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## **Cognitive-Behavioral Grief Therapy: The ABC Model of Rational-Emotion Behavior Therapy**

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### **Abstract**

The article briefly reviews the changes that occurred in the field of grief and bereavement, viewing it as a process of searching for a "rational" meaning to life without the deceased in line with the concept of continuing bonds and thus replacing that of Freud's concept of deatathesis. Cognitive-behavioral therapy (CBT) evidenced-based studies for PTSD and complicated grief and the Cognitive-behavioral therapy – Rational-emotion behavior therapy (CBT-REBT) model for grief are reviewed. The focus of intervention based on CBT-REBT is to facilitate a healthy adaptation to loss following death. A distinction is made between rational (adaptive) and irrational (maladaptive) grief processes. Case example illustrating the application of the model specifically a dialogue with repetitive thoughts, are presented.

**Keywords:** grief, complicated grief, cognitive grief therapy, CBT-REBT based intervention

### **From Deatathesis to Continuing Bonds and Implication for Therapy**

Grief following loss through death is a universal, normal human reaction as well as a highly individual one and always occurs within a socio-cultural context. Death of a loved one constitutes a major life-cycle event encountered frequently by therapists. Treatment with bereaved people has undergone significant changes related to development in both theoretical and applied fields. A wealth of literature has described in detail the course of grief as stages (Bowlby, 1980; Kubler-Ross, 1969), phases (Ramsay, 1979; Sanders, 1989), components, tasks (Worden, 2003), or tracks (Rubin, 1981, 1999). In the normal grieving process, reactions are known to be intense immediately following the loss, and to decrease over time (Parkes, 1985; Parkes & Prigerson, 2010; Rando, 1984; Sanders, 1989). Grief has

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traditionally been seen as a healthy normal and universal process that is aimed at decathexis – abandoning or letting go of commitment to one's relationship to the deceased, a process known as "grief work" (Freud, 1917).

However, evidence – based studies have not found support for the theory of relinquishing bonds with the deceased (Neimeyer, Keese, & Fortner, 2000). On the contrary, empirical studies repeatedly suggest that inner relationships with the deceased often continue throughout one's life (Klass, Silverman, & Nickman, 1996; Malkinson & Bar-Tur, 2004/2005; Rubin, 1999). Grieving, based on this conceptualization, often includes the act of reconstructing a world of meaning that was challenged by the loss.

The adoption of the continuing bonds perspective emphasizes grief and mourning as a lifelong developmental process that serves to maintain a continuing bond with the deceased. Moreover, the latter approaches have shifted from expecting a predetermined course and outcome of bereavement to emphasizing that there is no single predictable pathway through grief, and regarding it as an idiosyncratic process (Neimeyer, 1999). Similarly, the time framework of what is considered normal "grief work" has shifted from the "mythological" 12-month period resulting in individuals resuming "normal life" upon its completion and it is now recognized as a far more complicated process. Thus, the individual grief process often includes grief for the individual lost as well as a process of searching and constructing meaning to life without the deceased. Complicated grief is described as the intensification of grief which does not lead to assimilation of the loss, but instead to repetitive stereotypic behavior as well as impaired functioning (Boelen, 2006; Malkinson, 2007). Risk factors connected to complicated grief include traumatic circumstances of the death, which in turn can result in additional reactions such as depression, anxiety states, and PTSD (Auster, Moutier, Lanouette, & Zisook, 2008). Often these coexist and overlap, stressing the importance of assessment prior to applying treatment. Research studies have set the stage for differentiating complicated grief (obsessional preoccupation with the deceased, crying, persistent yearning, and searching for the lost person) from depression (clinical signs of depression with preoccupation with self), (Prigerson et al., 1995a; Sheer, Frank, Houck, & Reynolds, 2005). The implications of these findings lend themselves to differential treatment interventions for grief (psychotherapy with a focus on caring and support) and for depression (combined psychotherapy and psychopharmacology).

