Traumatic Grief Treatment: Case Histories of 4 Patients

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Background: Traumatic grief treatment is a newly developed intervention for a debilitating bereavement-related condition. Traumatic grief treatment uses imaginal and in vivo exposure techniques to target emotional distress and behavioral avoidance hypothesized to be core features of the syndrome, along with interpersonal psychotherapy techniques to engage patients and maintain rapport. The present report describes 4 case histories of patients treated in this way.

Method: Each patient met our criterion for traumatic grief, defined as a score of at least 25 on the Inventory of Complicated Grief. Additionally, all 4 patients met DSM-IV criteria for a current episode of major depression and 1 patient for bipolar II disorder. The treatment course followed a direct replication design and ranged from 14 to 18 weekly 60- to 90-minute sessions.

Results: These 4 cases illustrate reduction in distress during exposure to painful emotional memories and avoided situations that was associated with decreased scores on measures of traumatic grief, depression, and anxiety and increased participation in and enjoyment of daily-life activities.

Conclusion: Case histories of traumatic grief treatment suggest it is a promising treatment for individuals suffering from traumatic grief. It appears that imaginal reliving and in vivo exposure are effective in reducing grief intensity and lead to reduction in symptoms.

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Grief is a universal reaction to the loss of a close relationship. Most individuals who suffer such a loss experience gradual relief from painful grief-related emotions over time and reengage in activities and relationships.[1] For a significant minority, however, such a sense of loss can be traumatic and debilitating, persisting for many months or years following the death.[2–4] Prigerson et al. and others have recently proposed that traumatic grief is a distinct syndrome.[4–9] Individuals with traumatic grief appear to be experiencing a prolonged grief reaction, with symptoms similar to those typically experienced following a sudden unexpected death.[10] However, this syndrome is more prolonged and can occur even after a death that is expected. Individuals with traumatic grief often report that they experienced numbness and/or disbelief at the time of the death, followed by persistent longing, searching, and yearning for the deceased. Distressing thoughts or images related to the death are common, as are self-blaming thoughts. Life loses its purpose and joy. To avoid distressing emotions, individuals with traumatic grief may refrain from talking or thinking about the death or shun activities, places, or people that remind them of the loss of their loved one. Such avoidance may interfere with grief resolution and constrain social and occupational functioning.

Although traumatic grief shares some features with major depression and posttraumatic stress disorder (PTSD), Prigerson and colleagues[4,7] have shown that traumatic grief is distinct from bereavement-related depression and anxiety. Only 52% of our patients with traumatic grief met criteria for a DSM-IV mood disorder, and only 30% met criteria for PTSD.[11] In addition, prior work[12] has suggested that depression-focused treatments do not ameliorate this condition. Given the similarity of some symptoms of traumatic grief to those of PTSD, Shear and colleagues (M.K.S.; E.F.; U. Feske, Ph.D., unpublished manual, 1998–1999) developed a treatment utilizing behavioral exposure procedures successfully employed with PTSD patients.[13] Results of a pilot study with 21 patients showed a large effect size for symptom changes (M.K.S.; E.F.; E. Foa, Ph.D.; et al., manuscript submitted), and a randomized controlled study of this treatment is currently underway. The current article provides case histories of 4 patients treated in the pilot study. In the absence of any known efficacious treatment for this condition, we present these cases to provide clinicians and researchers with in-

formation about the treatment procedures and course of this promising new approach. We make no claims for efficacy at this point, since there are no controlled data to permit this.

METHOD

Recruitment and Assessment

Each of the 4 patients presented in this series was in ongoing psychotherapy and was referred by clinicians because of grief symptoms persisting for 18 months to 2 years following the death of a family member. All patients were medication free throughout the protocol. Each patient met our criterion for traumatic grief, defined as a score of at least 25 on the Inventory of Complicated Grief (ICG).[6] In addition, prior to beginning the traumatic grief treatment protocol, the patients were administered the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID)[14] to assess for co-occurring Axis I disorders. All 4 patients described in the present series met DSM-IV criteria for a current episode of major depression. One (Ms. D) met criteria for bipolar II disorder. All patients provided written informed consent after the treatment procedures were fully explained.

