bring it to the next session to share and read aloud. Mary returned to session the following week with a two-page letter that she read aloud. Her voice shook slightly at the beginning and at poignant parts of the reading, however, she was always able to recover quickly. During her second reading of the letter, Mary did not appear to experience any difficulty reading the material and no longer read with a shaky voice. Mary believed this task allowed her to “get a lot of things off [her] chest and get it down on paper.” Her success in reading the letter aloud without “choking up” helped to disconfirm her dysfunctional beliefs about her grief reaction, specifically that she would “break down.” The second task of writing a response letter back from her mother was “easier to write” and felt “reassuring” to hear what her mother would have said to her.

Cognitive Behavioral Strategies Employed to Address Complicating Factors that Contribute to Bereavement-Related Distress

There are several additional factors that may have contributed to Mary's bereavement-related distress. The bereavement literature suggests that girls experience higher levels of internalizing problems with interpersonal stressors and fear of abandonment as mediators (Little et al., 2009; Schmiege et al., 2006; Worden & Silverman, 1996). Prior to treatment, Mary experienced significant stressors due to her mother's declining health. Not only did she experience the emotional stress of caring for her ill mother, but she also experienced the physical stress of increased responsibilities and chores at home. The family as a whole experienced much financial distress as well due to the high cost of medical care required of her mother's condition and her inability to work.

After her mother died, Mary went to live full-time with her father, who was better able to support her financially. Mary no longer had the burden of caring for her ill mother and running the household, therefore, the amount of stress decreased markedly. Mary was able to manage and cope with her stress more effectively by reacquainting herself with the FEAR plan coping skills. Mary found relaxation and the use of coping thoughts to be the most helpful strategies for coping with stressors.

In addition to emotional, physical, and financial stressors, Mary experienced significant interpersonal stressors. Her beliefs that others would be uncomfortable talking about her mother or death resulted in her often feeling alone and disconnected from even her closest friends. As discussed above, Mary enjoyed writing a pamphlet to give to her friends to help them better understand her experience. Role-plays were also used to practice initiating conversations about her mother and to practice handling difficult conversations with friends.

Mary's fear of abandonment was addressed by targeting her daily checking behaviors. Exposure and response prevention was used to decrease her reliance on checking, which served to decrease her fear of abandonment as she thought less and less of her father dying.

Treatment Outcomes

By the end of treatment, Mary demonstrated marked behavioral improvements. In terms of bereavement-related distress, Mary was less tearful and better able to express herself when discussing her mother. She reached out to her friends for support, reengaged in previously loved activities, and took up new hobbies. Mary also reported less distress during the holidays, as she prepared ways to honor her mother and still make them special. There were also significant improvements in Mary's generalized anxiety. Her ability to handle school-related stressors increased with her practice of the FEAR plan and specific exposures.

As shown in Table 1, at the time of the post-treatment assessment, Mary no longer met diagnostic criteria for any disorder. She demonstrated statistically reliable change in self-rated anxiety symptoms on both the STAIC (RCI=3.53, $p<.05$) and the MASC (RCI=2.95, $p<.05$). Statistically reliable change was also found in parent-rated anxiety symptoms on both the STAIC (RCI=2.75, $p<.05$) and the MASC (RCI=2.29, $p<.05$). Mary's self-rating of her chosen therapy targets showed improvement throughout treatment and mirrored the change demonstrated by quantitative measures. "Dealing with my mother's passing" decreased from a self-rated "7" to a "2" by the end of treatment. "Handling anxiety" decreased from a "6" to a "1." Her father's chosen therapy targets also showed improvement. He rated her initial problem of being "unhappy most of the

time” as a “7” and rated it as a “2” by the end of treatment. Additionally, “getting upset easily and crying” decreased from an “8” to a “2.”