Presently, there is an increased application of CBT as a preferred form of treatment, which is evidence-based of its effectiveness in caring for people with depression and anxiety (Compton et al., 2004; Whitfield & Williams, 2004) anxiety (Kavanagh, 1990), stress, and post-traumatic stress disorder (PTSD) (Foa & Rothbaum, 1998; Pynoos, Nader, Frederic, Conda, & Stuber, 1987; Resick & Schnicke, 1995) and complication in grief (Boelen & de Keijsers, 2007; Shear, 2003).

A substantial number of evidenced- based CBT protocols to treat PTSD are available (Foa & Rothbaum, 1998; Horowitz, 2003; Resick & Schnicke, 1995). The main tenet of cognitive therapies is the centrality of the cognitions in understanding emotional disturbance. It assumes that emotions, behaviors and somatic (physical) sensations are moderated by cognitive processing of events and hence can be changed or reconstructed so as to reduce emotional stress. In other words, appraisals of events can be changed as a mean to reduce distress. In this paper we will elaborate on the application of CBT-REBT in complicated grief.

It may be recalled that studies on evaluating the results of CBT in complications of bereavement were conducted in the 1970s (Gutheir & Marshal, 1977; Mawson, Marks, Ramm, & Stern, 1981; Ramsay, 1979) when the concept of breaking the bonds was the basis for understanding and evaluating the processes of normal mourning, whereas difficulties in breaking the bonds were considered as pathological grief. The aim of treatment intervention based on breaking bonds was therefore to assist the bereaved to part with and sever the relationship with the memory of the deceased. In terms of CBT the assumption was that grief complications are caused by social reinforcements that repeat themselves as "pathological". For example, in Gauthier and Marshall's study (1977) there is a description of the use of the techniques of behavioral desensitization and changes in social reinforcements that induced a behavioral change and eradication of the relationship with the deceased's image. Ramsay (1979) described an additional example of treatment intervention in "pathological grief" by applying the technique of flooding and guided mourning for encouraging the expression of emotions that result in reintegration. A further study of Mawson et al. (1981) focused on prevention as a form of behavior that preserves "pathological mourning", and incorporated the use of guided mourning to recall the memories and painful emotions that accompany them, with homework in between the sessions. The results of the research showed an improvement among the participants in the treatment group of guided mourning (reinforcements in avoiding painful memories) even 28 weeks later, as compared with the control group that was instructed in avoiding memories connected with mourning and "retaining" the symptoms.

The transition to the idea of "continuing bonds" (Klass, Silverman, & Nickman, 1996) modified the view of grief, its process and outcomes from breaking (decathexis) relationship with the deceased to one that sees the grieving process as searching and constructing meaning to death and life in the absence of the deceased's image (Malkinson, 2007; Neimeyer, Keese, & Fortner, 2000), and the organization of the interpersonal relationship with its representations. Thus the outcome of the grief process is a balanced relationship with the deceased's representation, in which there is no denial or avoidance of their memory of the deceased's image, and without their flooding (Horowitz, 2003; Prigerson et al., 1995a). In contrast, in complicated grief there are difficulties in functioning and organizing the interpersonal relationship, especially the oscillation between

avoidance response and flooding, as well as dealing with pain and yearning (Rubin & Malkinson, 2001; Stroebe & Schut, 1999).

As a consequence of these changes, there are also advanced interventions in creating the conditions for the process of adaptation to life without the deceased. Evidenced-based studies evaluating the results of CBT have noted apparently efficacious strategies such as exposure, cognitive reconstruction and writing (Boelen & deKaiser, 2007; Reynolds et al., 1999; Shear et al., 2005). Shear et al., (2001, 2005), for example, have compared treatment intervention based on CBT with interpersonal therapy and found that CBT was more valuable in treating complications of bereavement.

Boelen & deKaiser (2007) have carried out a study in which they compared CBT and supportive treatment given to bereaved diagnosed with complicated grief. The bereaved were divided into three groups: CR (cognitive restructuring), and exposure (ET), and social support (each received 12 sessions). The results showed that the two groups receiving CBT improved more than did the third group. An additional important finding emerged when the two CBT groups were compared: It was seen that "pure" exposure was more successful than "pure" cognitive construction, and the addition of exposure to cognitive construction involved a further improvement compared with the addition of cognitive construction to exposure. Thus, in general, the results indicate the superiority of CBT over supportive treatment. The comparison of CBT strategies in complicated grief, showed that exposure was more effective than cognitive construction. A possible explanation for exposure's superiority over cognitive construction lies in its inclusion of emotional and behavioral elements.