Treatment Procedure

The patients described below participated in at least 14 weekly 60- to 90-minute sessions of traumatic grief treatment. The first author (K.L.H.) treated case 2 and the fourth author (R.A.S.) treated cases 1, 3, and 4. Both therapists are doctoral-level psychologists trained in traumatic grief treatment methods. Both participated in weekly supervision meetings with the treatment developers. The treatment followed procedures outlined in a manual that provided the treatment rationale and session-by-session instructions (M.K.S.; E.F.; U. Feske, Ph.D., unpublished manual, 1998–1999). The first 3 or 4 sessions focused on interpersonal history taking and rapport building, obtaining a history of the death, and gathering information about the patient's relationship with the deceased. The therapist described treatment procedures and rationale and began the process of creating an in vivo exposure hierarchy. Imaginal exposure and in vivo exposure assignments typically began in session 4 or 5 and continued until the end of treatment. The final 1 or 2 sessions were devoted to a discussion of treatment termination.

During imaginal exposure (now called "revisiting"), patients were instructed to tell the story of their loved one's death with as much detail and emotional engagement as possible as if it were happening in the present. During this procedure, the therapist provided encouragement and periodically asked the patient to report his or her subjective distress level (Subjective Units of Distress Scale [SUDS][15]). As described by Foa and Jaycox,[13] early exposure sessions included the entire story. Later sessions focused on "hot spots," or parts of the story associated with the highest SUDS levels. Imaginal exposures were audiotaped, and patients were instructed to listen to the exposure tapes daily as homework.

In vivo exposures were planned after a hierarchy of activities currently avoided or endured with pain was developed, with each activity ranked in order from least to most distressing. The particular situations varied from patient to patient. At each session, the therapist and patient agreed on at least 1 exposure that the patient would practice as often as possible during the ensuing week. Patients moved up the hierarchy, facing increasingly difficult situations following each session.

Measures

Traumatic grief symptom change was assessed at each session using the ICG.[6] The 19 ICG items were empirically derived, and the measure has excellent reliability.[6] In addition, since symptoms of depression and anxiety are important to the clinical picture of most individuals with traumatic grief, the 21-item Beck Depression Inventory (BDI)[16] and the Beck Anxiety Inventory (BAI)[17] were also administered. Both of these measures have excellent psychometric properties.[17,18]

Level of distress was assessed during imaginal and in vivo exposure using the SUDS,[15] a widely used scale ranging from 0 to 100, in which 0 represents no distress and 100 represents the highest amount of distress imaginable to the patient. During each in-session imaginal exposure, the therapist elicited SUDS scores at approximately 5-minute intervals. In addition, patients were asked to record their preexposure, peak, and postexposure SUDS levels when they listened to the imaginal exposure tape as homework and during in vivo exposure sessions. We believe that reductions in SUDS scores across exposure sessions facilitate needed emotional processing to reduce feelings of grief. Therefore, we hypothesized that reductions in subjective distress across in-session and homework exposure sessions would be reflected in improvements in traumatic grief, depression, and anxiety symptoms as assessed weekly by the ICG, BDI, and BAI. In the case descriptions that follow, we provide peak levels of distress experienced during in-session and homework exposures.

CASE REPORTS

The case summaries that follow provide a description of each patient and her treatment course. All 4 patients read this manuscript and provided written informed consent for publication of the report. Consistent with the rationale for traumatic grief treatment, each experienced decreases in symptoms of traumatic grief, as assessed by the ICG. By posttreatment, 3 of the patients no longer met criteria for traumatic grief based on a cutoff score of 25

on the ICG; the ICG score for the fourth patient (Case 1) had decreased 33 points from pretreatment to posttreatment to a score of 27. Further, while traumatic grief was the primary problem in each of the 4 cases, we hypothesized that traumatic grief treatment would have effects on the associated symptoms of depression and anxiety. Consistent with this prediction, each of the 4 patients reported marked decreases in their BDI and BAI scores by the end of treatment. Symptom improvement occurred in parallel with reductions in subjective distress reported during imaginal exposure sessions. We highlight treatment events that appeared to be associated with the greatest reduction in distress and behavioral improvement.

