

Group Counseling for Complicated Grief: A Literature Review

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Abstract: Grief is a universal experience; however, the response to grief is different for many people. Individuals who have a prolonged or delayed reaction to a loss may develop complicated grief. The need for therapeutic intervention is important for people suffering from this type of grief. Group counseling provides a viable option for treating the severe distress and impairment experienced by these people. This literature review explores three theoretical approaches to group counseling for complicated grief (psychodynamic, interpersonal, and cognitive-behavioral) in terms of effectiveness and multicultural concerns. The author discusses suggestions for additional research as well as implications for counseling.

Grief is the term used to describe the distress or suffering related to loss, particularly death. Everyone experiences grief or bereavement at some point in their life; however, the duration and expression varies among different cultural groups (MacNair-Semands, 2004). The feelings associated with grief often include sadness, anger, helplessness, and despair (Toth, 1997), in addition to denial, disbelief, confusion, shock, guilt, humiliation, and yearning (Mental Health America, 2007). Such feelings may be intense and long lasting, but they are natural and normal reactions to loss. Experiencing grief is necessary to heal and grow emotionally.

Although not everyone experiences loss the same way, it can be helpful to look at grief as a process. A common way of identifying grief is the five-stage model put forth by Kübler-Ross. According to Kübler-Ross (1969), individuals experiencing grief typically follow a pattern of emotions. When first learning of a loss, an individual may go through a period of denial. The person does not want to believe that the loss is real and may try to avoid it. Following the denial stage is the anger stage, during which the individual experiences an intense expression of emotion. Next, the individual begins to bargain in an attempt to prevent the loss. The person is searching for a way to circumvent the loss. After bargaining, the individual enters the depression phase. The person realizes the loss is inevitable and struggles to work through the emotions associated with it. The final stage in Kübler-Ross' model is acceptance. During this time, the individual acknowledges the loss and begins to move forward with her/his life.

Building upon Kübler-Ross' work, Lamb (1988) proposed a different model to understand the grief process. In this framework, there are three stages of grieving. During the adjustment stage, a variety of feelings and

thoughts occur. These are the things typically associated with grief, such as sadness and guilt. The purpose of the adjustment stage is to “enable the individual to sustain the impact of the loss without being overwhelmed by the pain and sorrow” (Lamb, 1988, p. 563). It is also a time for the grieving individual to develop coping mechanisms and deal with the meanings and implications of the loss. In the second or intermediate stage, the individual actively experiences the emotional states of grief (e.g., despair, anger, yearning, etc.). It is characterized by an obsessive review of the circumstances surrounding the loss and a search for meaning. It is often during the intermediate stage that individuals seek professional help because they begin to feel isolated. Family and friends typically return to their daily activities and the grieving individual spends more time alone. The third stage, also referred to as the final stage, is marked by a return to activities and behavior that occurred before the loss. Daily functioning increases and they no longer focus on the loss. These models help to elucidate typical grief and bereavement responses.

COMPLICATED GRIEF

Although the frameworks put forward by Kübler-Ross (1969) and Lamb (1988) explain the grief process for many individuals, sometimes people do not progress through these natural stages, and are unable to accept the loss and move forward with their own lives. The grieving process may be disturbed for these individuals. When this process is blocked or disturbed, complicated grief may arise (Piper, McCallum, Joyce, Rosie, & Ogrodniczuk, 2001). Typically, this occurs in people who have experienced a major loss in the last three months and have a prolonged or delayed grief reaction related to the loss (Kipnes, Piper, & Joyce, 2002). The most common types of losses associated with complicated grief are those of a parent, partner, child, sibling, grandparent, or friend (Abouguendia, Joyce, Piper, & Ogrodniczuk, 2004; Ogrodniczuk, Joyce, & Piper, 2003; Piper, et al., 2001). Complicated grief is characterized by a preoccupation with the loss, yearning, disbelief and inability to accept the loss, bitterness or anger about the loss, or avoidance of reminders of the loss (Ogrodniczuk, Piper, Joyce, McCallum & Rosie, 2002). These symptoms are often accompanied by a sustained disruption in social or occupational functioning.