Discussion

Currently, there is no standard of care for the psychological treatment of bereavement or its related distress. Based on the bereavement literature, it appears that cognitive behavioral therapy is an appropriate approach to treat the dysfunctional cognitions and avoidance behaviors that can occur after the loss of a loved one. Boelen’s (2006) cognitive behavioral model of complicated grief is a useful framework for conceptualizing bereavement-related distress. When using the cognitive behavioral model of complicated grief with bereaved youth with co-occurring anxiety, it is important to adapt it and use it flexibly so that treatment can be individualized to meet their specific needs. The two cases described show two different approaches to flexibly applying the cognitive behavioral model of complicated grief. Each case had its own individualized conceptualization, goals, and treatment targets.

Anna presented at intake primarily with generalized worry and separation anxiety that caused significant interference in her daily life. Initially it was unclear how much the loss of her uncle contributed to her fears and worries about the safety and well-being of other family members. Therefore, the focus of treatment was primarily on her anxiety, and the Coping Cat protocol for child anxiety (Kendall & Hedtke, 2006) was utilized. As treatment progressed, Anna revealed that her uncle’s death was something that was still difficult for her and went into detail about her significant avoidance of loss reminders. It appeared that her uncle’s death had exacerbated her longstanding anxiety and that her bereavement-specific distress also generalized to other areas of her life, particularly with

her fear of separating from her parents. Specific distressing situations related to her grief were placed on her exposure hierarchy, and bereavement-focused exposures were seamlessly conducted in addition to more typical anxiety-focused exposures during the second phase of Anna's anxiety treatment. This case illustrates the importance of flexibly using a manual-based treatment to tailor it to the individual client, while still adhering to the protocol (Kendall et al., 1998). In this case, the targets of treatment were prioritized based on continual assessment of Anna's symptoms and their level of interference throughout treatment.

Mary presented to the clinic seeking therapy to help her cope with her mother's death and related depressive symptoms. She experienced much interference in her daily functioning, social life, and academic functioning, due to her bereavement-related distress. In this case, bereavement issues were much more salient; therefore, focusing therapy on her mother's death was the priority. Mary's anxiety was a secondary focus due to her longstanding history of GAD and her concerns about her next major life event, college. Mary's treatment followed a two-phase approach. The first goal of treatment was to normalize her grief reaction, increase her acceptance of her mother's death, and decrease her avoidance of loss reminders. Once she had better processed her mother's death and what had happened in the past, treatment looked to the present and future. Re-engaging in activities and her relationships in her daily life was paramount to her ability to move forward with her life in a healthy manner and find her "new normal." Managing her anxiety using the FEAR plan and increasing her interpersonal effectiveness through role play helped her to re-engage in life. The psychoeducational and cognitive behavioral strategies used in Mary's treatment were adapted from the grief-focused sessions from

the Cognitive Behavioral Therapy for Childhood Traumatic Grief manual (Cohen, Mannarino, and Deblinger, 2006). The mood tracking exercises and behavioral activation were adapted from The Skills Group Behavioral Activation Treatment (Chu & Areizaga, 2010). Coping skills from the Coping Cat (Kendall & Hedtke, 2006) were also reviewed and practiced to help Mary manage her anxiety about school stressors.

Though their treatment followed slightly different courses, there were several commonalities in the bereavement themes that were present in sessions. *Fear of abandonment* and *anxious dysfunctional thoughts* were prominent for each adolescent. This makes considerable sense given that they both carried a primary diagnosis of GAD. Both held fears that something bad would happen to their remaining family members. For Anna, she feared that her father would die while away on business, just as her uncle had. In Mary's case, her fears that her father would stop breathing while asleep on the couch had her checking on him every night.

Where Anna and Mary differed was in their approach to loss reminders. Anna had an intense *avoidance of loss reminders* since her uncle's death. During treatment, her avoidance was significant, causing her to freeze up with an inability to make eye contact or respond to the therapist during bereavement exposures. On the other hand, Mary sought treatment as a venue for speaking about her mother and was willing and motivated to explore difficult topics. Mary had often attempted to engage her friends in conversations about her mother, but believed that they were uncomfortable talking about the loss. Throughout the course of therapy, she often remarked how it was helpful to share stories and talk about the things she missed.

