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Interventions to Enhance Adaptation to Bereavement

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ABSTRACT

This paper reviews quantitative evaluations of the efficacy of intervention programs designed to reduce the pain and suffering associated with bereavement. After identifying the psychological and physical health impacts of bereavement and outlining the prevalence of detrimental outcomes, we conclude that a minority of bereaved persons experience severe and sometimes lasting consequences, whereas the majority manage to overcome their grief across the course of time. We detail criteria for establishing the efficacy of bereavement intervention and examine the impact of intervention according to these stringent criteria. We critically examine previous reviews and summarize their conclusions. Using a narrative review approach, we apply a public health framework to organize intervention programs into primary, secondary, and tertiary prevention strategies. A comprehensive, updated review of empirical studies in these categories leads to the following conclusions: Routine intervention for bereavement has not received support from quantitative evaluations of its effectiveness and is therefore not empirically based. Outreach strategies are not advised, and even provision of intervention for those who believe that they need it and who request it should be carefully evaluated. Intervention soon after bereavement may interfere with "natural" grieving processes. Intervention is more effective for those with more complicated forms of grief. Finally, a research agenda is outlined that includes the use of rigorous design and methodological principles in both intervention programs themselves and in studies evaluating their efficacy; systematic investigation of "risk factors"; and comparison of relative effectiveness of different intervention programs (i.e., what works for whom).

INTRODUCTION

DO PEOPLE WHO LOSE a significant person in their lives through death actually need help from counselors or therapists to adapt to their loss? Do such interventions really help bereaved individuals to adjust? Such questions have been the subject of considerable debate and a growing number of empirical investigations in recent years. The issues involved are critical. Today, psychological intervention is more often put to stringent empirical test for its efficacy, and the implementation of empirically supported treatments (ESTs) is becoming a more standard requirement.[1] Bereavement intervention programs need to be empirically assessed for their effectiveness and associated costs to bereaved individuals and to society.[2] It is also important to establish that intervention efforts are directed to those bereaved who need and benefit most from them. In this paper, we examine the ability of bereavement intervention programs to reduce symptoms of grief, to prevent or cure complicated grief, and to mitigate long-term negative consequences of bereavement. We use stringent criteria to review the empirical studies of the efficacy

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of intervention programs, and we draw conclusions about the helpfulness of bereavement interventions.

OCCURRENCE AND PREVALENCE OF MENTAL AND PHYSICAL HEALTH PROBLEMS

Bereavement (the situation of a person who has recently experienced the loss of someone significant—notably a parent, partner, sibling, or child—through that person's death) is well-recognized as a debilitating experience, one that causes a great deal of emotional pain. Nevertheless, before considering issues concerning intervention to enhance adaptation to bereavement, the health impact and prevalence of problems in bereavement need to be more precisely identified. There is, in fact, a substantial body of scientific research on the consequences of bereavement.[2,3] Bereavement can be viewed as a normal, natural human experience, one that is part of nearly everyone's life, even an essential element of the human condition. Studies have shown that most individuals manage to come to terms with their bereavements over the course of time, in many cases even emerging with "new strength" as time goes on and new challenges are mastered. However, it has also become evident that bereavement is associated with a period of intense suffering for the majority of individuals and with an increased risk of negative mental and physical health outcomes for some. Adjustment can take months or even years. Reactions are subject to substantial variation, both among individuals and across cultures. Furthermore, although most individuals eventually recover from their grief and its accompanying symptoms, for a substantial minority mental and physical ill health is extreme and persistent. Death of a loved one even increases the mortality risk for the survivor. This effect has been empirically well substantiated after partner loss and, more recently, among parents who have lost a child.[3,4]