Studies on treatment evaluation grief therapy emphasize the efficacy of CBT that focuses on cognitive changes whose emotional results are negatively healthy enabling a normal process of grief and adaptation to loss (Shear et al., 2005). A framework of interventions for PTSD was developed by Foa and Rothbaum (1998) and adapted for treatment of complicated grief by Shear and associates (2005). Exposure therapy (PE) enables adaptation of traumatic experience by means of imagery exposure which includes the details of the event and the accompanying cognitive and emotional responses. Shear's exposure framework consists of 16 sessions divided into three stages: pre-treatment, mid-treatment and the final stage combining the DPB (dual process of bereavement) (Stroebe & Schut, 1999) which views the process of adaptation to loss as oscillating between loss and restoration orientation. Therapy consists of exposure therapy, thought restructuring, writing journals, letter-writing to the deceased as homework assignment as well as pre-loss activities. The homework assignments that are given between sessions are an important part of the therapy.

### **The CBT-REBT Model**

We will now briefly present the ABC model (Adverse event – Beliefs – Consequences), a cognitive theoretical model originated by Ellis (1962, 1976, 1985) that may be directly applied to our understanding of grief and bereavement. Like other cognitive models, the CBT-REBT model emphasizes the centrality of cognitive processes in understanding emotional disturbance following an adverse event. However, it distinguishes between two sets of cognitions - rational and irrational ones - and their related emotional and behavioral consequences that differ qualitatively, and mark the difference between healthy and unhealthy adaptation to adverse events (Ellis, 1994). Applying this model to bereaved persons is based on the distinction between healthy reactions to loss and prolonged dysfunctional grief. It provides guidelines for the assessment of bereaved individuals' interpretation of their experience of loss, and offers cognitive, emotional, and behavioral strategies for facilitating a healthier course of bereavement in cases of loss. Assessment based on the ABC model, and cognitive therapy for complicated grief will be outlined and clinical illustrations will be provided.

Several tenets underlie the ABC model of CBT-REBT (Ellis, 1991): the origins of emotional disturbance are cognitive, emotive, and behavioral; cognition is a mediator between an event and its emotional consequences; dysfunctional emotions largely stem from irrational thinking (demandingness); human beings are born with a biological predisposition to think irrationally, some are born with a greater tendency, and therefore exhibit more irrational thinking; the biological tendency to think irrationally coexists with the healthy human tendency to think rationally and actualize oneself (Daniel, Lynn, & Ellis, 2010).

According to the CBT-REBT model, people's emotional consequences (C) are not solely determined by the activating event (A) but largely by the beliefs (B) they have about the event. Death (especially sudden and unexpected death) may be regarded as an adverse external event (A) that affects one's belief system (B) and, consequently, one's emotions and behaviors (C). A cyclical interaction occurs between the event (A), beliefs about the event (B), and the emotional and behavioral consequences (C) (Ellis, 1962).

What distinguishes rational from irrational thinking? Beliefs (B) are irrational or dysfunctional because they are absolutistic evaluations – demandingness – that past, present, or future life events ought, or must be different from the way they are, generally resulting in emotional distress at point C (consequence). Frustration intolerance and self-downing are forms of irrational demandingness that are often followed at point C by emotional distress such as depression, anxiety, extreme shame, and guilt. Frequently, the human tendency to think irrationally reaches a peak following a death event, because bereaved individuals think that the death should not have happened to them, or that it is too painful for them to stand (Ellis, 1976, 1994a; Malkinson, 2007; Malkinson & Ellis, 2000).

On the other hand, rational, functional beliefs (B) are realistic evaluations of adverse events based on evaluation of preference and acceptance (e.g., "How sad and unfortunate that this happened to me"; "My life will never be the same, it's sad and painful"), and their related emotional consequences (C) are negative but not as upsetting: sorrow, sadness, regret, frustration, and concern (Ellis, 1994a).