In terms of a *poor integration of the loss*, a major component of Boelen's (2006) conceptualization of complicated grief, there was also a mixed picture. While Anna did not demonstrate any difficulty integrating the loss into her biographical knowledge throughout the course of treatment, Mary showed a few examples in the first few sessions. Her strong desire and wish to have her mother back, even to "want her back in pain," showed a yearning seen in those who have not fully integrated the death as a permanent, irreversible event. Boelen, van den Hout, and van den Bout (2006, p. 113) note that in uncomplicated grief, "these reactions are present but gradually subside as the information that the loss is irreversible gets increasingly connected with other information in memory." As Mary handled the difficult bereavement-exposures of talking about her mother and her loss, indicators of a *poor integration of the loss* were no longer present.

Given that most of the stated bereavement themes were salient for these two cases at the beginning of treatment, support is shown for the cognitive behavioral model of complicated grief. That is, depressive and anxious dysfunctional thoughts, depressive and anxious avoidance, and poor integration of the loss all contribute to bereavement-related distress. As discussed in these youth case studies, each bereavement theme was addressed using cognitive behavioral strategies. A treatment protocol for bereaved youth that targets the cognitive, behavioral, and integration difficulties may help clinicians work more effectively with bereaved youth.

As with any cognitive behavioral protocol, it could begin with an explanation of the rationale behind treatment and an individualized case conceptualization incorporating the client's dysfunctional thoughts, avoidance strategies, and poor integration of the loss,

as well as additional factors that contribute to the client's bereavement-related distress. Psychoeducation about death and loss would be an important next step to help younger children better understand the concept of death and help normalize their experience. Normalizing the grief experience was particularly helpful for Anna when she experienced more depressive symptoms during an anniversary grief reaction of her uncle's death. Learning that grief can be a life-long process and that it is common for those who have lost a loved one to feel better at times and then worse at others, particularly during an anniversary, was helpful in validating her feelings.

The client and therapist could then collaboratively construct a bereavement-focused exposure hierarchy of uncomfortable or distressing situations. These could include avoided places, people, or activities that serve as reminders of the loss. It is important to consider situations that may be peripherally related to the loss. Both Anna and Mary were triggered by topics brought up by school materials. Anna had difficulty watching war movies, while Mary avoided poems in her English class. Bereavement exposures would then be conducted with the goal of helping the child approach their painful loss reminders, gain acceptance of the loss, and integrate the loss into their lives. For Anna, bereavement exposures helped her to learn that she could handle the intensely negative emotions she felt when she thought about her uncle. She successfully completed her most distressing situation, a week-long stay at her uncle's home, without any difficulty and was eager to return for another visit. Successful bereavement exposures can also disconfirm anxious dysfunctional thoughts about a grief reaction, for example if there is a belief that they might "breakdown" or "freeze" if they come into contact with a

loss reminder. The exposure in which Mary read her letter to her mother out loud helped to disconfirm her beliefs that she would “breakdown” in front of others.

A second target of the treatment protocol would be to target depressive dysfunctional thoughts and depressive avoidant behaviors, such as isolation and withdrawal behaviors. By employing mood tracking and behavioral activation, the child could begin to re-engage in activities and relationships. By becoming more active with daily scheduled activities, they will naturally receive positive reinforcement and become more present in their daily lives. This was particularly important for Mary, who experienced anhedonia and isolated herself from her friends. Mary was able to track her mood throughout the day and see that her mood improved when she spent time with her friends or attended her extracurricular activities. Making the pamphlet for her friends also helped her to feel more connected to them and more eager to spend time with them.