How prevalent are psychological and physical health problems after bereavement? Prevalence rates for the various health detriments vary not only according to the particular debility in question but also across investigations of different bereaved samples.[5] Consistently, however, in a minority of cases the psychological reactions are so severe as to reach levels equivalent to the diagnostic criteria for mental disorder. A review of studies of pathological grief reported estimates from different studies ranging from 5% to 33% among acutely bereaved persons.[5] However, it is difficult to know precisely how to interpret such prevalence rates for pathological grief because criteria have not been established and the definition of pathological grief (also labeled traumatic or complicated grief) remains imprecise. At this point we need to be cautious in drawing conclusions about the incidence and prevalence of pathological grief.*

With respect to other bereavement-related disorders, although 50% of a spouse-bereaved sample in one study reached the criteria for diagnosis of post-traumatic stress disorder (PTSD) at one of four points of measurement (first 2 years of bereavement), only 9% met this level at all four points.[6] In another study, young persons who had experienced the violent loss of a significant person in their lives and who had no previous history of trauma had high rates for PTSD and acute stress disorder.[7] Of those participants, 22% met lifetime criteria for a trauma-related diagnosis combining acute stress and PTSD. With respect to affective disorders, 42% of widowed persons have been found to reach levels equal to or above the cut-off point for mild depression 4–6 months after loss, compared to 10% of married persons.[8] In this study, the depression rate declined to 27% after 2 years, still significantly

*Pathological grief is not (yet) a diagnostic category of mental disorder, and any agreed-on standard for diagnosis is so far still lacking (although scientists are currently working hard to validate classification procedures and come to better consensus.[32] This state of affairs is in contrast to the Post Traumatic Stress or Major Depressive Disorders categories that have established criteria and cut-off points in, for example, the Diagnostic and Statistical Manual of Mental Disorders.[33] Classification of pathological grief at present is frequently based on a somewhat arbitrary statistical cut-off point (e.g., the top 20% of scores on a complicated grief scale are classified as reflecting pathological grief). Another problem relates to the fact that there may be other forms of pathological grief than persistent, debilitating "chronic grief" that is closest to proposed DSM criteria.[3] Some researchers have described absent, inhibited, or delayed grief as pathological[34] categories that are also well-recognized by grief therapists whereas others deny the existence of such categories.[35] Jacobs and Prigerson[3] acknowledged that subtypes such as delayed or inhibited grief may not be identifiable in their proposed criteria. Following these arguments, we need validation of criteria and consensus on types of pathological grief before we can make firm statements about its prevalence.

higher than for married persons. According to Zisook and Shuchter,[9] major depressive syndromes have been found to occur in 24–30% of widowed persons 2 months after the death, approximately 25% at 4 months, and 16% at 1 year.

Research on physical ill health has consistently reported elevated rates among bereaved persons on measures of physical symptoms, doctor visits, use of medication, disability, and hospitalization.[3] For example, in one study, 20% of widowed (as compared to 3% of married) individuls scored above the cut-off point for severe physical symptoms 4–6 months after the loss. This rate declined to 12% after 2 years.[8] Mortality is a dramatic consequence in terms of risk; but in terms of actual numbers, very few bereaved individuals die as a result of their loss.[3]

In conclusion, we can infer from the various prevalence rates that there are marked differences among bereaved persons, not only with respect to the intensity of their grief reactions but also with respect to the types of complication and patterns of comorbidity that they may experience.[10] Even though the severe effects on mental and physical health outlined above appear to affect only a minority of bereaved persons, the prevalence rates are of sufficient magnitude to cause societal concern.

Intervention: definition and efficacy criteria

To answer the questions "Is intervention for the bereaved necessary?" and "Is intervention actually effective?" we must first define "intervention." The range of potentially available behavioral interventions in current western society includes crisis teams visiting family members within hours of a loss; self-help groups with the goal of fostering recognition and friendship; programs to educate bereaved individuals about working through grief; cognitive restructuring and behavioral skills programs; treatments involving the sharing of information, emotions, and support; brief group psychotherapy, as well as behavior therapy, hypnotherapy, and dynamic therapy.[11,12] It is useful here to confine the scope to consideration of organized or institutionalized counseling or therapy. Types of intervention for the bereaved vary from voluntary counseling for bereaved persons in so-called "self-help" aid to individual or family therapy programs designed to help when grief complications have arisen.[13,14] We focus here on help that is specifically aimed at bereaved persons (thereby excluding, for instance, palliative care, which is primarily intended for the dying) and that provides person-to-person support, either individually or in groups.