Case 1

Ms. A, a 56-year-old widowed woman employed full-time as a laboratory technician, lost her husband to lung cancer 2 years prior to beginning traumatic grief treatment. Her husband's condition had deteriorated markedly in the 3 months prior to his death, and, during this period, he underwent intense and debilitating radiation treatment. Ms. A felt very dependent upon her husband and relied on him for family decisions and financial matters. She could not imagine life without him and, therefore, refused to believe that his condition was deteriorating so markedly, continuing to think right up until his death that he had several months left to live. As a result, his death came as a great shock to her. She felt anger toward his doctors for not doing more to save him, and she was angry with her husband for "abandoning" her. She also felt guilty for being angry and for not being at her husband's bedside at the moment of his death. To avoid experiencing these difficult emotions, Ms. A tried to avoid thinking about the death.

These different painful emotions emerged strongly during Ms. A's imaginal exposures, as she told the story of her husband's death. The main incidents in this story included the discouraging discovery that his tumor had grown, the decision to try a radical treatment procedure, learning that there was nothing more the doctors could do for him, efforts to make him comfortable at home, and his progressive weakening, death, and funeral. Ms. A's peak distress was consistently maximal (SUDS levels at 100) during each of the early imaginal exposures, and this level of distress persisted even while listening to the taped story during the week at home. She expressed her emotions very strongly, often sobbing almost uncontrollably, and she reported that the scenes were extremely vivid in her mind. Correspondingly, Ms. A experienced no change in her symptoms of traumatic grief, depression, or anxiety across these first 3 exposure sessions, with ICG scores consistent at 59 or 60, and BDI and BAI scores in the high 20s and mid-30s, respectively.

Progress in imaginal exposure began in a subsequent session when she expressed regret and frustration that she had not had enough time to say good-bye to her husband at the funeral. Her therapist suggested that she repeat this experience imaginally, taking as long as she needed. Ms. A imagined opening the casket and telling her husband she loved him. She also apologized to him for not being at his bedside when he died. This exercise produced much relief, as she now reported that she believed her husband could forgive her, and she could finally forgive herself.

Following this exercise, a pattern of habituation to the story of the death was observed. In-session imaginal exposures produced slightly lower distress levels, with SUDS levels of 80 to 90, while peak homework SUDS levels declined to 40 to 50. Ms. A experienced less anger during these imaginal exposures and no longer mentioned her feelings of abandonment or worries about coping without her husband. She confirmed that telling the story and listening to the tape were getting easier as the sessions progressed, and she no longer felt the urge to cry. Across these sessions, Ms. A's symptoms of traumatic grief and depression improved slightly, and by session 8 her ICG and BDI scores had decreased to 53 and 20, respectively. Her symptoms of anxiety showed more improvement over this period, with BAI scores dropping to 8.

As imaginal exposure sessions turned to specific "hot spots," Ms. A described her husband in his bed at home during his final days. This was a particularly distressing scene for Ms. A given her husband's marked physical deterioration to the point at which she barely recognized him. During one session, after several minutes in which Ms. A described this scene in detail, his image started to fade in her mind, markedly increasing Ms. A's distress. Her therapist suggested that she imagine herself leaving the bedroom and standing outside in the hallway until she was ready to return. Ms. A followed this instruction, repeatedly returning and leaving the bedroom. Each time she returned to the image of her husband in bed, the image would fade. Gradually, she reported that the scene was transforming from her husband's sick room to her present bedroom. As this occurred, her husband's presence gradually faded until she could see only his hand on the covers. Then, after squeezing his hand and saying good-bye, even this image faded.