There are three main forms of complicated grief (Bete, 1999). These include absent, delayed or inhibited grief, distorted grief, and chronic grief. Those persons experiencing absent, delayed, or inhibited grief may not show any feelings of grief until two or more weeks after the loss, and the feelings may seem less intense or be unresolved. Distorted grief



manifests itself when one or more grief reactions become very exaggerated. An example of distorted grief may be that the person is only able to show and feel anger for an extended period of time, which blocks out other feelings, such as sadness. Individuals who experience the third type of complicated grief, chronic grief, may never accept the loss. They may stay consumed with the loss for months or years and act as though it just occurred.

Even though there are general patterns of grief and types of complicated grief, there is no standard diagnosis for pathological reactions to loss (Piper, et al., 2001). The DSM-IV-TR (APA, 2000) lists bereavement as a V-code, or “other condition that may be a focus of clinical attention” (p. 740), but typically V-codes are reserved for individuals who do not have a mental disorder. It could be argued that the symptoms associated with complicated grief could classify an individual as having a mental disorder. Indeed, many individuals experiencing complicated grief do receive a diagnosis. The most common diagnoses of complicated grief are depressive disorders (i.e., major depressive disorder and dysthymia), adjustment disorders, post-traumatic stress disorder (PTSD), and personality disorders (i.e., avoidant, dependent, borderline, and obsessive-compulsive) (Abouguendia, et al., 2004; Enright, & Marwit, 2002; Kipnes, et al., 2002; Piper, et al., 2001).

Despite sharing some descriptive features with these diagnoses, none of these completely encompasses complicated grief (Enright & Marwit, 2002). For example, some common core symptoms of PTSD include numbness and disbelief, which are similar to some typical symptoms of complicated grief. However, other core symptoms of complicated grief (such as, yearning, searching, and excessive loneliness related to the loss) are not usually exhibited in individuals suffering from PTSD. Although, people with PTSD may experience complicated grief related to the trauma they have experienced, certainly not all individuals faced with a loss develop PTSD.

In much the same way, depressive disorders cannot completely account for all the individuals with complicated grief. It may be true that most symptoms of complicated grief are similar to those of depressive disorders, particularly Major Depressive Disorder, though not all individuals will meet the criteria for such diagnoses (Enright & Marwit, 2002; Piper, Ogrodniczuk, McCallum, Joyce, & Rosie, 2003). A final example involves the diagnosis of an adjustment disorder. By definition, the symptoms related to adjustment disorders must occur “within three months of the onset of the stressor(s)” and do not last for more than six months after the stressor has ended (American Psychiatric Association, 2000, p.683). Most theorists agree that grief lasts longer than six months,

and the complicated form does not present until after three months after the loss (Enright & Marwit, 2002). Thus, adjustment disorders (and other DSM-IV-TR diagnoses) cannot completely account for all individuals experiencing complicated grief.

Despite a lack of consensus regarding definitions and diagnoses of complicated grief, it clearly interferes with an individual's ability to function and can lead to other serious problems. The prevalence rates for complicated grief are relatively high, ranging from 15-33% in psychiatric outpatient groups (Ogrodniczuk, Piper, Joyce, et al., 2002), and approximately 20% of all acutely bereaved individuals (Piper, et al., 2001). As may be inferred by the typical diagnoses associated with complicated grief, many individuals develop additional physical and mental health problems. Such concerns include depression, anxiety, sleep difficulties, alcohol and other drug problems, physical illnesses, and increased risk of suicide in addition to their symptoms of complicated grief (Ogrodniczuk, Piper, Joyce, et al., 2002; Ogrodniczuk, Piper, McCallum, Joyce, & Rosie, et al., 2002; Piper, et al., 2001; Sikkema, et al., 2006). Such impairments make it clear that therapeutic intervention is especially important for individuals experiencing complicated grief.