As we noted in our earlier review,[15] the basic principle underlying any provision of intervention is that it benefits the bereaved person in terms of mitigating the emotional and practical problems that have been experienced after the loss of a loved one. Researchers must establish that the psychological treatments for bereaved persons have been demonstrated to be efficacious in controlled research with a delineated population.[1] As a starting point, reviewers need to set up stringent criteria to structure the evaluation of treatments, following as closely as possible the empirically supported treatment criteria provided in the general psychological treatment literature.[1] Establishment of the efficacy of bereavement intervention needs to be based on the following:

1. Empirically tested intervention programs. Frequently, judgment is based on subjective assessments made by the bereaved persons themselves who report their satisfaction with the intervention program and its benefits in overcoming problems. Clearly, such reports are subject to biases. For example, dissatisfied dropouts are typically not counted; people may respond in a manner that is desirable, having committed themselves to continue in a program; and respondents may say nothing in terms of actual change.

2. Methodologically sound research designs. Major shortcomings in bereavement intervention efficacy studies still remain:

- Control groups. Many studies still lack a no-treatment-control group or placebo group comparison condition.[15†] Grief is a process that is expected to change over time, so if there is no non-intervention control group, it is impossible to attribute effects to the intervention itself. Furthermore, it is conceivable that the grief intervention may do harm rather than

†Alternative treatment groups provide a potential control group condition too,[1] but well-established interventions (i.e., those well-described and transferable, with treatment manual, tested, replicated and found effective, and accompanied by indications and counter-indications) are not available in the area of grief counseling).

good, an effect that also must be measured against a no-treatment control.
- Participant assignment procedures. Assignment to conditions should be random or by matched assignment. For example, a comparison of accepters versus decliners of the intervention is not a valid assessment of efficacy, because there are likely to be systematic differences between the groups.
- Consideration of nonresponse and attrition. Bereavement intervention studies typically have low acceptance and attendance rates.[15] Yet nonresponse and attrition can seriously influence results and affect generalizability. For example, participants may be more depressed than nonparticipants. Those who drop out may be less depressed, may have recovered, or may have benefited least.
- Reasonable levels of adherence. Absence from sessions or high dropout in control conditions can seriously bias evaluation of efficacy of an intervention program. Existing studies differ markedly in adherence, from hardly any absences to as little as 30% regular attendance.[15]

Adopting the strict criteria outlined above for efficacy studies necessitates excluding consideration of several kinds of counseling: for example, pastoral care, intervention by medical doctors, and support from funeral directors. This is not to deny the potential importance of these types of intervention. They have simply not, to our knowledge, been adequately put to the test.

Reviews of efficacy studies

There are many individual studies and a few reviews on the efficacy of intervention programs in helping the bereaved to adapt to their loss. Some reviews cover the whole range of bereavement interventions for a variety of bereavements, adopting either meta-analytic and/or narrative approaches.[15–18] Others are more limited with respect to the type of bereavement (Curtis and Newman[19] focused their review on benefits of intervention for children), type of intervention (Jacobs and Prigerson[7] focused specifically on psychotherapeutic treatment), or specific bereavement-related pathology (Zisook and Shuchter[9] focused on so-called depressions of bereavement). Additional authors have provided secondary reports of the primary reviews noted above.[2,16] There are other similarities and distinctions between the major reviews, both in selection criteria and in the conclusions drawn about efficacy. We summarize and evaluate these reviews next.