Ms. A believed that this exposure symbolized the final letting go of her painful memories of her husband's death. She felt at peace and now expressed that his death was simply part of the "passage of life." By the end of this exposure, her peak distress level was 70 and declined even further to 30 over the course of several homework exposures. At this point (session 12), Ms. A's ICG score had decreased substantially to 30. In addition, her symptoms of depression and anxiety were very much improved, with BDI and BAI scores of 10 and 4, respectively. Her symptoms remitted even further by the end of 18 sessions of traumatic grief treatment.

While Ms. A was achieving significant emotional gains through her imaginal exposures, she was also making progress on her in vivo exposure hierarchy. At the outset of treatment, Ms. A avoided certain rooms in her house, and she could not bring herself to organize her husband's papers, clothes, and other effects. When her husband was alive, his space in the home had been clearly defined, and she knew not to invade it. Indeed, since his death she had not entered the master bathroom or dressed in the master bedroom, because these rooms had been his. She had also not touched any of her husband's effects. Ms. A believed that she would never be able to confront these tasks because of her grief and also because of her belief that interfering with his space and belongings in this way was "wrong."

During her first exposure practice, Ms. A sat near her husband's desk and looked at his papers. This exercise was associated with a peak distress level of 90, which declined to 70 over 4 practice days. Next, Ms. A sat at her husband's desk, and her peak SUDS level increased to 100, again decreasing to 50 with practice. She now began to organize the contents of his desk, and again her distress level increased to 100. Once again, repeated exposures led to marked reduction in distress, and over the next several weeks, she succeeded in throwing out many of his papers and organizing his closets, bathroom, and the garage. By the end of this exposure, her peak SUDS levels had decreased consistently to 50.

For Ms. A, it seemed clear that in vivo exposures became easier each time she made noticeable gains in her imaginal exposures. This correspondence fits with our treatment model. Namely, reduction in the emotional intensity related to the death through imaginal exposure sessions facilitated functional and behavioral improvements through in vivo exposures. Also consistent, these gains were associated with corresponding reductions in her symptoms of traumatic grief, depression, and anxiety. Furthermore, she made a number of significant changes in her life. For example, she joined a community organization that provided her with new social relationships and a variety of activities. She started exercising, and she invited friends to her home. Ms. A reported that treatment helped her to feel more comfortable with memories of her husband, as she put the preoccupation with his death behind her and moved on with her life.

Case 2

Ms. B, a 68-year-old married retired woman, lost her 33-year-old son to a car accident 2 years prior to beginning the traumatic grief treatment protocol. Ms. B's son and the driver of the car had been drinking. The driver was killed instantly, and her son was airlifted to the hospital. Ms. B and her husband spent half a day with their son, who was on a ventilator, before he was pronounced brain-dead. They were approached about organ donation and decided to donate his organs and tissues. He has helped over 200 people with this gift, which has helped Ms. B and her husband tremendously in coping with their loss. They have met one of the recipients who received his left kidney, pancreas, and bone marrow. This man is no longer a diabetic and no longer needs dialysis.

Ms. B exhibited marked improvement in her subjective distress and traumatic grief symptoms following 3 imaginal exposure sessions in which she related the story of her son's death and funeral. She reached a peak SUDS level of 80 during the first in-session exposure, as she imagined the scenes vividly and expressed her distress openly and intensely. A "hot spot" for Ms. B involved seeing her son on the respirator in the hospital. She had the thought that he looked young and strong, and as though he was only sleeping. She squeezed his hand and was sure that he squeezed back. While she thought this belief comforted her at the time, on reliving it, her sadness at losing her son intensified. Ms. B's son had recently suffered a relapse after spending some time in an inpatient alcohol rehabilitation facility, and Ms. B felt guilt and sadness for not acting more forcefully to get him back into treatment.