As with any treatment, relapse prevention is an important last step before terminating therapy. In working with bereaved youth, it is important to consider all of the future events that they will need to endure without their loved one by their side. Proactive problem solving may help children to prepare for difficult future situations by brainstorming ways to honor their loved one despite their absence. Rather than let the event take them by surprise, they could prepare and have a plan ready to manage their distress. For Mary, this was one of the most important components of treatment. Mary’s dysfunctional thoughts that “it’s never going to be the same” were replaced by the thought that she can experience a “new normal.” She was able to endure the first holidays, birthdays, and anniversaries with less distress by planning out ways to still include her mother in these events. At the end of treatment, Mary was able to brainstorm

ways to maintain her mother's presence in future major life events, such as incorporating material from her mother's wedding dress when she gets married and telling stories about her mother when she has children of her own.

Limitations

There were several limitations to this study. First, this study consists of two cases; therefore, limited conclusions can be drawn. The purpose of this study was to illustrate the incorporation of bereavement issues in the treatment of these two youth. It is not meant to be representative of the bereaved youth population as a whole. Second, the design of this study is a secondary analysis of case material. Therefore, at the time of treatment, specific bereavement or grief measures were not utilized to monitor treatment progress. Conclusions about treatment progress in terms of bereavement-related symptoms were based on observed levels of distress, self- and parent- report, and progress on target goals, rather than objective measures. These observations were subjective, and therefore more prone to bias. Future studies on the treatment of bereaved youth could include measures to monitor specific grief symptoms, such as the Inventory of Complicated Grief for Children (Dyregrov, Yule, Smith, Perrin, Gjestad, & Prigerson, 2001), in addition to the anxiety instruments utilized in the current study.

Despite these limitations, care was taken to conduct this study with as much rigor as possible by reviewing and coding all videotaped sessions, rather than relying on therapy notes alone. Approximately 88% of the sessions for Anna's case and 79% of Mary's case were reviewed. The remaining sessions were not reviewed due to recording and disc errors. An additional strength of this study is the combination of qualitative and

quantitative methods, which helps to present a richer picture of the treatment through use of both clinical observation and symptom measures.

Conclusions

In the general practice of cognitive behavioral therapy, treatment is individually tailored through use of the case conceptualization. Incorporating bereavement issues is one example of complicating factors that can help to individualize treatment and devise the appropriate targets of treatment. However, therapists may face specific challenges when treating bereaved youth and conducting bereavement-related exposures. First, there is no official diagnosis for complicated or prolonged grief in the DSM-5, resulting in less clinical research in this area and possible stunted development of treatment. Clinicians will therefore need to rely on their clinical training, observations, bereavement literature, and use of supervision to guide treatment. A second challenge is being open and comfortable discussing death and loss. Therapists often model acceptance and empathy, two things that are important in bereavement work. A related challenge for therapists is to understand their own loss experiences so they are comfortable with the subject matter, particularly during intense and emotional exposure sessions.

This study supports the use of a cognitive behavioral approach to conceptualizing and treating bereavement issues in anxious youth. The principles and framework of cognitive behavioral therapy appear to appropriately target the dysfunctional thoughts, avoidance behaviors, and poor integration of the loss that work to complicate the grieving process. Additionally, the six specific bereavement themes studied suggest potentially important areas to target in bereavement work. Future directions in the treatment of bereaved youth could involve the development of a manual-based protocol that could

then be studied in community-based clinics. Randomized controlled trials to study its efficacy could follow.

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Table 1

Diagnosis, Impairment, and Symptom Severity at Pre-treatment and Post-treatment

Case	Diagnoses	Pre-Tx CSR ^a	Post-Tx CSR ^a	Pre-Treatment				Post-Treatment			
				MASC -C ^b	MASC -P ^b	STAIC -C	STAIC -P	MASC -C ^b	MASC -P ^b	STAIC -C	STAIC -P
Anna	GAD	6	(3)	75	73	42	50	56	74	30*	44
	SAD	4	(2)								
	SOP	(3)	-								
Mary	GAD	6	-	11	8	36	43	3*	3*	18*	29*

Note. CSR=ADIS-IV Clinician Severity Rating; MASC-C/P=Multidimensional Anxiety Scale for Children-Child/Parent raw total scores; STAIC-C/P=State Trait Anxiety Inventory for Children-Child/Parent raw total scores; GAD=Generalized Anxiety Disorder; SAD=Separation Anxiety Disorder; SOP=Social Phobia.