Comprehensive reviews. Kato and Mann[17] focused on the efficacy of group versus individual intervention, using selection criteria that required random assignment to treatment versus control groups, similar recruitment procedures for both groups, and post-bereavement initiation of intervention. These reviewers concluded that there were methodological flaws in most of the studies and that neither group nor individual intervention had been shown to be particularly effective. Litterer, Allumbaugh, and Hoyt[18] provided an in-depth review that also included meta-analysis but that did not impose stringent criteria for selecting studies. In contrast to the Kato and Mann[17] review, they concluded that intervention was helpful and, in particular, they argued for help soon after bereavement. The limited attention to methodology raises doubts about these conclusions. The overall quality of efficacy studies of grief intervention is frequently too poor to permit meta-analysis. There are huge differences between studies, making it extremely difficult to carry out detailed standardized comparison across studies. Furthermore, when meta-analysis is conducted, important information necessarily gets lost. For example Litterer, Allumbaugh, and Hoyt[18] excluded longer-term follow-up effects of intervention from investigation because too few of the studies included follow-up data. Yet this information is critical because the general aim of intervention is to achieve enduring effects. Litterer, Allumbaugh, and Hoyt[18] may have come to less positive conclusions about the efficacy of intervention had they included long-term assessment. In addition, these reviewers made no distinction between different types of bereavement intervention in assessing efficacy. An evaluation of which types of interventions help which groups of bereaved persons is critically needed.

We previously presented a narrative review[15] based on a public health framework, whereas other reviews have lacked theoretical structure. We based selection of the studies for review on the stringent criteria defined above. We also categorized studies into different types of intervention, following the well-established distinctions described by Caplan.[20] The review covered both short- and long-term effects of bereavement intervention. We concluded that intervention was differentially effective according to the degree of complication in the grieving process (as detailed

below). However, we presented this conclusion tentatively because we recognized that methodological shortcomings were a major obstacle to establishing efficacy.

Limited-scope reviews. Curtis and Newman[19] reviewed the efficacy of a range of community-based interventions for bereaved children, reporting limited empirical evidence and considerable methodological weaknesses in designs. They concluded that the case for universal inclusion of children in support programs remains unproved. Jacobs and Prigerson[6] reviewed evidence specifically for the treatment of their proposed new diagnostic entity of traumatic grief. Because no interventions had been designed for this diagnosis, the review covered existing psychotherapeutic treatments. The coverage and conclusions were similar to those in our 2001 review[15] Zisook and Shuchter[9] reviewed interventions specifically for bereavement-related major depressive disorders, noting that the onset, exacerbation, or persistence of this type of disorder are among the most frequently encountered complications of bereavement. Surprisingly, therefore, they found very few well-controlled studies of the treatment of bereavement-related depression. Although evidence suggests that intervention could prevent complications in high-risk populations, no studies were available to establish efficacy specifically for individuals with past personal histories of major depression.

Secondary reports. Jordan and Neimeyer[16,21] summarized some of the above qualitative (narrative) and quantitative (meta-analytic) reviews of the literature on the efficacy of individual and group interventions, primarily for adults, including a report of an unpublished meta-analytic review by Fortner and Neimeyer. Their conclusions were more in line with those of Kato and Mann[17] and our previous paper[15] than with Litterer, Allumbaugh, and Hoyt.[18] Evidence for the efficacy of grief intervention is quite weak. Most recently, Genevro[2] provided a concise overview, based largely on our previous review[15] and that of Jordan and Neimeyer,[16] and drawing conclusions consistent with those preceding reviewers.

Overview of empirical studies

For the current paper we updated our review of the literature to see whether problems with design and methodology and shortage of studies have been overcome. We follow the approach we used in our earlier review,[15] observing the stringent criteria outlined above in providing a critical assessment of the available studies of bereavement intervention programs. In this section, we first summarize our previous findings[15] and then extend this review to include studies that have appeared since that review and meet the identified criteria. As before, a qualitative rather than quantitative approach is followed. Examination of the studies revealed that there are still an insufficient number of methodologically comparable and rigorous studies to use meta-analytical techniques.