### **CBT-REBT in Grief**

We mentioned earlier that an important basic assumption of the model relates to people's innate tendency of irrational thinking during crises, such as a loss through death. Research studies now show that mental changes occur following such a loss (Boelen, Kip, Voorsluijjs, & van den Bout, 2004; Boelen, van den Bout, & van den Hout, 2003; Fleming & Robinson, 2001; Janoff-Bulman, 1992; Neimeyer, 2004). The process of adaptive bereavement from the cognitive perspective is the ability to adapt (change) the thoughts to a new situation; difficulties in doing so indicate dominancy of irrational beliefs that enhances the risk of complicated grief. One study that examined the relationship between loss and irrational beliefs was published by Boelen et al., (2004) who examined a group of 30 students who were grieving the loss of a parent or a sibling against a control group of 30 non-bereaved individuals with the object of tracing the relationship between beliefs and emotional responses, and whether a loss affects the cognitive process. They also examined whether there was a relationship between cognitive variables and symptoms of traumatic grief, and whether there were differences between bereaved and non-bereaved in their basic suppositions and level of irrational thinking. They found that the group of bereaved had fewer positive beliefs about the significance of the world, of their self-worth, and a higher level of irrational thinking than did the group of non-bereaved. They also showed a connection between the overall usage of irrational thoughts and those specifically associated with bereavement and between symptoms of traumatic grief. They found no relationship between basic beliefs and traumatic grief, although the beliefs reflected a lower cut-off of frustration that explained the higher rate of variability in traumatic bereavement. Such findings support the proposition that there is a connection between the adaptation to loss, and the ability, even partially, to change the beliefs and adapt them to the new situation. It means that treatment interventions should focus on identifying the patterns of irrational thinking and the emotional, non-adaptive consequences and adopting patterns of rational thinking, whose consequences are healthy negatives. Such a thought pattern emphasizes the choice that we have to adapt more healthily to an unwanted situation (Dryden, 2009; Ellis, 1994b; Ellis & Dryden, 1997). In the case of the death of a close relative, an adaptive and healthy response during the bereavement process includes among other things, feelings of sadness, pining and pain related to the changed situation and its recognition.

Central to CBT-REBT perspective is the distinction between healthy and

unhealthy consequences of one's belief system in reaction to loss. Grief is a normal and healthy reaction to a very stressful event. As distinguished from depression (in which the person is preoccupied with low self esteem), grief is a process of experiencing the pain of the loss and searching for a new meaning to life without the dead person (deceased – focus) (Prigerson et al., 1995a, 1995b). It is also a process of restructuring one's irrational thinking concerning the loss event into a more rational, realistic mode and its emotional consequences are moderate (Boelen, 2006; Malkinson, 1996, 2001; Neimeyer, 1999; Neimeyer, Keese, & Fortner, 2000).

Within the CBT-REBT conceptual framework, the grief process is a healthy form of thinking and emoting that helps the bereaved person organize his or her disrupted belief system into a form of healthy acceptance. Thoughts about the death are not avoided nor constantly remembered, but are rearranged into a system of sadly deploring, but successfully living with, the great loss of the bereaved person ("I know there will always be a big hole in my life where she was, but I will always remember her with love;" "I'll always miss my mother, but I have great memories to keep in my heart and pass on to my kids - my children will always remember her as a great grandma").

Table 1. Characteristics of Grief Related Rational and Irrational Beliefs

Rational beliefs	Irrational beliefs
Flexible evaluation of the event: <i>Life has changed forever.</i>	Rigid and extreme evaluation of the event: <i>Life is worthless without him.</i>
Consistent with reality: <i>It is difficult without him.</i>	Inconsistent with reality: <i>It's intolerable, awful, I can't think of it.</i>
Acceptance of life without him: <i>Whenever I think of him it's sad and painful, I miss him.</i>	Unacceptability of life without him: <i>It's too painful to think of him, I avoid it.</i>
Continuing search for meaning to life: <i>I think of ways to remember her.</i>	Life is "frozen" and lost its meaning: <i>Life is meaningless.</i>

The goals of cognitive grief therapy (CGT) are: (1) To enable grief that has a healing effect and assist the bereaved to adapt to the sad reality, which no longer includes the deceased, a reality that involves pronounced negative emotions such as sadness, frustration, and pain; (2) To change irrational beliefs (irBs) into rational beliefs (RBs) that minimize unhealthy, self-defeating feelings of depression, despair, horror, and self-deprecation (Table 1).