^a CSR \geq 4 is threshold for clinical diagnosis, CSR in parentheses are subclinical.

^b The 39-item MASC was administered to Anna. The 10-item MASC was administered to Mary.

* RCI $p < .05$

Table 2

Examples of bereavement themes present in therapy sessions

Depressive Dysfunctional Thoughts	
<i>Anna</i>	"I've realized that I've been with so many deaths in my family that I've sorta been like almost scarred."
<i>Mary</i>	"Today in school I felt really alone like I wasn't a part of anything anymore. Even though I am, but it just didn't feel like that. Like I'm disconnected. Like they're having fun in class, I won't want to laugh." "I'm scared it's never going to be the same."
Anxious Dysfunctional Thoughts	
<i>Anna</i>	"That's something that keeps going on in my head, the night that I found out is just always constantly in my head." "The way he died was really disturbing, not a good thought to have in your head all the time. I try not to think about it." "Every time I hear his name, I automatically put bad thoughts in my head."
<i>Mary</i>	"I'll lose control and breakdown. Others will see me as weak. I don't want them to pity me."
Fear of Abandonment	
<i>Anna</i>	"What if someone else dies or something bad happens? Is everyone okay? Safe? Happy?" "I relate a lot of things to 'oh someone could get hurt.' It's not usually me I'm worried about, it's more about my family." "I always get bad thoughts, like if he's never coming home, all the dangerous things that could happen. I make a list in my head, like he could get shot, or stabbed, or fall because my uncle fell."
<i>Mary</i>	"If I see my dad sleeping on the couch I check, and if my sister's asleep by the time I go in. I just look to see if they're breathing." "I don't want to be in college and have to call him to make sure he's living."
Depressive Avoidance Behaviors	
<i>Anna</i>	"Well, it just recently passed, one year since my uncle died, so after that I haven't been feeling much anxiety, but feeling sad and not wanting to do anything."
<i>Mary</i>	"Just sometimes I don't feel like going out." "Hard to talk to my friends. Like I'll bring it up and then the conversation moves on so I just stand there and don't say anything."
Avoidance of Loss Reminders	
<i>Anna</i>	"I was surrounded by pictures of my uncle, and it was really depressing to me. Even though I want to see them, that's one reason I wouldn't want to go there because I don't like being around the pictures of him." "It's not that I don't want to remember him, it's just that I don't want to see the pictures."
<i>Mary</i>	"I went back to the house to clean out my stuff and I didn't do well with that. I just wanted to be in and out 'cause I didn't want to be in there 'cause that's the last time I saw my mom. I refused to go back."
Poor Integration of the Loss	
<i>Anna</i>	--
<i>Mary</i>	"Sometimes I feel selfish to want her back and back in pain, but I still want her back. No matter what the reason is I don't want it to be true. Even just to get her out of pain, I just want her here." "I want you to be here. I want you back."