The efficacy of primary, secondary, and tertiary prevention. As in 2001,[15] we subdivided bereavement interventions into three types. (1) General or primary prevention interventions are open to all bereaved persons, to anyone who has experienced a loss through death. Sometimes these interventions are targeted toward specific subgroups of the bereaved (for example, bereaved parents or spouses). Primary prevention is directed toward those who are experiencing uncomplicated bereavement. (2) Secondary prevention interventions are designed for bereaved persons at high risk, that is, for those who are deemed for one reason or another to be likely to experience a complicated form of grief. Examples would be death through homicide or the concurrent loss of multiple family members under traumatic circumstances. (3) Tertiary prevention interventions are targeted toward persons who are experiencing complications in their grieving process. Treatment of bereaved persons with depressive disorders would fit in this category, as pre-existing pathology is present. Treatment involves implementing psychotherapeutic treatment techniques specifically aimed to alleviate complicated or pathological grief and associated disorders.

In our 2001 review,[15] 16 studies fell into the primary prevention category, although many were methodologically flawed. We concluded then that "primary preventive interventions receive hardly any empirical support for their effectiveness. The rare positive effects that are found often seem only temporary, and sometimes negative results of the intervention have been reported too." However, we also noted that primary prevention for bereaved children can be effective. Fewer (seven) studies fell into the secondary pre-

vention category, and results were somewhat mixed. Effects, if found, were rather modest, and there were some indications that improvement was only temporary. Screening for high risk seemed to increase efficacy. Finally, seven studies of the efficacy of tertiary prevention interventions were available. Most of these studies found positive and lasting results, although they too were often modest. In general, the quality of the tertiary prevention studies was higher than those in the other categories (e.g., pre–post control design). Importantly, in these latter studies, the provision of intervention was based on a request for—rather than an offer of—help.

Review update. A comprehensive search of the MEDLINE and PsycInfo databases identified 30 additional studies of intervention efficacy that have been published since our previous review.[15] Many are still methodologically unsound, a striking problem being the continued absence of control groups. Only seven of these newer studies met the design criteria and will be reviewed here.

Four of these fell within the primary category.[22,25] Generally better results were found in these studies than in the earlier ones.‡ These studies also contrasted with earlier ones in that all but one used inreaching procedures: that is, intervention was given to those who requested it themselves rather than being offered it on an outreaching basis. Thus, contrary to earlier studies, participants in these newer programs were self-selected. The outreaching procedure used in the earlier studies was regarded as a possible explanation for the lack of positive results or the presence of negative results.[15] The newer studies suggest that an inreaching primary prevention strategy leads to better results. The one outreaching study[22] found positive results only with the high-risk group. Another possible explanation for the better results of the more recent inreaching studies was that they provided intervention later in bereavement (after several months or years), which had also been suggested as a more effective procedure. Further studies are needed to determine the relative importance of the time and inreach and outreach factors in contributing to efficacy.

‡The efficacy of intervention in the Goodkin et al.[22] study is questionable. Significant pre- to post-intervention improvements were reported (sometimes for the control group too) but no significant interactions were reported, to indicate relatively better improvement for the intervention compared with the control group.

Only one additional secondary prevention study was found.[26] In this study of children bereaved by suicide, those in the intervention group showed more improvement in depressive symptoms than those in a community-care control group. The primary prevention studies of Sandler et al[24] and Murray et al[23] also addressed secondary prevention. These investigators found intervention to be more effective for high-risk children and adolescents who had higher distress at baseline. Thus, there is now more support for the efficacy of secondary prevention, at least for children and adolescents.

Finally, two recent tertiary prevention studies have been conducted.[27,28] Reynolds and colleagues[28] investigated the impact of medication and therapy (alone and in combination) on subjects with bereavement-related major depressive episodes (onset between 6 months pre-bereavement to 1 year post-bereavement). They found no significant effect with psychotherapy, whereas medication alone appeared to be helpful. Piper and colleagues[27] offered time-limited group psychotherapy to patients who had been bereaved on average 9 years earlier and who met criteria for complicated grief. This study is somewhat difficult to interpret because there was no nonintervention control. It was further limited by the fact that assessment was "soon after therapy ended," so long-term effects are not known. However, comparison was made between two different programs (interpretive and supportive therapy), and patients in both programs improved in both grief symptoms and general outcomes.