### **Description of Therapy Focused on Complicated Traumatic Grief What do the Interventions Include?**

- a. The therapeutic alliance and cognitive assessment (in addition to demographic one), and agreement on the aim of therapy.
- b. Providing information about grief, its process and components, normalizing its emotional and behavioral consequences grief process ("its normal to cry when one experience such a loss"), legitimizing the temporality and feeling the shattered world.
- c. Identifying dysfunctional irrational beliefs and their distressing emotional behavioral and physical consequences and formulating a hypothesis (Malkinson, 2001).
- d. Explaining and teaching the ABC model of emotional distress and the B-C connection.
- e. Teaching and practicing adaptive rational thinking and functional emotional and behavioral consequences.
- f. Assisting the bereaved in a search for ways to reorganize life without the deceased and ways to continue bonds with him or her (memories, memorabilia).
- g. Between - session's assignments.
- h. Preparing for termination and a follow up.

### **A Case Illustration of Applying CBT-REBT Interventions in Complicated Grief**

Suzie, a woman in her 40s, requested therapy following the death of her husband from brain hemorrhage 10 months earlier. The family was watching a football game on TV and suddenly the husband collapsed. The medical team that was called immediately pronounced his death. She is the mother of 2 children, a son aged 13 and a daughter aged 8. She works as an accountant. She described her husband as a healthy, energetic person, a loving husband and a devoted father to the children. He was a talented person who decided to change his career and faced some difficulties during that transition period. Since the sudden death of her husband she has difficulties in functioning, she cries a lot and worries that if "she doesn't pull herself together", it will be terrible, and the children will suffer, she feels angry with herself. Following the death, she told the children that life will go on and she made efforts to return to the usual routine but alas with no success: "I can't take it any longer". She has difficulties in sleeping, lost appetite and lost interest in her work. She is repeatedly asking "why, why did it happen to me? I lost my best friend and life lost its meaning, why did it happen to me".



*The Therapeutic Alliance, Cognitive Assessment, and Agreement on the Aim of Therapy*

The therapeutic alliance with Suzie was carried through the provision of information about grief process, normalizing her overwhelming experience and legitimizing the temporality of her emotional state, and feeling the shattered world: "You lost your husband so suddenly, and it's normal to feel that your world has been shattered. This is grief that people experience after such a loss, and many times it feels as if you are going crazy." To the question what she would expect from therapy, Suzie replied: "I don't really know what to expect." Suzie accepted the therapist's suggestion to meet two or three more times to explore what she could and would like to gain from therapy.

During the next two sessions the ABC model of emotional distress was explained, and details about rational and irrational thinking and the emotional consequences was provided. Also, information about what is distinctive about an adaptive course of grief (sadness, pain, yearning, moderate anger, moderate feelings of guilt). The introduction of the ABC components of the model brought Suzie to comment on the way she was obsessively asking "why" questions that increased her distress but did not help in finding an answer. It was agreed that therapy will focus on assisting Suzie to learn and adopt a healthier way of grieving, a more rational way of thinking about the loss and life that followed it, and search for ways to function and continue with life and the pain and sadness that are part of it.

*Identifying Irrational Beliefs*

It was hypothesized that the main irrational beliefs dominant in Suzie's narrative are: "I must pull myself together"; "I must return to routine and must not cry". "I must find the answer to why did it happen to me". Suzie's irrational beliefs were self-directed and included self-devaluation resulting in emotional consequences of anger, depressive mood, and difficulties in functioning.

*A Dialogue with Repetitive Thoughts*

The flooding effect following a loss event, especially sudden unexpected loss under traumatic circumstances is frequently expressed in as repetitive manner, often times in the form of questions such as "why" or "how" could it happen to me. Repetitive questions also known as rumination are defined as "...engaging in thoughts and behaviors that maintain one's focus on one's negative emotions and on the possible causes and consequences of those emotions" (Nolen-Hoeksema, 2002, p. 546). Paradoxically, the bereaved is engaged in a search for an answer but the repetitiveness forms a continuous cognitive loop that blocks the solution and increases the distress. In CBT-REBT terms, the bereaved person's thinking is irrational: "I must find the answer", "I must function, and I must not cry", a

cognitive demandingness that increases emotional and behavioral distress (Malkinson, 2007).