Because of a malfunctioning tape recorder, Ms. B was not able to practice listening to the exposure tape following the first exposure session. Nevertheless, during the second in-session exposure, while relating the same story, her peak SUDS level was only 50. Over the course of 7 days of listening to the tape following the second session, this gain continued, and her peak SUDS levels declined to 5. By the third in-session exposure, her peak SUDS level was only 10, and during ensuing homework sessions declined to 0. She stated that, while she still felt sad thinking about squeezing her son's hand in the hospital, the intensity of the sadness was much diminished. She now took comfort in these memories, knowing that she was able to connect with her son and show her love for him this last time. She said that repeatedly telling the story of his death had helped her to realize that he lived a dangerous life and that he was an independent adult who made his own life decisions. She also felt comfort in knowing that they had been able to donate his organs to help others, as this gave his death meaning. Ms. B evidenced a dramatic decrease in her self-reported symptoms of traumatic grief, depression, and anxiety. The steepest declines occurred over the same period as her marked declines in SUDS levels (sessions 4–8). Her ICG scores dropped 14 points, her BDI scores dropped from 18 to 2, and her BAI scores dropped to 0. She ended treatment with an ICG of 2.

The emotional gains made by Ms. B through the imaginal exposures were paralleled by functional improvements, though her initial pattern of behaviors was somewhat different from the avoidance described by the other patients in this series. Instead of avoiding activities that reminded her of her son, Ms. B was preoccupied with thoughts of him and spent much of her time engaged in

activities that evoked her son's memory. She seemed to be intent on holding onto him, at the cost of reconnecting with her own life. For example, she kept a scrapbook of her son's life and clippings related to his death, which she revised daily. She spent time every day making crafts out of his belongings; for example, she made a flowerpot from his motorcycle helmet. She stated that these activities enabled her to feel close to her son and to keep his memory alive. However, they were so extensive as to prevent her participation in other activities. In particular, she did not socialize with friends, and she neglected essential housework.

In addition to this preoccupation with activities that reminded her of her son, she avoided situations and activities that were reminders of his death. Ms. B's in vivo exposure focused on such avoidance and included looking at sympathy cards, visiting the hospital where her son had been taken, and visiting his gravesite. Although she anticipated that these activities would elicit high SUDS levels (i.e., 60–90), Ms. B's distress was very low when she actually carried them out. For example, her SUDS levels declined from 20 to 0 over 9 sessions of reading sympathy cards. She began these activities after she had already made substantial gains in her imaginal exposures. In parallel with the improvement in emotional distress and avoidance, there was also a marked decrease in the time she spent going through her son's belongings and working on the scrapbook. Ms. B stopped these activities without prompting by her therapist because she reported that she no longer felt the need or desire to do them. She now began to spend more time on home projects and calling friends and family. Most striking in the treatment of this patient was the rapidity of response. At her final session, Ms. B reported that traumatic grief treatment had allowed her to work through her grief and begin to enjoy her life again.

Case 3

Ms. C, a 67-year-old retired woman, lost her husband to heart failure 2 years prior to beginning traumatic grief treatment. Two days before her husband died, he had been feeling poorly, so Ms. C took him to the emergency room where he was diagnosed with a virus and sent home. He felt increasingly ill over the next 24 hours, but refused to return to the hospital. The next morning he was having trouble breathing, and when Ms. C touched him to help him turn over, he abruptly stopped breathing. She attempted cardiopulmonary resuscitation (CPR), but this was unsuccessful. He was pronounced dead by the paramedics.

Caring for her husband and family had been the focus of Ms. C's life. She feared she would be incapable of living on her own and believed that his death meant that her life no longer had meaning. Before her husband's death, Ms. C had been very active socially. However, she had since lost touch with most of her friends, and had stopped her part-time job and volunteer activities. In addition to sadness at losing her husband, she also reported anger with him for "abandoning" her, for not paying more attention to his health, and for not spending very much time with the family while he was alive because of his demanding occupation as a minister. However, Ms. C firmly believed that she should not express strong emotions, so she tried not to think about her husband's death. She also avoided the church where her husband had ministered. She feared that she would cry in front of others and embarrass herself. She suffered from debilitating stress-related gastrointestinal problems.