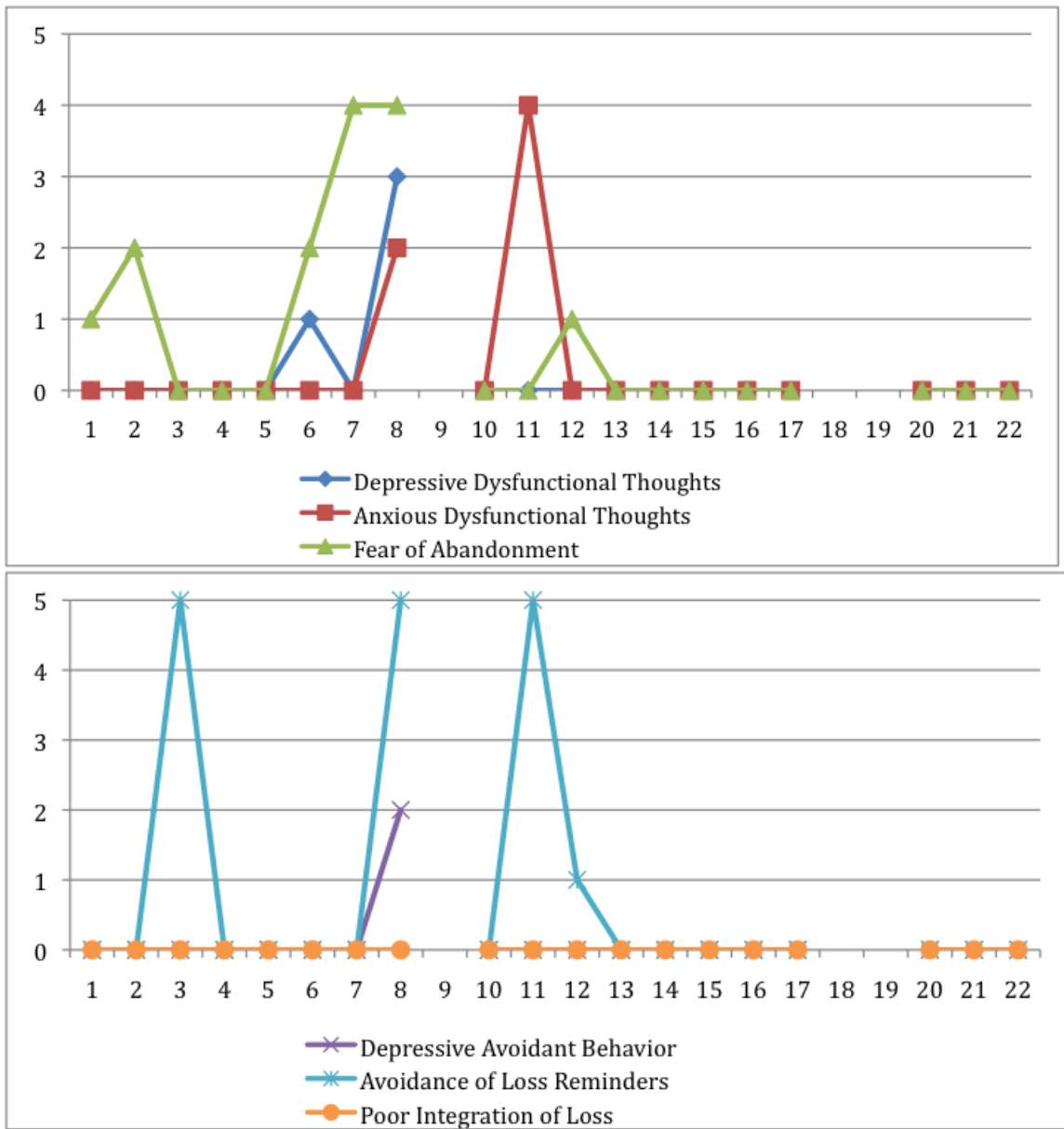


Figure 1. Bereavement themes present in Anna's therapy sessions

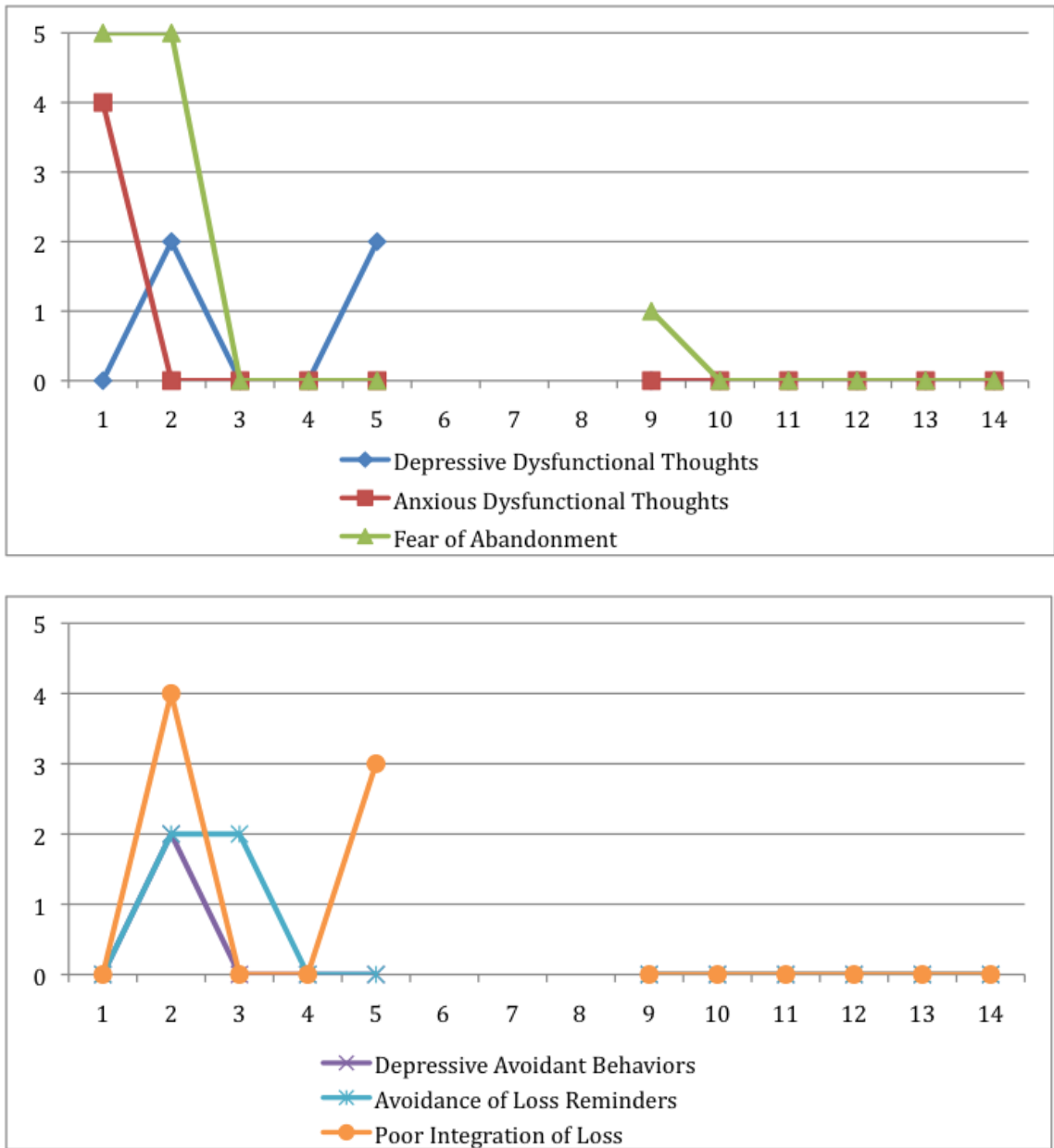


Figure 2. Bereavement themes present in Mary's therapy sessions

Appendix

Description and Coding of Bereavement Themes

For each: Rate sessions on intensity from 1-5. Use 0 if the theme was not present in session.