To help Suzie experience a healthier grief process in addition to thought stopping and distraction, a dialogue with repetitive thoughts was applied. Creating a dialogue with "why" question is a way of increasing cognitive control over an inner sense of not having one. If distraction and thought stopping aim at distancing oneself, at least momentarily from the disturbing emotion, a dialogue with a repetitive "irrational" thoughts involves attending to, confronting the thought, experiencing its emotional and physical consequences, and searching for a more "rational" reply.

### *Applying a Dialogue with the Repetitive Thought*

Following normalizing the sense of flooding of the question "why", the therapist distinguishes between the loss as an external uncontrollable event and its internal way of cognitive processing as a way to increase the feeling of control. This is followed by an explanation about the idea of the dialogue in which there is an answer to each question that pops in the head: This, the question "why" is not left unanswered but instead is being answered. The question- answer form increases a sense of inner control and as a consequence minimizes its flooding effect. In Suzie's case it was a way of introducing an alternative way of thinking about her anger at herself for not being able to overcome her crying.

Here is an excerpt of applying this intervention with Suzie:

*Suzie:* I can't stop thinking why, why did he die? How could he have left me? Why, why did it happen to me? Why did my best friend and my lover die?

*Therapist:* This is a justified question but you also say: "I must have an answer" and that bring additional questions. What could you possibly tell yourself as an answer?

*Suzie:* That's the problem that the question keeps popping over and over again.

*Therapist:* Let's think of an answer because without an answer the question as you described it will keep popping.

*Suzie:* I have no answer to that question. I can't think of an answer only of the question.

*Therapist* explains the nature of rumination in terms of a thought that repeats itself but can be identified and answered: In a way this is an answer, can you tell yourself when the question "why" pops again "I have no answer to that question"?

*Suzie* listens and pauses for a minute, takes a deep breath, and then says loudly: Why, why? And she answers: "I have no answer to that question".

She adds: Rationally, I know that it is irrational. "I realize that I need not insist on finding an answer".

*Therapist* encourages Suzie on her effort and comments on the deep breath she took: Did you notice what you did? You took a deep breath, that's good. And, you are right in realizing that as of now there is no point in insisting (I must have an answer) on finding an answer. How do you feel now with the answer of "I don't have an answer and I need not insist on finding one?" Do you feel more, less or the same level of flooding?

*Suzie*: Less.

*Therapist*: Good, that helps you take a better care of yourself in moments of great pain and sadness. Paradoxically, not answering the question increases your sense of helplessness. So, I suggest you practice and apply it when you feel distressed as well as in between these feeling so you master it.

In the next session Suzie told the following: "I cried and couldn't stop thinking that he left me never to return. My life is worthless and I couldn't stop thinking "why?" And then I remembered what you told me and said to myself that a "why" question need to be answered, and I don't have to insist on finding an answer. It helped because then I could think about other things. It helped to feel less overwhelmed. In a sort of a way it eased the pain which was mixed with yearning for my husband. The yearning was most intense and at times unbearable".

Therapist's comment referred to both efforts to apply the dialogue and the experience of pain and yearning: "So you felt more in control over your questions and that's good, but you experienced intense yearning for your husband, what did you tell yourself over feeling the yearning? If you could choose between the two (yearning mixed with pain or feeling flooded over "why" questions), what would your choice be?"

*Suzie*: I was asking myself the same question. I don't know whether I am strong enough to withstand the pain of yearning.

*Therapist*: This is how you feel as of now. Would like to explore it?