Ms. C's imaginal exposure included telling the story of her husband's death from the first emergency room visit, describing his respiratory arrest and her failed attempts at CPR, and recalling her experience at the funeral. Her strong feeling that she should not express emotion publicly emerged during the exposure sessions. She reported that she had "blanked out" in the days following his death and was "hardly there" during the funeral. She said that she barely heard or saw anything of the service because all of her energies were devoted to keeping herself together emotionally. Although she sobbed uncontrollably when alone, she would not allow herself to show emotion in public. She thought she should protect other people from her strong emotions: "I don't want people to be sadder than they already are." Ms. C also worried that, if she allowed herself to feel her emotions, she would lose control and make a scene, "shrieking, sobbing, wailing, and fainting," and that this would cause great embarrassment.

Ms. C experienced visibly intense emotion in her therapy sessions. She cried freely during imaginal exposures and reported consistently high peak levels of distress. This experience helped Ms. C to see that she could express strong emotion without losing control. A "hot spot" identified during Ms. C's initial imaginal exposures involved the moment when her husband abruptly stopped breathing and she attempted CPR. In the reliving exercise, she realized that she had interpreted her husband's death as his "ultimate rejection" of her. She recalled anger toward her husband for his rejecting behavior throughout their marriage. Often he had rebuffed her attempts to help him, and his failure to respond to CPR felt like another devastating example of this. At the same time, she felt guilty for her anger, since he had been a noble man who ministered compassionately to many people. Furthermore, she worried that she had not performed CPR correctly and, perhaps instead of helping him, she may have been inadvertently responsible for his death.

Repeatedly reviewing this episode over several imaginal exposure sessions led to a marked reduction in distress and to a revision of the ideas that were associated with guilt and anger. Her peak in-session SUDS levels fell from 100 to 80, and during subsequent homework, her

peak SUDS levels fell further to 50. Feelings of guilt and anger also lessened in intensity and frequency. Ms. C experienced a decrease in her symptoms of traumatic grief, depression, and anxiety over the course of treatment. Her greatest gains on all measures occurred between sessions 8 and 12, corresponding to the largest reduction in peak exposure SUDS levels. In particular, during this period her ICG scores fell from 20 to 9, her BDI scores fell from 14 to 5, and her BAI scores fell from 10 to 3.

Listening to the tape of the funeral service was assigned as in vivo exposure homework and initially evoked intense distress, with peak SUDS levels of 80 to 95 during the first 5 practices. Ms. C again told the therapist of feeling anger toward her husband, who seemed to be so available and loved by his congregation, while she felt she could not reach him. She also reported frustration that she had not expressed her feelings more openly throughout their marriage. Following this discussion, exposures to the tape elicited gradually lower SUDS levels, which dropped over 5 more weeks to a level of 40. This improvement occurred in parallel with the reduction in peak SUDS levels during imaginal exposure. As Ms. C's grief diminished she could more easily remember the good times she and her husband had spent together. She began to enjoy seeing friends again and to reengage in a number of activities. Also of interest, her gastrointestinal problems diminished, and she associated this improvement with the process of fully expressing her difficult emotions in the exposure sessions.

Case 4

Ms. D, a 60-year-old single woman employed full-time as a clerk, lost her 55-year-old brother to sudden death 18 months prior to referral to our program. Although her brother was married and lived in another state, his business brought him to town frequently, and he stayed with his sister. The siblings were very close since Ms. D had raised her brother after the death of their mother when Ms. D was a teenager. Ms. D and her brother enjoyed a warm and playful relationship and had many pleasurable times together.

Ms. D and her brother returned to Ms. D's home from a pleasant dinner at a favorite restaurant. He went into the bathroom and remained there somewhat longer than usual, but then joined her to watch television. A few minutes later, he experienced a cardiorespiratory arrest. Ms. D immediately called the emergency operator who instructed her in CPR, which she attempted unsuccessfully. The paramedics arrived and also failed to revive him, and he was pronounced dead soon after arriving at the hospital. Following the death, Ms. D felt intensely guilty because she thought she had not done enough to save him, and she was angry with the paramedics and doctors who did not perform a "miracle" to bring her brother back. She became depressed, had a recurrence of eating disorder symptoms, and entered treatment with another therapist. She was referred by this therapist to the present protocol when her grief symptoms seemed refractory to treatment.