GROUP COUNSELING FOR COMPLICATED GRIEF

One type of counseling that has been theorized to be beneficial to individuals suffering from complicated grief is group counseling. Grief and loss typically cause people to feel isolated, because complicated grief reactions may directly affect social support (Ogrodniczuk, Joyce, Piper, 2003). In the event of a loss, family and friends typically express concern for and assist the grieving individual. However, those experiencing complicated grief may place excessive demands on their social support groups. The stress may alienate the social network and isolate the grieving person. Grief counseling groups seem like an appropriate alternative source of social support. In addition, groups can provide a means of catharsis and a place to learn coping skills and stress management techniques (MacNair-Semands, 2004; Piper, et al., 2001; Sikkema, et al., 2006). Furthermore, grief groups are often brief, which may offer some relief to the suffering individual (Toth, 1997). The three theoretical orientations that typically underlie counseling groups for treating complicated grief are psychodynamic, interpersonal and cognitive-behavioral.

Psychodynamic Group Counseling



Of the approaches that focus on grief counseling groups, those utilizing psychodynamic theory have been studied the most (MacNair-Semands, 2004). Psychodynamic group counseling has a strong theoretical base, and it has been investigated intensely by a group of researchers in Canada. Piper and colleagues have implemented many short-term groups for patients suffering from complicated grief since 1986. The purpose of such groups is to understand how underlying unresolved conflicts contribute to current difficulties dealing with loss (Kipnes, et al., 2002; MacNair-Semands, 2004; Piper, et al., 2001). Typically, the groups last for 90 minute weekly sessions over 12 weeks. Most often two types of psychodynamic group therapies are employed: interpretive and supportive groups.

Interpretive

The primary objective for interpretive group therapy is to “enhance the patients’ insight about repetitive conflicts (both intrapsychic and interpersonal) and trauma that are associated with the losses and that are assumed to serve as impediments to experiencing a normal mourning process” (Piper, et al., 2001, p. 531). In addition, interpretive therapies seek to help the patients develop a tolerance for ambivalence toward the people they have lost. The role of the therapist is to create an atmosphere in which clients can examine conflicts in a here-and-now experience. The counselor encourages the client to find a balance of tension and comfort, and helps the client to explore uncomfortable emotions (Ogrodniczuk, et al., 2003). Instant praise and gratification are withheld with goal of helping the client to better tolerate anxiety and tension. It is an active, interpretive, and transference-focused approach.

Supportive

The primary goal for supportive group therapy is to “improve the patients’ immediate adaptation to their life situation” (Piper, et al., 2001, p. 532). According to this perspective, positive adaptation results from the provision of support and problem solving techniques. The counselor creates a climate of gratification so that clients can share common experiences and feelings, and receive praise for their efforts at coping. The therapist is active, non-interpretive, and focused on the patients’ current interpersonal relationships (Ogrodniczuk, et al., 2003). Supportive therapies typically are less demanding, depriving, and anxiety arousing than interpretive therapies.

Interpersonal Group Counseling

Another popular form of group counseling for the treatment of complicated grief is the interpersonal approach. In this model, the primary goals are to facilitate the mourning process and help the grieving person regain interests and relationships (MacNair-Semands, 2004). Clients are encouraged to think about, discuss the sequence of events and consequences surrounding, and explore feelings and emotions related to the loss. In addition, relationship patterns are examined to develop an understanding of current relationship difficulties. As in psychodynamic group counseling, an important tenant of the grief process in interpersonal group counseling relates to ambivalence toward the lost person. Ambivalence must be shared and explored in order to facilitate change. Interpersonal group techniques often involve establishing norms, encouraging process reviews, and making here-and-now interventions.

Cognitive Behavioral Group Counseling

A final approach to be reviewed in this paper is cognitive behavioral group counseling (CBT). CBT is a structured approach that clearly outlines an agenda and activities for group settings (MacNair-Semands, 2004; Sikkema, et al., 2006). Typically, techniques involve encouraging group members to gain closure through writing, visiting a cemetery, and expressing and reliving painful memories until the distress is reduced. In CBT groups, the counselor and clients choose topics for discussion and identify common themes. The goal is to detect automatic thoughts. Once clients' become aware of automatic thoughts, they are able to realize the consequences related to them and diminish the power associated with them. Clients are then able to determine alternative ways of thinking and share ideas to reduce the negative thoughts. Other techniques related to CBT grief reduction groups involve stress management and coping skills.