Gaining control over "why" question was made possible by giving up the "must", the insistence of finding an answer. However at this point in therapy it was perceived by Suzie as partial and specific, and not yet generalized. Therapy will proceed by further exploring the meaning of inner control and the issue of the choice one has over feelings of pain (a secondary symptom) that comes along with the yearning and searching for ways to deal with the pain involved in thinking about her husband. Suzie was asked to continue practicing in between sessions the dialogue with "why" question, identify irrational beliefs and change them into rational ones. She was also instructed to be attentive to her breathing as a way of reducing physical tension.

*Planning a Visit to the Husband's Grave*

Since the death of her husband Suzie avoided visiting his grave and as the first anniversary was approaching it is part of Jewish tradition to visit the grave and put a gravestone and pray for the soul of the dead. In therapy Suzie talked about her fears as the day was approaching, a common reaction among bereaved persons. Visiting the cemetery and the grave are signs of the finality of the loss. The cognition "if I go there then he is really dead and I don't want to think of him in this way" and the behavioral consequence is avoidance. Again, normalizing and legitimizing her fears on the hand and exploring her thoughts and emotional and behavioral consequences on the other were ways to assist Suzie overcome her avoidance.

*Suzie:* If I go to visit his grave then I really believe he is dead and I am not ready yet to tell it to myself. Rationally, I know he is dead but emotionally I don't believe in it.

*Therapist:* What you are saying is important and in an irrational way "protects" you from telling yourself something. Let's distinguish between a thought and an emotion: When you tell yourself: "rationally I know he is dead but emotionally I don't believe it", this is not an emotion, this is also thought. And when you say "I am not yet ready to tell myself he is dead" (a belief) what do you feel (an emotional consequence)?

*Suzie:* It's too painful to tell myself that he is dead.

*Therapist:* Yes, it is painful. So maybe you are telling yourself that it will be too painful and you will not be able to stand it?

*Suzie,* tears in her eyes, quiet for a moment answers: Yes, I will not be able to stand its awful, I don't even want to think about it.

Therapist explains the difference between the pain which is a normative emotional consequence in a healthy grief and the evaluation (meta-cognition) that it is too painful and awful which increases the distress (Malkinson, 2007).

Explaining Rational Emotive Imagery (REI) and applying it, Suzie imagined herself going to the cemetery and visiting her husband's grave. She was instructed to focus on her emotions (fear), and measure it on the SUDS (9), and at her own pace, do something to reduce its intensity. Suzie's face looked much tensed at first and gradually she looked less distressed and said she reduced the intensity of the pain to 7.

*Therapist:* What did you do?

*Suzie:* I told myself that it's painful, and pain is part of my life nowadays.

*Therapist:* That's a good way of self-talk. What is the difference between pain intensity of 9 and 7?

*Suzie:* There is a sense of a little relief.

*Therapist:* That is the idea, to be aware of the pain but to relieve its intensity.

The idea is to assist Suzie change her evaluation about the pain that cannot be avoided but can be accepted.

Suzie's homework assignment was to practice REI daily which she did and as the day of the first anniversary approached she was able to experience the pain and overcome its avoidance.

Therapy terminated a number of sessions after the first anniversary of the death and at follow up three months later Suzie summed up her experience during therapy: "This was very hard, I was very skeptic that anything can help me after my life shattered. I miss my husband a lot and feel very sad when I think that he will not be with us to see the children that he loved so much are growing but we talk about him and laugh when we remember his playfulness. It will always be sad."

### **Concluding Remarks**

CBT-REBT following the death of a relative emphasizes the ability of people to choose their thoughts even when they have no control over the traumatic event. The purpose of grief is to mould the network of bonds with the representation of the deceased with the result that the pain, and the pining are woven into the fabric of life, and the memories are a force for continuing bonds with him or her. In this paper we have addressed complications of grief which from the perspective of CBT-REBT denotes difficulties in changes in the beliefs and their adaptation to a reality that excludes the deceased, as this difficulty points to the preservation of irrational beliefs and aggravates the development of complications such as depression, anxiety, guilt and unhealthy anger. Therapeutic intervention is directed at facilitating the adaptive process to grief including changes in irrational-rational thought: the feeling "I can't bear the pain" to one of "it's painful to think of life without him, but I know that to remember is to feel pain". Moreover, expected "positive" bereavement outcomes are not necessarily detachment from the deceased but weaving the loss event into the continuing life.

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