Ms. D began imaginal reliving at the time of returning home from dinner and proceeded through arrival at the hospital where her brother was pronounced dead. The first 3 sessions were associated with maximal peak SUDS levels of 100, and Ms. D described "numbing out" in order to avoid feeling distress. Perhaps because of this numbing, little progress was made in the initial imaginal exposure sessions. A "hot spot" for Ms. D involved the moments following her brother's death when she looked into his face, saw his startled eyes, and then had to move his body to the floor to attempt CPR. She stated that she could still feel his "wet, dead" skin on hers and could not look at pictures of him since all she could see was his dead face.

An important turning point in Ms. D's treatment came during her 10th treatment session. Because of Ms. D's continued difficulty habituating in the exposures, the therapist asked her to bring in a picture of her brother and conducted an exposure exercise focused on this picture. Ms. D initially saw her brother's face at the time he died, and this was associated with a SUDS level of 100. As she proceeded once again to relate the story of the death, her thoughts began to change. She had the new idea that she was glad to have been there when he died and to have tried to help him. She imagined him telling her that he needed her. As she had these thoughts, the picture seemed to brighten and her brother's real face emerged. She said that she could now see his soul in his eyes thanking her for taking care of him and telling her that there was nowhere he would rather have died. The picture continued to brighten, and her SUDS level declined to 30 by the end of the session. Her peak distress levels during practice viewing this picture at home declined markedly to 30. At this point, she told the therapist that she realized it was time to let go of thinking that things could have gone differently, to "let go of the hurt," and to see her brother's death as a peaceful one. Ms. D's most dramatic symptomatic improvements also occurred during this period. Between sessions 8 and 12, her ICG scores fell to 7, her BDI scores fell to 1, and her BAI scores fell to 0. She ended treatment with an ICG score of 3.

Before treatment, Ms. D avoided many places that she and her brother had frequented together, including several restaurants and stores. Following the exposure session with the picture of her brother, Ms. D evidenced habituation both within and between activities during in vivo exposures to these places. For example, going to a favorite restaurant initially elicited a peak distress level of 85, which declined to 30 over the course of several additional visits. Her exposure to a second restaurant elicited an initial peak SUDS level of 70, which declined to 30 over 6 visits, and to a third restaurant a peak SUDS level of 50, which declined to 20 over 5 visits.

Ms. D also completed in vivo exposures to the emergency room where her brother had been taken the night of his death. On her first 4 visits to the emergency room, standing outside was associated with peak SUDS levels of 70. She visited the emergency room an additional 6 times the following week, and was able to enter the waiting room, but still reported peak SUDS levels up to 70. After 3 weeks of practice, her peak SUDS levels decreased to 30. She reported that she felt good sitting in the emergency room knowing that she had made the right decision in bringing him. She also saw a demonstration of CPR and realized that she had done CPR correctly.

By the end of treatment, Ms. D was more accepting of her brother's death and expressed comfort that she had been there to see him through the death. She could now feel happy when reminded of the times they had spent together. She had also begun to engage in social and recreational activities.

DISCUSSION

This report summarizes case histories of 4 patients who received a newly developed treatment for a condition called traumatic grief. These patients participated in an initial uncontrolled pilot study, designed as an early phase of a treatment development project. The treatment resulted in reduced emotional intensity associated with imaginal reliving of the death, increased accessibility of positive memories of the deceased, and more freedom to engage in satisfying daily activities. Although at this phase of the research efficacy cannot be confirmed, we believe these cases support the likelihood that this treatment is efficacious. The long-term baseline of symptoms and the participation of these patients in other treatments prior to traumatic grief treatment support the proposition that traumatic grief treatment was active in reducing grief symptoms.