Effectiveness of Group Counseling

Brief Counseling Groups

There seems to be a consensus that brief therapy groups are among the most effective counseling groups for complicated grief (Abouguendia, et al., 2004; MacNair-Semands, 2004; McCallum, Piper, Ogrodniczuk, & Joyce, 2002; Piper, et al., 2001; Ogrodniczuk, Piper, Joyce, et al., 2002; Toth, 1997). According to Toth (1997), brief therapy is an especially good fit for those suffering from grief because the time constraints intensifies group members' existential anxiety and serves as a reminder of the finite



nature of interpersonal interactions. Among the benefits of short-term counseling groups are increases in self-esteem, mental health, and social functioning and reductions in general symptoms of grief and use of psychotropic medications (Ogrodniczuk, Piper, Joyce, et al., 2002; Toth, 1997).

Psychodynamic Group Counseling

As mentioned above, the most extensive research on group counseling for grief has been conducted on psychodynamic groups (MacNair-Semands, 2004). Piper and his colleagues (e.g., Piper, et al., 2001; Piper, et al., 2002; Piper, Ogrodniczuk, Joyce, Weideman, & Rosie, 2007) have demonstrated that short-term psychodynamic groups can help reduce depressive symptoms and target problems, as well as increase self-esteem, life satisfaction, social support, and autonomy. The researchers utilized large sample sizes, actual clinical populations, standard forms of therapy, and random assignment of patients to improve the scientific rigor (MacNair-Semands, 2004).

The two types of psychodynamic group counseling described above, interpretive and supportive, have shown to have different effectiveness rates (Piper, et al., 2001). The average effect size for interpretive psychodynamic groups was .75, a large effect by Cohen's standard *d* (Cohen, 1988). An effect size of .75 means that the average patient at post-therapy was better off than 77% of the patients at pre-therapy. The average effect size for supportive therapy was .50, a moderate effect according to Cohen. An effect size .50 for this study means that the average patient at post-therapy was better off than 69% of the patients at pre-therapy.

In addition, interpretive and supportive groups may be effective with different types of people (Ogrodniczuk, Piper, McCallum, et al., 2002; Piper, et al., 2001). For example, individuals with a history of more mature, give-and-take interpersonal relationships typically fare better in interpretive groups. They may do better in this type of group because they are better able to "tolerate and work with the demanding, depriving, and anxiety-arousing features of interpretive group therapy, including the examination of painful conflicts and their relationships to the lost persons" (Ogrodniczuk, Piper, McCallum, et al., 2002, p. 528). In addition, people with a history of relatively unsatisfactory relationships may find supportive therapy more beneficial than interpretive therapy. They may be less able to handle conflict in their relationships and are more dependent on others to satisfy their interpersonal needs. Thus, professionals should keep in mind individual differences when considering the type of counseling group for participants.

Interpersonal Group Counseling

The empirical support for interpersonal group counseling is scarce despite having a solid theoretical base. The argument could be made that interpersonal theory is ingrained in both psychodynamic and cognitive behavior group counseling, thus providing support for its effectiveness. For example, aspects of supportive psychodynamic group counseling bear resemblance to those of interpersonal group counseling (i.e. the provision of support and focus on interpersonal relationships). In much the same way, part of group CBT for grief is learning coping skills and stress management, which is also a goal of interpersonal group therapy for grieving adults. However, there are distinct differences among the theories; therefore, more empirical research is needed on interpersonal group counseling for complicated grief.

Cognitive Behavioral Group Counseling

Group CBT is one of the only empirically supported interventions for grief work (MacNair-Semands, 2004). In addition, group CBT has been shown to reduce symptoms of grief and psychiatric distress significantly more than individual psychotherapy (Sikkema, et al., 2006). In the randomized controlled trial by Sikkema, et al. (2006), women demonstrated higher baseline scores on grief and distress than men, but also showed greater improvements than men did. Despite the rigorous design of the study, the generalizability of these findings is limited. The study looked specifically at adults with HIV who experience AIDS-related bereavement. It could be argued, though, that these individuals provide an accurate representation of complicated grief because they have the double burden of coping with their own illnesses and multiple losses related to AIDS.