- (1) *Global Dysfunctional Beliefs*: Global, depressive or dysfunctional statements about the self, life, world, or future. For example, “Things will never get better”, “It will never stop hurting”, “I won’t ever be happy again”). Expressed concern that one should not work towards goals because the “future is bleak.”
 - a. *Intensity Scale (1-5): In-session*
 - 1 – makes a statement, but easily moves on
 - 2 – makes more than one statement, but moves on
 - 3 – makes multiple statements, moves on with therapist intervention
 - 4 – makes multiple statements, appears to be stuck
 - 5 – makes multiple statements, appears to be ruminating, despite therapist intervention

- (2) *Specific Dysfunctional Beliefs*: Misinterpretations about the grief reaction, beliefs that crying or a persistent sad mood is a signal of losing control or going crazy (e.g. “I’m going to break down”), or that one is not grieving in the correct way or for the appropriate length of time. Or concerns that others will evaluate or judge based on their grief reaction, (e.g. “Others will think I’m weak”)
 - a. *Intensity Scale (1-5) In-session*
 - 1 – makes a statement, but easily moves on
 - 2 – makes more than one statement, but moves on
 - 3 – makes multiple statements, moves on with therapist intervention
 - 4 – makes multiple statements, appears to be stuck
 - 5 – makes multiple statements, appears to be ruminating, despite therapist intervention

- (3) *Fear of Abandonment*: Expressed concerns about losing remaining family members or having to take care of oneself, displaying any behaviors used to reassure oneself (checking behaviors), difficulty separating from other family members or friends
 - a. *Intensity Scale (1-5) In-session or Out of session*
 - 1 – makes a statement, but easily moves on
 - 2 – makes more than one statement, but moves on
 - 3 – makes multiple statements, moves on with therapist intervention
 - 4 – makes multiple statements, appears to be stuck
 - 5 – makes multiple statements, appears to be ruminating, despite therapist intervention

- (4) *Depressive Avoidant Behaviors*: withdrawal from relationships or activities, isolating oneself from others (e.g. not attending a planned activity or turning

down opportunities for social interaction), inability to disclose feelings or thoughts to others

a. *Intensity Scale (1-5): Out of session*

- 1 – describes minimal withdrawal (e.g. does not seek out or initiate social interaction)
- 2 – describes some withdrawal (e.g. cancels a scheduled activity)
- 3 – describes significant withdrawal (e.g. cancels more than one scheduled activity during the week)
- 4 – describes significant withdrawal in multiple areas (e.g. cancels activities, does not answer phone calls)
- 5 – describes severe withdrawal (e.g. cancels activities, does not answer phone calls, does not interact with family)

(5) *Avoidance of Loss Reminders*: avoidance of specific people, places, or things that serve as reminders of the loss, stated refusal to be in close proximity to loss reminders, inability to mention person's name or personal details, refusal to talk about loss

a. *Intensity Scale (1-5): In-Session or Out of session*

- 1 – describes minimal avoidance (e.g. able to talk about deceased, able to confront reminders of loss, however, does not enjoy it)
- 2 – describes some avoidance (e.g. able to talk about deceased, but generally avoids more painful loss reminders)
- 3 – describes significant avoidance (e.g. unable to talk about deceased without significant encouragement)
- 4 – describes significant avoidance (e.g. unable to talk about deceased despite significant encouragement and use of coping skills)
- 5 – describes severe avoidance (e.g. unable to confront loss reminders, refuses to engage in exposure exercises, freezes, flees, or panics)

(6) *Problems Integrating the Loss*: a sense of shock about the loss, beliefs that the separation is reversible, yearning for the person, persistent urge to restore proximity to the lost person. Ch may make statements that the loss is “just a bad dream” or persistent wishing that things will go back to normal

a. *Intensity Scale (1-5) In-session*

- 1 – makes a statement, but easily moves on
- 2 – makes more than one statement, but moves on
- 3 – makes multiple statements, moves on with therapist intervention
- 4 – makes multiple statements, appears to be stuck
- 5 – makes multiple statements, ruminating, despite therapist intervention