We hypothesize a mechanism of action similar to that of the exposure treatment designed by Foa and Jaycox[13] for treatment of PTSD. For traumatic grief treatment, we postulate that the reliving of the experience of the death activates pathologic emotional structures that are blocking the progression of grief. During imaginal exposure, misconceptions are identified and corrected (e.g., "I could have done something to prevent the death"), providing new information incompatible with the existing emotional structure. The result is reduction of the intensity of problematic emotions.[13] Repeated recounting of the events surrounding the death provides exposure to emotional cues in the story, permitting habituation of intense emotions and correction of the common misconception that, once activated, these painful emotions will never abate. These cases provide some support for the hypothetical mechanism of action in that reduction in ICG scores generally followed reduction in level of distress evoked in reliving the death.

Nevertheless, we draw attention to the fact there are some important differences between traumatic grief and PTSD and their respective treatment goals. Individuals with traumatic grief are less likely to experience hyperarousal symptoms, and the predominant affect in traumatic grief is sadness, rather than fear. Unlike the person suffering from PTSD, a bereaved person with traumatic grief is often strongly drawn to thoughts of their loved one, feeling a sense of longing and yearning. The goal of treatment for PTSD is to facilitate forgetting of the trauma, while for traumatic grief treatment the goal is to help the person remember the deceased in a more comforting way. Therefore, we have added a component of this treatment specifically focused on positive memories.

In addition to improvement in grief, reduction in symptoms of anxiety and depression occurred with traumatic grief treatment. Each patient reported here met DSM-IV criteria for major depression and reported BDI scores in the moderately to severely depressed range. By the end of treatment, patients' BDI scores had decreased by at least 10 points and ranged from 1 to 11. Similarly, by the end of treatment, patients' BAI scores were very low, ranging from 0 to 4. Therefore, not only was traumatic grief treatment effective in these patients at relieving targeted symptoms of traumatic grief, but these effects generalized to symptoms of depression and anxiety. By contrast, depression-specific treatments do not appear to significantly affect scores on measures of traumatic grief.[12,19,20]

Furthermore, the patients we treated met DSM-IV criteria for a variety of Axis I disorders, including bipolar II disorder.[1] Although the sample size for this pilot study is small, the type or number of disorders did not appear to make a difference in the effectiveness of traumatic grief treatment, attesting to the strength of the treatment. Overall, we consider these cases to be further support for the idea that traumatic grief is not a depressive syndrome. Instead, it is best conceptualized as a variant of normal grief in which the progression of grief is blocked. Imaginal reliving of the loved one's death provides a mechanism for removing the block. Both the goal and strategy of this treatment are different from those of psychotherapy for depression.

Traumatic grief treatment is the first treatment shown to be associated with reduction in symptoms of the target condition. Moreover, this is a time-limited and cost-effective treatment. In the present series of patients, each of whom had been suffering from debilitating symptoms of traumatic grief for up to 2 years prior to beginning the protocol, remission was achieved in 14 to 18 weekly 90-minute sessions. We acknowledge that the intense pain engendered by exposure is a disadvantage of this treatment. Evoking such pain is difficult for patients and therapists as well. So far, in a series of 35 patients, 3 have dropped out because of inability to tolerate exposure. Two were in treatment with a new therapist who was ambivalent about the treat-

ment. The husband of the third was strongly opposed to her participation. However, given that a recent meta-analysis found a strikingly low effect size (0.15) for supportive grief interventions and a significant minority worsened with these treatments,[21] the pain of our acute intervention may be justifiable. Nevertheless, we wish to emphasize that we consider it very important to fully explain to patients and their families the procedure and rationale behind exposure and to provide maximal support during this difficult procedure.

Traumatic grief is a recently identified condition of public health significance. We developed a treatment for this condition that is currently being testing in a randomized controlled trial. The illustrative case histories are provided to help inform clinicians and researchers about the work we are doing. Given our preliminary results, we are optimistic that the quality of life of these individuals can be improved.

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