In conclusion, the more recent studies are quite consistent with and confirm the patterns that we identified in 2001.[15] The quality of investigation has improved somewhat since the last review, and we identified a few well-controlled studies among the still large number of weak studies. More fine-grained patterns are beginning to emerge. For example, newer studies suggest that the impact of intervention is greater for girls than for boys.[23–25] Future studies should also examine the interaction of gender and type of therapy. There has been continued focus on the efficacy of intervention for bereaved children. Newer studies support our earlier, tentative conclusion[15] that not only secondary and tertiary but also primary prevention may be effective for children.[25] However, as Curtis and Newman[19] concluded, the case for universal inclusion in support programs remains unproved, and the basis for referral needs careful evaluation.

GENERAL CONCLUSIONS

A number of implications can be drawn from our review of the efficacy of primary, secondary, and tertiary preventive intervention programs. First and foremost, the notion that routine intervention should be given simply on the basis that an individual has experienced a bereavement has not received support from quantitative evaluations of its efficacy and is thus not empirically based. This conclusion is endorsed by other reviewers[16,17] and by leading experts. According to Raphael and colleagues[10] "there can be *no justification for routine intervention* for bereaved persons in terms of therapeutic modalities—either psychotherapeutic or pharmacological—because grief is not a disease" (emphasis added). Similarly, Parkes[30] stated, "There is no evidence that *all* bereaved people will benefit from counseling and research has shown no benefit to arise from the routine referral of people to counseling for no other reason than that they have suffered a bereavement." He went on to conclude: "To be of benefit counseling needs to be provided for the minority of people who are faced with extraordinary stress, who are especially vulnerable and/or see themselves as lacking support." Children are likely to be a special case, perhaps benefiting even from primary intervention. However, indications are that not all children need or benefit from intervention, and strategies of inreaching and screening for risk would seem to be advisable.

Our second conclusion is that provision of intervention soon after bereavement may interfere with natural grieving processes. Third, outreach strategies have not been shown to be effective and are therefore not generally advised. Almost without exception the studies with less favorable results have been those that used this procedure, while inreaching interventions have continued to show better results. Those who seek out and ask for help are likely to be motivated and to have trust in counselors or therapists. They may have suffered more and have a greater need for help. However, provision of an intervention should be carefully evaluated even for those who feel that they need it and who request it. Finally, the more complicated the grief process, the better the chances that an intervention will be effective. These conclusions all emerge from a comparison of the general effectiveness of primary, secondary, and tertiary prevention programs.

Research improvements still need to be made. Bereavement intervention programs themselves should be tightly designed, and studies evaluating their efficacy should follow stringent design and methodological principles. Interventions that are based on "inreaching" need further development to see whether efficacy can be improved to match interventions with an "outreaching" strategy. Furthermore, systematic comparison of the relative effectiveness of different therapeutic approaches is needed. We need to establish answers to the question, "*What works for whom?*" We also need better identification and understanding of "risk factors" as well as a theoretical frameworks to guide our research. Finally, American Psychological Association (APA) guidelines (including ethical principles) should be applied to implementation of grief intervention programs as well as to the investigation of their effects.

More than a decade ago, Robak[31] criticized the bereavement research field for failing to provide empirical studies on psychotherapy and counseling: "This is a troubling state of affairs, as it confirms an important discrepancy between science and practice in psychology and perhaps even indicates that practitioners are practicing without being informed about loss, death and bereavement through empirical work. . . . Not everything in print is research! Therapists, counselors, and educators should reexamine the database for their assumptions. Where are the empirical studies? They are not in psychotherapy and counseling."

Although small steps in the right direction are now being taken, this fundamental message still holds. To create a body of sound scientific knowledge, the research agenda for the future must expand the number of well-designed and executed empirical studies on the efficacy of bereavement intervention.

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