MULTICULTURAL CONSIDERATIONS

A number of multicultural considerations arise when examining the research on the effectiveness of group counseling aimed at diminishing grief symptoms. Although loss is a universal experience, the reactions to loss are not (MacNair-Semands, 2004). Most of the literature focuses on adult (19-67 years old) Caucasian females, which is quite a specific population. Each sample has distinct characteristics that may or may not apply to other populations. There may be cultural or gender differences in the expression of grief, which may limit the effectiveness of the treatment. Therefore, clinicians must be cautious in generalizing research findings across gender and cultural groups.



In addition, the outcomes assessed may not be endorsed by all populations. For example, studies have shown that psychodynamic groups can increase autonomy. Autonomy is typically considered an important value for people from individualistic societies, but is not necessarily valued by those from collectivistic cultures. Individuals from such cultures may view an increase in autonomy as a setback rather than positive step in the grief process. The outcomes measured may not be valued across cultures, therefore limiting the effectiveness of the intervention in different contexts.

The strict exclusion criteria for most of the studies also limit the generalizability of the findings to other populations, especially those with severe mental illness. For example, several studies excluded individuals with suicidal intent, psychosis, addiction, sexual deviation, sociopathic behavior, or comorbid disorders that may interfere with therapy (Kipnes, et al., 2002; Piper, et al., 2003; Piper, et al., 2007). Arguably, these studies excluded people who may need intervention the most. However, research has shown that individuals with severe mental illness often do not benefit from group therapy and may hinder the progress of others (Yalom, 2005). In any case, it is important to remember that the findings may not apply to all populations.

FUTURE RESEARCH AND CLINICAL IMPLICATIONS

In conclusion, group counseling appears to be a viable option for those experiencing complicated grief. It provides an additional source of social support and a safe place for clients to progress through the grieving process. Brief psychotherapy groups (i.e., those consisting of 6-12 weekly 90 minute sessions) appear to be especially effective.

In general, more research is needed on group counseling for complicated grief. Although, three different counseling groups have strong theoretical foundations, there is little empirical support for the treatments. Additional research on the effectiveness of different theoretical orientations would be beneficial. Furthermore, future research should compare group theoretical models in order to determine the most effective approach for treating complicated grief.

It is interesting that the majority of the work reviewed for this paper used data from one study conducted by Piper, et al. (2001). The study was well designed, and builds upon years of previous work; however, no study is flawless. If most of the current literature regarding group counseling for complicated grief is based on one study, there are significant limitations with regard to generalizability. Professionals should be wary of applying the results to populations that are different from that of the study. In

addition, they should consider possible researcher biases that may influence the interpretation of the data. All researchers bring their own biases to their work, whether they are aware of them or not. It is important to be cautious when such a large portion of the literature is conducted by the same group of researchers.

The research that is available suggests group counseling is effective in treating complicated grief; however, that research is based primarily on a narrow sample, consisting of adult Caucasian females. This group may be representative of the population that experiences complicated grief; however, there may be distinctive traits and values specific to Caucasian females that do not apply to other populations. Future research should include samples that are more diverse in order to increase the generalizability of the results. Professionals need to consider the population of interest, in addition to cultural values, when recommending group counseling for the treatment of complicated grief in order to ensure favorable outcomes.

Despite limitations, all three of the theoretical approaches to group counseling have strong clinical implications. For example, according to the research, professionals should utilize interventions that provide guidance to help clients communicate needs to others, suggest adaptive interpersonal behaviors, and help to clarify expectations for support (Ogrodniczuk, et al., 2003). These techniques are consistent with the goals of interpersonal and cognitive behavioral groups. In addition, clinicians should explore patients' impressions of what the lost person did and did not provide to understand the reluctance to accept the loss (Ogrodniczuk, Piper, McCallum et al., 2002). As demonstrated by psychodynamic and interpersonal groups, understanding ambivalence is a critical component to facilitate change and growth. These applications help counselors to treat individuals experiencing complicated grief skillfully and effectively.

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